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◆ Deadline: 5:00 pm (CST), March 1, 2014.
◆ Late submissions are not permitted. There are no considerations made for “late-breaking abstracts.”
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Titles and locations current at the time articles were submitted for publication.
Looking forward

by David B. Hoyt, MD, FACS

As the New Year approaches, Fellows and staff of the American College of Surgeons (ACS) can look back at 2013 and take pride in the achievements that have occurred over the past year. Details of these accomplishments are summarized in the Executive Director’s annual report on pages 19–30, but for those of you who are time-pressed, I would like to provide this brief overview.

Advocacy and Health Policy
Congress again postponed repeal and replacement of the flawed sustainable growth rate (SGR) formula used to calculate Medicare physician payment. The ACS has continued to lead efforts to eliminate the SGR and is one of the few physician organizations to have testified before the three congressional committees with jurisdiction over Medicare: Senate Finance, House Energy and Commerce, and House Ways and Means. At those hearings, in meetings with committee staff, and in written correspondence, the College has advocated for implementation of a Value-Based Update (VBU) proposal—a patient-centered model aimed at improving quality while controlling spending.

Payment reform and the VBU were widely discussed at the College’s second annual Advocacy Summit this past spring in Washington, DC. More than 200 ACS members attended, and most of these participants met with their U.S. legislators and congressional staff to advance the College’s advocacy agenda.

In addition, the College published several important advocacy and health policy resources.

A special issue of the Bulletin (March 2013) focused on liability issues, drawing from discussions that occurred at an October 2012 Medical Liability Reform Summit. The ACS also issued two policy-related primers—one on surgeons as institutional employees and one on emerging payment models.

Research and Optimal Patient Care
The College’s National Surgical Quality Improvement Program (ACS NSQIP®) presented its largest annual conference in July and recently introduced a surgical risk calculator for assessing the likelihood of a patient experiencing complications. Another ACS quality improvement tool, the ACS Surgeon Specific Registry, has been endorsed for use in the Centers for Medicare & Medicaid Services Physician Quality Reporting System.

The Committee on Trauma played an integral role in development of a revised ACS Statement on Firearm Injuries issued in response to the increasing number of mass-casualty events. In related activity, the College helped to lead the formation of a Joint Committee to Create a National Policy to Enhance Survivability from Mass-Casualty Shooting Events, which has issued two reports known as the Hartford Consensus I and II.

Earlier this year, the National Accreditation Program for Breast Centers (NAPBC) announced that it had accredited more than 500 breast centers in 48 states. The NAPBC projects 80 new accreditation applications in the coming year and plans to expand its reach to international centers, starting with pilot sites in Montreal, QC; London, UK; and Dubai, UAE.

The ACS Clinical Research Program continues work on the Surgical Standards Manual, which will outline op-
erative standards for clinical trials, surgical practices, and CoC accreditation programs. The manual also will cover oncologic principles, operative techniques, and surgical checklists.

**Member Services**
The Board of Governors (B/G) finalized a plan aimed at revitalization. Central to the redesign is a focus on leadership in advancing the five Pillars of the ACS: Member Services; Education; Advocacy and Health Policy; Quality, Research, and Optimal Patient Care; and Communication. Likewise, the College intends to re-activate and better coordinate the chapters.

To expand the College’s global outreach, the International Relations Committee played an instrumental role in presenting an International Surgical Leaders Forum in July at the College’s Washington (DC) Office. This conference attracted 19 presidents of large international surgical societies, who discussed areas of mutual concern and the prospect of forming a global surgical coalition.

**Integrated Communications**
ACS staff and consultants have been working diligently to redevelop the College’s Web properties, convening more than a dozen stakeholder meetings to assess the background, goals, and expectations for the project. Some of these meetings centered on integrating the content currently accessible through the Web portal into the public website to provide members with a state-of-the-art online physician community. Several focus groups convened during the Clinical Congress to help ensure widespread appeal. The new website is scheduled to launch in May 2014.

In April 2013, the College published *ACS Inspiring Quality Tour: Lessons Learned in the Pursuit of Quality Surgical Health Care*, which summarizes best practices and case studies gleaned from ACS Surgical Health Care Forums. These forums have proven invaluable in terms of increasing awareness about the College’s commitment to quality improvement and enhancing our influence in health policy circles.

**Other activities**
The ACS Foundation continued to seek out innovative ways to recognize individuals who provide financial support for the College’s scholarship programs. A highlight of the last year was establishment of the 1913 Legacy Campaign in honor of the College’s Centennial and to benefit The Surgeon, The Profession, and The Societal Good (see related news story, page 59).

Many areas of the ACS are engaged in performance improvement (PI) activities. One major College-wide undertaking involved establishing and training staff in the ACS Values of Professionalism, Excellence, Innovation, Introspection, and Inclusion.

The ACS continues to undergo transformative changes aimed at ensuring that College Fellows can continue to provide optimal care to their patients now and in the future. We look forward to building on the momentum of the Centennial into the New Year and the next century.

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

THE SURGEON OF THE FUTURE:

Anchoring innovation and science with moral values

by Carlos A. Pellegrini, MD, FACS, FRCS(l)(Hon)
I believe that the lessons I have learned in my work as a surgeon and my involvement with our College will be useful to some of you as you move into this new era of your life, the one after Fellowship.

I want to offer my heartfelt congratulations to the 1,622 Initiates, now new Fellows of the American College of Surgeons (ACS), and to their families and their friends. I also extend my warm welcome to the new Honorary Fellows, and my sincere thanks to all those of you who chose to join this celebration.

Few events in our lives become permanently etched in our memory. Those events define for a person or for an organization a before and an after in their life cycle. Those are the events that make history. Tonight, we are gathered here to celebrate two such events. For our organization, the American College of Surgeons, it is the celebration of its 100th year. Indeed, on a night like tonight, in the fall of 1913, the College celebrated its first Convocation and admitted 1,065 initiates from Canada and the U.S. and five Honorary Fellows. For you, the new Fellows, it is the celebration of an incredible achievement: not only did you manage to get through college, medical school, residency training, and board certification, but you also became sufficiently established in your communities to be recognized by your peers and elected to Fellowship in this College.

Tonight, I would like to highlight the significance of this event for both the College and the Fellows.

I hope you all feel as proud as I felt in 1982 when I was initiated as a Fellow of our College. I also hope that our organization's shining past will illuminate the path forward for all of us.

Now let me turn to you, the new Fellows of our College. You are exceptional, and you are diverse. You are exceptional in that this group totaling 1,622 Initiates is one of the largest ever admitted to Fellowship. You are diverse in age, gender, interests, and origins. As for age, you span generations X, Y, and the Baby Boom, and although the great majority of you are younger than 50 years of age, we welcome 24 new Fellows who are older than 60. As for gender, 321 of you are women—the largest number ever admitted to the College in one group. As for your interests, you represent 14 specialties of surgery. As for your country of origin, 1,276 of you are from the U.S. and Canada, and 346 come from 55 countries around the world. To wit: 110 from Latin America, 111 from Asia, 72 from the Middle East, 37 from Europe, four from Australia and New Zealand, and 12 from Africa.

The future of surgery and surgeons

Now I want to talk about your future. I do not pretend to have a crystal ball, and I would much prefer to have a conversation with you rather than give a lecture, but due to the physical impossibilities of the former, we will have to settle for the latter. I believe that the lessons I have learned in my work as a surgeon and my involvement with our College will be useful to some of you as you move into this new era of your life, the one after Fellowship. There are three general aspects of your future I would like to touch upon. First, I want to describe some of the major forces affecting the practice of surgery in the course of the next decade or two. Second, I want to convince you that you can shape your future, you can craft it, and you can define it. Third, I want to suggest to you that this College, your College, provides you not only with the best and most comprehensive platform to leverage your quest in shaping your future, but also provides you with a set of values that can serve as your moral compass. To accomplish this task I will reflect on the past as needed, I will examine some aspects of our current practice, and, when discussing the future, I will describe it as I wish it to be: aligned with our noble mission—a mission that has not changed during the course of our history and I believe should not change in the next 100 years.

Major forces affecting surgery

Some significant forces are changing the way we practice surgery in a manner that I believe will significantly impact the way you will practice in the next decade. I have chosen three as examples that will affect all of you equally, regardless of country of origin or site of practice. These external influences reflect for the most part advances in medicine, and I am not here to criticize...
them, but rather to describe them. Surgeons need to know and understand them to better position themselves and the profession, and although they may pose challenges, I am an optimist and to paraphrase Winston Churchill, every challenge also represents a great opportunity.

Innovation and “the white waters” phenomenon

The introduction and adoption of new ideas, techniques, and devices has resulted in monumental progress in medicine and surgery. For many years, however, the pace at which innovation occurred allowed for intervals of time to test and validate the new idea and, when useful, to design educational and training methods that ensured its safe adoption. In some ways it resembled a trip down a river with rapids interspersed with waters of relative tranquility in which to recover. The pace of change has increased substantially over the last few years, and I predict that this pace will only accelerate in the future: the equivalent of navigating permanently in white waters.

However, it is not change, but the nature and pace of it that poses a significant challenge for the surgeon of the future. On the one hand, many innovations end up in failure, as they do not survive the test of time. On the other hand, failure to seize an opportunity can have catastrophic effects on a surgeon’s practice. Thus, decisions need to be made fast, and they need to be right. ACS Regent Gerry Fried, MD, FACS, FRCS(C), suggests that, when faced with the dilemma of whether to adopt a new idea or technique, the surgeon should consider four basic questions:

- Does this innovation fulfill a clinical need?
- Does it add value to the existing options?
- Is it financially viable?
- Can it be adopted by the average surgeon with relative ease?2

Your College, through its Program Committee and the Division of Education, under the leadership of Ajit K. Sachdeva, MD, FACS, FRCS(C), is constantly scanning the horizon for new ideas and developing appropriate programs to train Fellows.
ning the horizon for new ideas and developing appropriate programs to train Fellows. The meeting you are about to attend this week with its many offerings is one example. The network of Accredited Educational Institutes that your College has created and which now extends beyond the U.S. and Canada to include Europe, Asia, and the Middle East is another example of the rich platform you can use to advance into your future. Adapting to rapid change and learning how to choose the right path is as imperative to your survival and growth as avoiding boulders and finding the right currents is for those navigating white waters.

**Blurring of the boundaries**

As the specialties of medicine developed during the 20th century, they did so within well-established boundaries. For example, when I started the practice of surgery, we all knew that there was a clear delineation between what I did as a surgeon—primarily open operations—and what most of the medical specialists did—primarily diagnostic and noninvasive therapy. However, in the latter part of the last century, as innovation led to the development of new ideas, methods, and devices, the boundaries between specialties started to blur. The treatment of common bile duct stones, once the domain of the general surgeon, became part of the practice of a gastroenterologist; the treatment of intra-abdominal abscesses or the placement of central venous lines, done only by surgeons in the past, was now in the hands of interventional radiologists.

In some of these situations, the loss to surgery was caused by our failure to seize new opportunities. Many surgeons felt that retreating to the operating room and continuing to use the tools of the past was better than retraining and embracing the future. These boundaries continue to fade away, and my prediction is that the process will accelerate in the future. We see signs of it when we look at who cares for our complex patients in the intensive care units today or who uses the new endoscopic techniques to treat incipient mucosal cancers of the gastrointestinal tract. I believe that surgeons should think of themselves as uniquely qualified to perform interventions—interventions that may be done by the open approach, or through endoscopes, or through percutaneous approaches, or through natural orifices. Surgeons, in essence, should become what Thomas R. Russell, MD, FACS, former Executive Director of our College, called “interventional biologists.”

And I am happy to say that we have made progress in this arena. General surgeons are continuing to develop minimally invasive approaches. More recently, vascular surgery has transformed from a traditional open approach to image-guided endovascular approaches. These changes have had a major impact on the survival of patients with vascular disease. We must continue with this strategy. As I see it, the intelligent surgeon of the future will be someone who embraces the management of diseases, not just the use of techniques, and will also be someone who becomes knowledgeable of, and masters all, diagnostic and therapeutic aspects of his or her specialty beyond traditional boundaries.

**Quality, cost, and accountability**

The third major force that will impact your future practice is society’s increased concern with improving the quality while controlling the costs of care. Given that the practice of surgery involves greater risk than most other specialties, preserving and improving safety and being able to measure quality in a reliable way will continue to be an essential part of practice. Furthermore, since we do use substantial resources to fulfill the needs of our patients, our institutions and our society at large will put pressure on us to be accountable for these expenditures.

Michael Porter has defined “value” as the ratio between outcomes and costs. In his book, *Redefining Health Care*, he urges us to focus on outcomes and to measure them “systematically and comprehensibly.” As we do so, I predict that the measurement of outcomes will switch from the current focus on objective outcomes as determined by the profession to a focus on outcomes as determined by patients and employers. For example, when undergoing spine surgery for back pain, it will not just be a demonstration of fusion on X rays, but the relief of pain and the ability to return to work that will matter; when undergoing anti-reflux surgery it will not just be the normalization of esophageal pH, but the complete relief of heartburn as perceived by the patient. This is the “new” accountability
Tonight I am here to tell you that the path you have chosen, which is the same I chose, is a most rewarding one and that, given the chance, I would do it all over again.

of our craft: accountability for quality, for safety, for costs, and for outcomes.

Delivery of this type of care cannot be done by individuals acting alone; it requires the development of teams, high-performance teams. These teams require leadership. Not the authoritarian leadership of the past but the kind of leadership that fosters exceptional communication, mutual respect and support, and the development of the best and most straightforward ways to achieve the goals of the mission: improving the health of our patients. Leadership is an area that needs our direct involvement, and the smart surgeon of the future will devote a substantial portion of his or her time to the study of qualities of effective leaders, to the development of emotional intelligence, and to the improvement of so-called non-technical skills.

Your College is deeply involved in these areas and has developed the infrastructure to support it. I encourage you to get involved, not only because it will help your future, but because it is the right thing to do for our patients and our society.

Shaping your future
It is my hypothesis that, to a great extent, each of us has the opportunity to create the future. True, there are external influences, some of which I described earlier, over which we may not have total control, but our direct involvement will help to modulate those forces and change the outcome they would otherwise produce. Of course, there are pessimists who will tell you that the sky is falling. They usually start by pointing out how much the world has changed, how perfect things used to be, and how little reward you are likely to get for the many hours you will be working. Furthermore, they will suggest that there is nothing you can do to change things. They will portray us surgeons as victims. I ask you, using the words of former U.S. Secretary of State and retired U.S. Army General Colin Powell, to “reject the easy path to victimhood.” It is unappealing to the rest of society and leads nowhere.

Tonight I am here to tell you that the path you have chosen, which is the same I chose, is a most rewarding one and that, given the chance, I would do it all over again. Indeed, I feel extremely privileged for having been given the opportunity to touch so many lives,
for having my patients entrust me with their most valuable asset: their health. And I am here to tell you that there is not enough money in the world to provide that satisfaction, the satisfaction of helping someone in need. I am also here to tell you that the future is not predetermined, that your future can be shaped and that each of you can make it happen. “What you do makes a difference,” as Jane Goodall says. “...You have to decide what kind of difference you want to make.” You may not be able to achieve everything you want as you work to define the kind of health care system that will best fit the needs of your nations, but you should set for yourselves the highest goals and travel in that direction for as far and as long as you can. That is the only way to make a difference, one little bit at a time.

So, next time you see something that needs fixing, get involved rather than blame the system. Follow the advice of the famous proverb, “It is better to light one candle than to curse darkness.” Then exercise your leadership, recruit others to light more candles, and sooner than you know it you will have illuminated a path for a better future.

Your College, your platform, your moral compass
I hope that throughout my talk tonight I have shown you a few of the many areas in which your College, under the excellent leadership of its Executive Director David B. Hoyt, MD, FACS, has developed the infrastructure to help you deal with the forces of change. Whether it is through the Division of Education filling the gap between your practice and the current state of knowledge; or through the Division of Research and Optimal Patient Care with its measurements of quality, safety, and costs; or through the Division of Advocacy and Health Policy efforts to help modulate the implementation of policy that will influence the provision of health care; or through the Division of Member Services with its focus on you, your chapters, your projects—the College provides you with the right platform to exercise your leadership. My call to action today is for you to get involved and to get involved now, at this stage of your lives, to help you and your patients by defining an ideal future. As you travel this path you will need a moral compass, something that you can use to guide your actions and to help you distinguish right from wrong.

The American College of Surgeons staff has led by example this last year when through a thoughtful and well-defined process that lasted six months, they identified a set of values that they have made their own. These values I believe reflect not only the ideas of the great staff of our College, but I hope they also reflect their observation of the values expressed by the many surgeons with whom they have worked so closely. As I have had an opportunity to examine them I realize that they speak for me, as a surgeon, as much as they speak for our College staff. I offer the five values to you tonight:

- **Professionalism:** Professionals exemplify the highest standards of honesty, responsibility, respect, and accountability. The importance of professionalism to us surgeons was highlighted by LaMar S. McGinnis, Jr., MD, FACS, in his Presidential Address when he pointed out that it is “what sustains us, embodies us, invigorates us, and carries us onward.” To me, personally, professionalism is about caring. It is, as others before have eloquently put it, at the heart of medicine for “patients will not care how much you know until they know how much you care.”

- **Excellence:** Our staff believes excellence represents an aspirational goal—the goal to always exceed internal and external standards and the expectations of others. I can think of very few values that associate closer with what surgeons do every day than excellence. The relent less pursuit of perfection in everything we do should be a hallmark of a surgeon.

- **Innovation:** The staff defined innovation as the pursuit of creative and forward-thinking improvements to transform what we do for the better. We discussed earlier how influential the concept of innovation is for your future.

- **Introspection:** Through personal reflection, introspection allows human beings to explore their mind and their soul, to define the gaps that will motivate them to seek continuous self-improvement through professional development, self-assessment, and awareness.
• Inclusion: The active engagement of all appropriate individuals and entities to collaboratively harness collective intelligence is the hallmark of inclusion. The value of inclusion in today’s world cannot be overemphasized. Just respecting our differences with others as a matter of moral standards is not enough. We must embrace them, we must celebrate them, and we must cherish them, as they are the vehicle to collective intelligence and creativity. I encourage you to do that, but at the same time I ask you not to forget who you are and where you came from. Inclusiveness is not a matter of letting yourself disappear into a melting pot. You must also preserve and cherish what is different about you, your accent, your beliefs, your ways. Respecting and embracing others can best be done when you have respect for yourself and your values. It is time for the ACS to embrace other organizations with like-minded values, for physicians to learn how to work together with all other health care professionals in high-performance teams. It is only by gathering the minds and the energy of all involved that we shall succeed as a profession and as a society.

These five values can be summarized for those of you with a mathematical mind in the formula P + E + I’.

Every recent ACS President has had a theme for his or her year. Mine is the “The Surgeon of the Future: Anchoring Innovation and Science with Moral Values,” and I offer to you humbly the values I described to be used as your moral compass.

Ladies and gentlemen, as I reach the end of my remarks I want to congratulate you again on achieving Fellowship in this great organization. You can now proudly use the letters “FACS” after your name, indicating that you are a Fellow of the American College of Surgeons or, as ACS Past-President Gerald Healy, MD, FACS, so nicely put it, you are “Forever A Caring Surgeon.”

There are many challenges ahead, but I hope I have convinced you that we can face them and succeed. We are all in this together. You should trust what is inside of you. I trust you, and, as Christopher Robin said to Winnie the Pooh, “You must always remember: you are braver than you believe, stronger than you seem, and smarter than you think.” You, my friends, have the power to change the world.

REFERENCES

Fellow pays tribute to ACS and citizen surgeons

by Alexander Stojadinovic, MD, FACS

Editor’s note: At the request of Carlos A. Pellegrini, MD, FACS, FRCS(Eng)(Hon), President of the American College of Surgeons (ACS), Dr. Stojadinovic delivered a tribute to the American College of Surgeons and all citizen surgeons at the President’s Dinner during the 2013 Clinical Congress in Washington, DC. The following is an edited version of that presentation.

Distinguished guests, given the magnitude of these ceremonies and the celebration of the ACS’ 100th anniversary, I am honored and humbled to speak with you tonight.

I would like to take a quick moment to thank my fellow servicemen and women for their dedication and sacrifice to our nation.

On Memorial Day, I wrote this tribute. Perhaps I was overwhelmed with the spirit of that solemn day of remembrance for all of the blessings that have been bestowed upon me and my gratitude to be an American.

Nation of immigrants

I reflected upon a common thread that brings us together, binding us all into one, with the reality that we are a nation of immigrants.1 We or our forbears ventured to this land often with little or nothing, hoping for a better life and to establish a legacy to pass on to the next generation and generations to come.

Tonight, I dedicate this tribute to the late Peter Fiore, MD, FACS. Like many of us and our predecessors, Dr. Fiore and my mentor’s father, Sam Paletta, MD, served together during World War II. (Personal communication with Christian Paletta, MD, FACS, May 27, 2013.)

Dr. Fiore was a Brooklyn, NY, surgeon, a son of Italian immigrants. He, like so many citizen surgeons of his generation, left private practice to serve his country in time of war. After he returned to the U.S. from the front lines, Dr. Fiore continued to serve as a battalion surgeon, and when he returned to Brooklyn, he applied the knowledge gained in wartime service in his civilian practice.2

As a son of immigrants, Dr. Fiore understood and lived the American dream—a dream that comes with the understanding that this gift of freedom is not free, that many before us laid down their lives to protect our freedoms, and that the American dream is truly realized when one is dedicated to improving the lives of others. Dr. Fiore personified dignity, compassion, and high moral principles throughout his life of service.

We are honored to have with us tonight Dr. Fiore’s son, Andy Fiore, MD, FACS, a distinguished pediatric cardiothoracic surgeon at Saint Louis University, MO, and Fellow of the College. Andy, my humble thanks to you and your family for the gift of service you have given our nation.
Surgeons of the College have answered the call to duty throughout the organization’s history. These citizen surgeons have rendered excellent care to our service members who have borne the visible and invisible wounds of war.

As in Dr. Andy Fiore’s case, many present tonight have family members who have served in uniform, even as fewer of America’s citizens serve in the all-volunteer military.

Notwithstanding, the very fact that I was invited to attend this momentous occasion by ACS President-Elect Carlos A. Pellegrini—himself a son of immigrants, a leader, and citizen surgeon who served in uniform—that I was asked to present to our College, and that I am standing before you this evening to share a message of gratitude, of dedicated service to our fellow man, of solemn tribute to our College, clearly shows that “we are one.”

Called to serve

We gather at times like these to honor a long and distinguished history of service and leadership. Tonight, the American College of Surgeons celebrates 100 years of service, particularly the dedicated service to our nation in time of war.

Surgeons of the College have answered the call to duty throughout the organization’s history. These citizen surgeons have rendered excellent care to our service members who have borne the visible and invisible wounds of war.

One among them was the late C. Rollins Hanlon, MD, FACS, a former Director of the College and protector of its history, who served in the U.S. Navy during World War II.¹

I dedicate the following tribute to these surgeons, to all men and women—past, present, and future—who have and will shed their civilian roles and don a uniform to serve our country to, as Abraham Lincoln so aptly articulated in his second inaugural address, “…bind up the nation’s wounds…to care for him who shall have borne the battle, and for his widow, and his orphan…”²

I am blessed to stand before this distinguished audience in the uniform of a U.S. Army soldier. I am here, however, representing all citizen surgeons who have worn the uniform for their respective nation.

These citizen surgeons ventured bravely into battle to care for soldiers and innocent civilians alike. Citizen surgeons went into harm’s way not by choice, but rather because of an obligation greater than themselves, bearing witness to events that would forever change them.

Dr. Peter Fiore, a son of immigrants, was one of those citizen surgeons. Like so many of his generation, he is no longer with us. But he answered the call to duty and served honorably as a citizen surgeon, having spent 11 months in General George Patton’s Third Army, providing lifesaving care to American and German soldiers, as well as countless civilians caught in this terrible strife.

The calling of citizen surgeons, even in war, is unquestionably focused on preserving life and human dignity. Swiss businessman and social activist Jean Henri Dunant understood this calling. He witnessed the carnage at the Battle of Solferino in 1859, which changed his life forever. The lasting memory of “chaotic disorder, [unspeakable] despair and misery of every kind” inspired Mr. Dunant to envision the establishment of the Geneva Convention, for which he was a co-recipient of the first Nobel Peace Prize.³

In the Declaration of the Geneva Convention there is a solemn pledge to devote one’s life to serving humanity—to do all that one can possibly do to honor the traditions of our profession. This is precisely what the citizen surgeons of the American College of Surgeons have done during their 100 years of service and leadership, which has been an object example for surgeons the world over.

Wartime advances in surgery

Indeed, notable progress has been made during wartime, and our College’s century of service has led to transformational advances in military and civilian surgical practice. Truly, “the only victor in war is medicine.”⁴ George Crile, MD, FACS, a founder of the ACS, extended this concept, stating that more progress has been made in surgery from lessons learned during armed conflict than has been achieved by an entire generation.⁵

Time does not allow me to cover all advances in surgery over that century, and the multitude of indi-
The College played leading roles in communicating lessons learned on the battlefield broadly and implementing systematic programs to improve the education, organization, and delivery of civilian and military trauma care through such efforts as the Advanced Trauma Life Support® course and the Committee on Trauma’s civilian trauma center training programs to ready surgeons for combat surgery.

Individuals and institutions that have earned the credit for this progress. I would be remiss, however, if I didn’t recognize a few visionary leaders whose wartime surgical advances make possible tributes such as this to citizen surgeons of the College.

Since World War II, we have seen advances in antibiotics, surgical staplers, the development of battlefield blood banks, and the deployment of skilled citizen surgeons to front lines close to point of wounding. During the Korean War, helicopter evacuation significantly reduced time from wounding to definitive care and enabled transformational advances in the treatment of vascular injuries. In 1958, Carl Hughes, MD, FACS, reported incredible limb salvage rates, historically unattainable with treatment of wartime arterial injuries.8

As a medical student I was inspired by a 1970 report that Norman Rich, MD, FACS, wrote on using data from his Vietnam Vascular Registry on 1,000 casualties treated for combat arterial injuries. During Vietnam, significant advancements emerged in surgery, including helicopter evacuation and improvements in burn care and treatment of related infections at the Burn Unit at Brooke Army Medical Center, Fort Sam Houston, TX, under the leadership of Basil Pruitt, MD, FACS.

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The wars in Iraq and Afghanistan represent the longest continuous commitment of military medicine in our nation’s history. During these wars, significant advances in the integrated, coordinated, and multidisciplinary care of our wounded troops produced the lowest combat case fatality rates in the history of warfare.

Proven advances in civilian trauma system care have translated to the modern-day battlefield. Examples include the following:

• Rapid control of traumatic hemorrhage through damage control resuscitation and damage control surgery
• Rapid external fracture fixation, advanced wound care, and limb salvage across the continuum of care made possible through such advances as Critical Care in the Air
• Health information technology
• Trauma registry across echelons of care
• Remarkable advances in computer and robotic technology evident in lower-extremity prosthetics.

And as citizen surgeons have answered the call with ingenuity and solutions to complex problems, their family members have stepped up to the challenge as well. One telling recent example is Maribeth Russell Hoyt, the spouse of ACS Executive Director David B. Hoyt, MD, FACS. Beth has dedicated her life to improving the lives of others through leadership, advocacy, and innovation to support our veterans suffering the invisible wounds of war.

TIME magazine recently published a special article on the healing power of community public service for our wounded warriors and veterans. The article, “Can service save us?” by Joe Klein, suggests that service changes people.10 Reaching beyond self in service to others is personally enriching and therapeutic.

The lessons citizen surgeons learn on the battlefield extend beyond medicine itself. Lewis Flint, MD, FACS, recently reported on his survey of surgeons serving in conflicts since World War II. Almost all surgeons who participated in the study reported that wartime service had a profound effect on them, making them better people, improving their surgical skills, and expanding their understanding of teamwork.7

Dr. Flint said that the “experience of caring for the injured soldier gave the [citizen surgeons] a new perspective on what a ‘call to duty’ really means.”7

This is a compelling reminder of how service to others is a rich source of inner growth and healing.
Many of us can relate to life experiences that provided us with keen insights into how life-changing “real service” truly is.

One of the best-known poems of World War I was “In Flanders Fields,” written by the Canadian physician Major John M. McCrae. He was inspired to write this poem after presiding over the funeral of fallen friend and fellow soldier, Lieutenant Alexis Helmer.11,12 Mr. Helmer had, as President Lincoln put it, “borne the battle” and paid the ultimate price at the Second Battle of Ypres.5,11,12

From this poem, I share with you this charge from a fallen citizen surgeon who left us timeless words of wisdom and inspiration:11,12

Take up our quarrel with the foe:
To you from failing hands we throw
The torch; be yours to hold it high.
If ye break faith with us who die
We shall not sleep, though poppies grow
In Flanders Fields.

We owe a debt of gratitude to all the men and women who have answered the call to duty and have borne the visible and invisible enduring wounds of war.

All of us who proudly wear and have worn the uniform have learned from those who have walked and fought before us that we are sworn to defend our nation’s life, liberty, and the pursuit of happiness.

Military strategists have often said “no plan survives contact with the enemy.”

Much of this is based upon knowledge from our nation’s battlefields.

I salute the American College of Surgeons on this day of tribute and celebration of its century of service and leadership.

With appreciation for my blessings, and
In the spirit of St. Luke,
The patron saint of physicians
Knowing that
“to whom much is given, much is expected”

I proudly, and humbly, thank you for your attention and the privilege of the podium. ♦

REFERENCES


Executive Director’s annual report

by David B. Hoyt, MD, FACS
The ACS has continued to lead efforts to eliminate the SGR and is one of the few physician organizations to have testified before the three congressional committees with jurisdiction over Medicare: Senate Finance, House Energy and Commerce, and House Ways and Means.

Advocacy and Health Policy

As the American College of Surgeons (ACS) concludes its Centennial celebration, College Fellows and staff can take pride in the many achievements the organization has made both in the last 100 years and the last 365 days. Highlights from October 2012 to October 2013 follow.

• A keynote address by Bob Woodward, Pulitzer Prize-winning journalist for The Washington Post

• A political luncheon featuring Politico’s chief White House correspondent and author of the Politico Playbook, Mike Allen

• Addresses by U.S. Reps. Kevin Brady (R-TX), Chair, House Ways and Means Health Subcommittee; Larry Bucshon, MD, FACS (R-IN); and Ami Bera, MD (D-CA)

Physician payment continues to be of great concern to the College. Congress again postponed repeal and permanent reform of the flawed sustainable growth rate (SGR) formula used to calculate reimbursement when it passed the “fiscal cliff” legislation on January 1, stalling the 27 percent cut in Medicare reimbursement and freezing payment through December 31. The ACS has continued to lead efforts to eliminate the SGR and is one of the few physician organizations to have testified before the three congressional committees with jurisdiction over Medicare: Senate Finance, House Energy and Commerce, and House Ways and Means. At those hearings, in meetings with committee staff, and in written correspondence, the College has advocated for implementation of a Value-Based Update (VBU) proposal—a patient-centered model aimed at improving quality while controlling spending.

HIGHLIGHTS

• Summarizes the College’s activities from October 2012 to October 2013

• Describes the ACS’ advocacy efforts, including the development of a Value-Based Update for use in reforming the Medicare physician payment system

• Provides an overview of the College’s educational activities for medical students, residents, and practicing surgeons, as well as for those individuals transitioning from one phase of their training and career to the next

• Outlines the progress that the College is making in promulgating its quality improvement, cancer, and trauma programs

• Presents details on the activities of the ACS Board of Governors, the Advisory Councils, chapters, and other programs managed through Member Services

• Offers updates on the College’s website redevelopment efforts and other communications-related programs

• Describes the College’s development activities, including the initiation of a 1913 Legacy Program
The ACS also commented on multiple drafts of a joint proposal put forth by the House Ways and Means and Energy and Commerce Committees. The plan would start with elimination of the SGR followed by a period of stability and incremental change. This summer, the Energy and Commerce Committee unanimously approved an iteration of the proposal—the Medicare Patient Access and Quality Improvement Act. At press time, the House Ways and Means and Senate Finance Committees had yet to weigh in on the proposal or offer an alternative.

On November 1, 2012, the Centers for Medicare & Medicaid Services (CMS) released the final rules on the 2013 Medicare physician fee schedule (MPFS) and the 2013 outpatient prospective payment system (OPPS) for hospitals and ambulatory surgical centers (ASCs). Under the final MPFS, without congressional action on the SGR, payments to physicians would have been reduced by 26.5 percent. Other changes in the final MPFS call for reviewing the evaluation and management portion of global surgical payments and finalizing the physician valued-based payment modifier, which, starting in 2015, will pay groups of 100 or more physicians based on the quality and cost of care. The final MPFS also modified aspects of the Physician Quality Reporting System (PQRS), the e-Prescribing (eRx) Incentive Program, and the Physician Compare website.

The ACS, in collaboration with other surgical professional societies, submitted comments on the MPFS final rule supporting the inclusion of the Consumer Assessment of Healthcare Providers Survey (CAHPS) for Surgery as a measure to be reported for the PQRS group practice reporting option and posted on Physician Compare.

Under the OPPS/ASC final rule, CMS increased hospital outpatient payments by 1.8 percent and ASC reimbursement by 0.6 percent. CMS solicited and received comments on how to determine whether a patient’s status is designated as outpatient or inpatient but made no policy changes. CMS also finalized a list of 25 procedures for inclusion in the ASC list of covered surgical procedures. In May, the ACS submitted a letter to CMS requesting that eight laparoscopic colectomy-related codes be added to the list of procedures that must be performed on an inpatient basis to qualify for Medicare reimbursement.

The College continues to encourage physician participation in CMS’ PQRS, electronic health records (EHR), and eRx programs. The fiscal cliff legislation discussed previously would allow physicians to meet PQRS requirements through participation in specialty registries beginning in 2014. In a related effort, the ACS responded to provisions in the Tax Payer Relief Act on the use of clinical quality measures reported under PQRS and the EHR Incentive Program, offering support for the expanded use of specialty registries for participation in these programs.

Rep. Diane Black, RN (R-MI), introduced legislation in November to address concerns regarding the EHR Incentive Program. H.R. 6598 would create a hardship exemption for small practices and physicians in and near retirement to avoid workforce shortages, shorten the gap between the performance period and the application of the penalty, expand options for participation in the Incentive Program, and establish an appeals process.

In December 2012, the College commented on physician training before the recently formed Institutes of Medicine Committee on Governance and Financing of Graduate Medical Education, chaired by Donald Berwick, MD, and Gail Wilensky, PhD. Among other topics, the ACS addressed shortages and maldistribution of surgeons and the effects of the 80-hour workweek on the readiness of surgeons emerging from training. A follow-up letter was mailed in January.

A special issue of the Bulletin featured articles drawn from the College’s Medical Liability Reform Summit in October 2012. Advocacy staff have been sharing these articles with congressional offices and using them in discussions aimed at jumpstarting action on liability reform. In addition, the ACS Legislative Committee formed a Liability Reform Subcommittee.

Other Advocacy and Health Policy highlights include:

- The ACS issued two policy-related primers: Surgeons as Institutional Employees: A Strategic Look at the Dimensions of Surgeons as Employees of Hospitals, which mailed with the February Bulletin, and Surgeons and Bundled Payment Models: A Primer for Understanding Alternative Physician Payment Approaches, which is accessible via the ACS Web portal.
The College also has played a critical role in addressing the transition from residency to practice and from medical school to training.

- Now in its third year, the Chapter Lobby Day Grant Program provided funding to the following ACS chapters: Alabama, Brooklyn/Long Island, Northern California, Connecticut, Florida, Georgia, Illinois, Indiana, Kansas, Massachusetts, Metro Chicago, New York, Ohio, Oregon, Tennessee, and Virginia.

- The 2013 Coding Workshop series began January 24. Course instructors have focused on simplifying the complexities of office and surgical coding as well as effective billing and collection processes.

**Education**

The ACS remains at the forefront in establishing benchmarks and standards for surgical education, training, validation, credentialing, and accreditation. Special attention is being directed at gaps, transitions, and vulnerabilities in the professional careers of individuals and within systems of care.

The ACS is advancing simulation-based surgical education and training and has been recognized for its innovative contributions to the field. The College played a pivotal role in the National Simulation Summit of the Council of Medical Specialty Societies in November 2012, during which participants established a framework for collaboration. Best practices are being identified and will be used in future efforts. Furthermore, the ACS contributed to the inaugural American Society of Anesthesiologists Simulation Education Network Meeting, and activities of the Consortium of ACS-accredited Education Institutes continue to advance simulation-based education and training.

The College also has played a critical role in addressing the transition from residency to practice and from medical school to training. In the aftermath of the July 2012 National Invitational Conference on Transition from Residency Training to Independent Surgical Practice, a committee was appointed and charged with designing a model for a one-year Transition to Practice Program in General Surgery. The education, training, and accreditation model for this program is in development. The program will launch in 2014.

The ACS has been collaborating with the Association of Program Directors in Surgery (APDS) and the Association for Surgical Education (ASE) to develop a Resident Prep Curriculum. Pilot testing of modules began in 2013, and the curriculum is being tested at 20 U.S. medical schools; another 20 will be added in 2014. The goal is to launch the final curriculum in 2015. Additionally, the College participated in a summit that the American Board of Surgery (ABS) convened to address preparation for surgical residency.

The ACS and ASE have developed a Medical Student Simulation-Based Surgical Skills Curriculum to train medical students to perform essential procedures. Modules have been developed for the first three years of medical school, and all 25 modules were released in April.

To address transitions during the five years of surgery residency training, the ACS/APDS National Surgical Skills Curriculum has been developed. Phase I modules addressing basic surgical skills and tasks are being revised, and valid and reliable assessment tools and new videos are being added. Phase III modules that address team-based skills are under review.

A number of educational programs and products are available for practicing surgeons. The 2013 Clinical Congress comprised 25 tracks and 11 Named Lectures, 105 Panel Sessions, and 28 Postgraduate Courses, as well as 37 Meet-the-Expert Luncheons and 12 Town Hall Meetings. New Postgraduate Courses focused on health care systems, non-technical skills for surgeons, and Maintenance of Certification (MOC). Two new sessions, 10 Hot Topics in General Surgery and What’s New in Advocacy and Health Policy: Top 10 Advances in the Past Year were added to the program. Original scientific work was presented at the Scientific Papers, Owen H. Wangensteen Surgical Forum, and Poster Presentation Sessions.

Approximately 1,700 speakers and faculty participated in the 2013 Clinical Congress. Webcasts of selected sessions became available following the Clinical Congress. In addition to continuing medical education (CME) certificates and certificates for participation in patient safety, trauma, and ethics sessions, certificates of verification based on the Division of Education’s five-Level Verification Program are available to
Postgraduate Course participants, and Self-Assessment Certificates are available to individuals who attended designated Panel Sessions.

The 2013 Clinical Congress was supported with an enhanced app that allowed attendees to more easily manage their schedules on handheld devices. Also, electronic evaluations replaced paper evaluations for certain sessions with the goal of having an entirely electronic process in place for 2014.

The ACS has been designing training programs for acquisition and maintenance of skills in new procedures and technologies. Systematic reviews of new technologies from the literature have been posted on the Division of Education Web page through the efforts of the Committee on Emerging Surgical Technology and Education in collaboration with the Australian Safety and Efficacy Register of New Interventional Procedures—Surgical.

Updates on other ACS educational programs for practicing surgeons are as follows:

• Surgical Education and Self-Assessment Program 15 was released at the Clinical Congress.

• The ACS Comprehensive General Surgery Review Course attracts more than 200 attendees annually.

• Selected Readings in General Surgery (SRGS) currently has 2,500 subscribers. An ACS Practice Guidelines Program has been added to SRGS and launched at the 2013 Clinical Congress.

• The 9th Annual Surgeons As Leaders Course took place in May, and the 19th Annual Surgeons as Educators Course was presented in September 2012.

The College offers several programs for surgery residents and medical students, in addition to the innovative curricula mentioned previously, including:

• Fundamentals of Laparoscopic Surgery™, a collaborative program between the Society of American Gastrointestinal and Endoscopic Surgeons and the College

• Essential Skills for Surgical Practice: A Primer for Residents presented at the Clinical Congress

• The Residents As Teachers and Leaders Course

• The Resident Award for Exemplary Teaching

• The Medical Student Program at the Clinical Congress, which features a competitive poster session

The Surgical Patient Education Program supports active involvement of patients and their families in health care, particularly postoperative care. The program includes the Home Skills Training Kits; Education for Better Recovery; Informed Surgical Prep brochures and e-learning materials; and a new professional training program.

The Program for Accreditation of Education Institutes continues to receive national and international acclaim for simulation-based education. There are 78 ACS-Accredited Education Institutes: 68 comprehensive and 10 focused. The Consortium of ACS-Accredited Education Institutes continues to pursue collaboration in curriculum, research and development, simulation and new technologies, and administration of simulation centers. The Sixth Annual Meeting of the Consortium of ACS-Accredited Education Institutes convened in March.

The Accreditation Standards and Criteria for the ACS Program for Accreditation of Education Institutes have been revised, and the new standards have been implemented. Also, the Criteria for the Accreditation of Fellowships within the Consortium of ACS-Accredited Education Institutes were developed.

The “My CME” program includes systems for tracking CME and other credits required by various regulatory bodies. A newly developed system allows ACS members to seamlessly transfer CME credits directly to the ABS. In 2012, the ACS accredited 1,844 activities that provided 24,000-plus credits to more than 140,000 physicians.

CQI

The College’s Continuous Quality Improvement (CQI) programs have experienced significant growth. More than 500 hospitals participate in the College’s National Surgical Quality Improvement Program (ACS NSQIP®),
The ACS NSQIP Surgical Risk Calculator now can be accessed at riskcalculator.facs.org. CMS has offered preliminarily acceptance of the risk calculator as a PQRS measure, and the College is working to incorporate ACS NSQIP variables into EHR with a focus on quality improvement.

and collaboratives in Tennessee, Florida, and British Columbia continue to show improvement. ACS NSQIP presented its largest annual conference in July 2013 with more than 1,000 participants. Next year’s meeting will take place in New York, NY.

The ACS NSQIP Surgical Risk Calculator now can be accessed at riskcalculator.facs.org. CMS has offered preliminarily acceptance of the risk calculator as a PQRS measure, and the College is working to incorporate ACS NSQIP variables into EHR with a focus on quality improvement.

The ACS continues to work with the American Society for Metabolic and Bariatric Surgery to further develop the joint Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program. More than 700 facilities participate in the program. Newly revised standards for accreditation have been released and a national strategy for quality improvement as reflected in a reduction in readmissions for bariatric surgery patients is under development.

The ACS Surgeon Specific Registry (SSR) has been endorsed for use in the PQRS. The ACS and ABS worked together to develop new PQRs measures, which CMS has preliminarily accepted. The College is progressively implementing these new measures into the SSR and plans are under way to develop the next set of measures for MOC and PQRs. Furthermore, after discussions with The Joint Commission, the College is evaluating the development of standard Ongoing Professional Performance Evaluation and Focused Professional Performance Evaluation reports.

Six Clinical Scholars are working on the next iterations of ACS programs, including developing individual surgeon metrics, generating “cost” and “value” metrics, leading pilot consortium/collaborative QI programs, merging different data sources, and producing educational materials.

Lastly, a quality manual is in development. An outline has been completed, and standards are in development.

Trauma

The Trauma Quality Improvement Program (TQIP®) launched successfully and now has 182 participants. Another 34 centers have applied for enrollment, and 38 centers are participating in a pediatric pilot. Furthermore, the ACS is working on a model for collaborative participation, which will include a contract addendum to define data sharing among participants.

The National Trauma Data Bank (NTDB®) now houses information on 837,391 patients. The NTDB has completed the transition to a quarterly data collection model, which will allow for more contemporary TQIP reports and data validation efforts. The National Trauma Data Standard (NTDS) for 2014 was released this year and includes new fields for Pediatric TQIP.

NTDB benchmark, pediatric benchmark, and data quality reports for 2011 and 2012 admissions were released in September/October 2012 and 2013, respectively. TQIP has delivered the following risk-adjusted benchmark reports:

- October 2012: All Patients, Elderly, Penetrating, and Blunt Multisystem Injuries
- December 2012: Georgia Report on All Patients, Elderly, Penetrating, and Blunt Multisystem Injuries
- April 2013: Traumatic Brain Injury (TBI) and Shock Patients
- May 2013: Georgia Report on TBI and Shock Patients

In addition, TQIP has shifted to hierarchical modeling and added two new outcomes: major complications, and major complications and death. TQIP also released Guidelines for Geriatric Trauma Patients and Guidelines for Transfusion at its November 2013 conference.

Trauma Systems Evaluation and Planning Program consultations were completed in Arizona, Florida, Massachusetts, and Ohio. The ACS completed a consulta-
tion for Solano County, CA, to select a Level II trauma center and completed an international consultation in Doha, Qatar. We conducted follow-up interviews with 16 states and are collaborating with Wake Forest University, Winston-Salem, NC, to develop trauma system metrics. The ACS has verified 111 Level I, 152 Level II, and 58 Level III trauma centers and has approved 41 Level I and 33 Level II pediatric trauma centers.

Over the last year, the ACS has presented 2,099 Advance Trauma Life Support (ATLS®) courses, which have trained 35,262 students throughout the world. The ATLS app has been downloaded 44,535 times in 150 countries, and the ATLS e-learning project is expected to launch in spring 2014. The ATLS course management system is being enhanced to accommodate the Advanced Surgical Skills for Exposure in Trauma (ASSET) Program. Over the last year, 57 ASSET courses have been presented, training 507 students.

In addition, 89 Advanced Trauma Operative Management courses have been presented in 10 countries since August 2012 with more than 376 students trained, and the Rural Trauma Team Development Course has been offered 86 times with 1,312 students trained.

The Committee on Trauma (COT) sponsored several sessions at the Clinical Congress and presented its 91st Annual Meeting, with more than 200 members and guests in attendance.

The COT played an integral role in the development of the revised ACS Statement on Firearm Injuries issued earlier this year in response to the increasing number of mass-casualty events. In related activity, the College played a leadership role in forming a Joint Committee to Create a National Policy to Enhance Survivability from Mass-Casualty Shooting Events, which developed two reports that have been published in the Bulletin.

The COT received the American College of Surgeons Professional Association’s award for its advocacy activities. The COT also participated in the first meeting of The Way Forward Project, which is studying how military and civilian surgeons can collaborate to reinforce education, research, and systems-based practices.

On the international front, the COT became a member of the World Health Organization’s Global Alliance for Care of the Injured, and the International Injury Care Committee was formally launched.

Lastly, the COT presented the 2013 Meritorious Achievement Award to Ricardo Sonneborn, MD, FACS, and the 36th annual Residents Trauma Papers Competition was held in March 2013.

Cancer Programs
The Commission on Cancer (CoC) has accredited 1,507 cancer programs that provide care to 71 percent of all newly diagnosed cancer patients in the U.S. and Puerto Rico. The CoC conducted 433 cancer program surveys this past year, and 27 new cancer programs joined the accreditation program. A total of 79 cancer programs received the Outstanding Achievement Award.

One of the CoC’s most significant accomplishments this year involved working with consultants to develop a framework for Oncology Medical Home (OMH) standards for large group practices. A component of this accreditation is focused on data to measure OMH performance against 19 clinically based performance measures. We have requested more than $1 million in grant funding from the Center for Medicare and Medicaid Innovation to support development of the accreditation model.

The CoC and other stakeholders also have developed an initial framework for health care system standards, which will form the basis for a system accreditation model. In addition, the CoC plans to establish a cross-functional pediatric work group to evaluate existing standards and develop an enhanced set of performance measures.

The National Cancer Data Base (NCDB) added 7.3 million new and updated reports in January; 1.3 million were for cases diagnosed in 2011 representing 1.2 million deduplicated cases. The NCDB is approaching 30 million cases diagnosed between 1985 and 2011.

In September 2012, the NCDB released estimated performance rates to CoC-accredited programs through Cancer Program Practice Profile Reports (CP’R) for three new breast measures. The Quality Integration Committee at the May meeting approved eight additional measures for production in 2014. In July, the CoC and the Pennsylvania Health Care Quality Alliance (PHCQA) began working together to post
The College is seeking to expand its international vision. ACS leaders and members of the International Relations Committee met in the spring to discuss plans to retool the IRC. In addition, an International Surgical Leaders Forum took place in July at the College’s Washington Office.

CP’R performance measures on the PHCQA website: www.PAHealthCareQuality.org/. The primary purpose for this project is to provide more comparable information to patients. To date, nine of the 72 programs have agreed to participate in public reporting through the PHCQA Web page.

The format for the Cancer Quality Improvement Program (CQIP) has been completed. PowerPoint presentations are now available to help introduce this initiative to interested parties.

The CoC released the beta Participant User File (PUF) data last year to researchers at accredited programs. The PUF data have resulted in 22 publications and presentations at national forums. In February, the CoC began accepting requests for PUF data from all accredited programs; 178 requests for applications were submitted, and 155 were approved. PUFs will be released electronically to the awardees.

The Prospective Payment System (PPS)-exempt contract was received in October 2012, and staff began work in November. In April, the Alliance of Dedicated Cancer Centers hosted Rapid Quality Response System (RQRS) training for the 11 PPS-exempt centers. The first submission for their estimated performance rates was scheduled to occur November 15, 2013. As of August, 536 programs are participating in RQRS.

The National Cancer Institute, the American Cancer Society, and RTI International use the RQRS to identify patients treated at the National Cancer Institute National Community Cancer Centers Program hospitals to collect self-reported symptoms and side-effects during the first course of treatment. To date, approximately 5,000 surveys have been received.

The CoC sent 1,261 surveys to Cancer Liaison Physicians (CLPs) regarding the construct and operational aspects of their Multidisciplinary Team Planning program; 797 surveys were returned for a response rate of 63.2 percent. The Cancer Liaison Program continues to support the network of 62 CoC State Chairs and their activities. The ACS has processed more than 500 CLP appointments and reappointments.

Since its launch in September 2008, the National Accreditation Program for Breast Centers (NAPBC) has accredited more than 500 breast centers in 48 states. The NAPBC projects 80 new accreditation applications in the coming year and 148 applicants for reaccreditation. A survey was sent to 918 physicians at breast centers in 43 countries and to all international Fellows to measure interest in the program outside of the U.S. The responses were overwhelmingly supportive. As a result, the NAPBC has identified three pilot sites (Montreal, QC; London, UK; and Dubai, UAE).

The NAPBC Standards and Accreditation Committee developed a new standard for Breast Cancer Survivorship Care, and edits are being made to the current standards to strengthen requirements and improve quality. The NAPBC also developed three breast-specific quality measures that were vetted through the CoC and the NQF.

A May NAPBC workshop, Pursuing Excellence through Accreditation, sold out, and a two-day conference last November, Lead Your Breast Program to Excellence, was successful. The NAPBC has organized a logo recognition campaign to begin in conjunction with Breast Cancer Awareness Month. The ACS has contracted with a vendor to provide merchandise to accredited centers that will bear the NAPBC logo and emphasize that “Accreditation Makes a Difference.”

The ACS Clinical Research Program (ACS CRP) sponsored several sessions at the 2012 and 2013 Clinical Congresses and five surgical investigator meetings this past year to promote clinical trials. The ACS CRP continues work on the Surgical Standards Manual, which will outline operative standards for Alliance clinical trials, surgical practices, and CoC accreditation programs. The manual will include text covering oncologic principles, operative techniques, and surgical checklists. The target date for completion is March 1, 2014.

As of August 15, approximately 1,100 patients were enrolled in the ACS CRP ProvenCare Lung Cancer Collaborative. A proposal to expand the collaborative has been submitted to the Agency for Healthcare Research and Quality.

The American Joint Committee on Cancer (AJCC) has developed a new logo, tagline, and brand story and added a new Clinical Scholar-in-Residence in July 2013. The AJCC has begun work on the eighth edition of the Cancer Staging Manual. The AJCC also has
completed a Cancer Staging Content Transformation Project to develop the infrastructure for electronic delivery of AJCC content, which will launch this month. The second edition of the Cancer Staging Atlas is now available.

The CoC has developed a Web page that contains communications, tips, and resources that accredited programs may use to market their accreditation status. Using data from the American Hospital Association, we are developing state profiles that include the number of accredited and non-accredited programs in a state and the number of cancer cases diagnosed at each program. For the initial test, we are looking at three states—Florida, Pennsylvania, and Texas. The goal is to increase the number of programs by 8 percent per state.

Other highlights for ACS Cancer Programs are as follows:

• The ACS has evaluated the current CoC and NABPC advertising focus and has placed ads in Coping, The Patient Resource Guide, Hospitals and Health Networks, Crain’s Cancer Supplement, and The Patient Resource Women’s Cancer Guide.

• An eight-member CoC delegation attended the One Voice Against Cancer Lobby Day in Washington, DC, and participated in inaugural meetings of the Patient Quality of Life Coalition.

• A total of 19 papers were submitted for the 2013 CoC Paper Competition. The winner: Liam Smith, MD, Norfolk, VA, presented Gastrointestinal Cancers in Young Survivors of Lymphoma: Implications for Earlier Screening at the Clinical Congress.

• More than 300 staff from CoC-accredited programs attended the Survey Savvy: Enhance Quality—Commit to Patient-Centered Care conference in June.


Member Services

The College is exploring a lifetime membership program and has updated and revised international Fellowship requirements. To enhance recruitment, the ACS has reached out to other organizations that have agreed to disburse membership information. The College is focusing on increasing Canadian membership and is working on a campaign to attract young surgeons. We are engaging Governors and chapter leaders more fully in recruitment efforts and developing new membership brochures targeted at distinct demographic groups.

The Board of Governors (B/G) worked throughout this past year to explore the role and responsibilities of Governors and the selection criteria for nominating members of the B/G. Key elements of the redesign were finalized and implemented following the B/G Executive Committee meeting at the 2013 Leadership and Advocacy Summit. Central to the redesign are five Pillars based on the ACS Divisions. The newly formed Pillars and their Executive Committee Leads are as follows:

• Member Services: Fabrizio Michelassi, MD, FACS
• Education: Lorrie Langdale, MD, FACS
• Advocacy and Health Policy: James Denny III, MD, FACS
• Quality, Research, and Optimal Patient Care: Sherry Wren, MD, FACS
• Communication: Gary Timmerman, MD, FACS

The Advisory Council for Rural Surgery has established a rural surgery presence at the Clinical Congress and is conducting preliminary work on a set of rural surgery standards and guidelines. Plans for 2014 include a Rural Surgery Symposium. The one-and-one-half-day program will include topics on advocacy, practice issues, and clinical practice. Plans also are under way to establish a Rural Surgeon Ambassador Program with Council members speaking to chapters, medical students, and residents on issues in rural surgery. In addition, the Council has been using a robust listserv to relay information to targeted ACS members.

The Advisory Council for Otolaryngology has developed specialty-specific newsletters, and other Advisory Councils intend to follow suit. Discussions are under way to restructure the Advisory Councils to reorganize...
GROWING ACS MEDIA PRESENCE

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and more tightly coordinate Advisory Council activities with other areas of the ACS.

The Young Fellows Association (YFA) has increased its visibility among ACS Initiates through heightened publicity and increased personal contact with members of the YFA Communications Committee. The YFA has conducted a comprehensive review of all ACS committees to identify YFA demographic appointees and is in ongoing conversations with similarly structured groups internationally. The YFA Mentorship Program continues to grow in interest and participation.

The Resident and Associate Society (RAS) sponsored several programs at the Clinical Congress, including the annual Symposium and an expanded Surgical Jeopardy session, featuring a team of international residents. In addition, RAS participation on ACS councils and committees has expanded.

The College is seeking to expand its international vision. ACS leaders and members of the International Relations Committee (IRC) met in the spring to discuss plans to retool the IRC. In addition, an International Surgical Leaders Forum took place in July at the College’s Washington Office. The IRC was active in planning and presenting this session, which attracted 19 presidents of large international surgical societies. Agenda items aimed at discovering areas of intersection and the prospect of forming a global surgical coalition gradually emerged. Further discussion occurred during Clinical Congress.

Several Middle Eastern and Eastern European nations have expressed interest in forming ACS chapters, and the College has re-established contact with long-dormant chapters. The ACS is working with each chapter to develop strategic planning goals and expectations. A process for objectively assessing each chapter began this fall, with a dashboard created for feedback centrally and to individual chapters.

Other Member Services activities include:

- The Central Judiciary Committee reviewed 15 new cases and made six recommendations for disciplinary action.
- The ACS has been managing the Society of Surgical Chairs (SSC) for two years. The SSC now has 164 dues-paying members.
- More than 300 chapter officials and young surgeons participated in the Leadership Conference this year.
- Operation Giving Back (OGB) continues to assist surgeons who are interested in participating in global outreach. Additionally, OGB is working with Trauma Programs to provide ATLS materials in resource-poor countries.

Integrated Communications

A significant amount of planning and work has gone into the redevelopment of the College’s Web properties. The process began with more than a dozen stakeholder meetings with consultants and staff to assess the background, goals, and expectations for the project. Some of these meetings also covered how best to integrate the content currently accessible through the members’ portal into the public website and what software should be selected to provide members with a state-of-the-art online physician community. Several focus groups were convened during the Clinical Congress to help ensure the new site’s widespread appeal. The new site is expected to launch in May 2014.

As the data in the table on this page demonstrate, the College has made considerable progress in creating a strong social media presence.

The ACS and its various programs have been widely covered in the media. A total of 19,841 media hits were tracked over 11 months.
In December 2012, the College hired a marketing manager. To date, this individual, in concert with other staff, has contributed to efforts to more effectively market the Clinical Congress and ACS membership. This year, the ACS hosted nearly 500 health care leaders at six Inspiring Quality Tour events across the country. The forums were widely promoted via social media and yielded media coverage. The forums have generated leads for potential ACS partnerships and opportunities to implement ACS NSQIP in additional U.S. hospitals. Post-event surveys of forum attendees showed demand for ACS quality programs increased among audience members, generating additional leads and interest for ACS quality programs.

In April, the College published ACS Inspiring Quality Tour: Lessons Learned in the Pursuit of Quality Surgical Health Care, which summarizes best practices and case studies gleaned from the forums. Six additional ACS Inspiring Quality Tour stops are planned in 2014.

The Journal of the American College of Surgeons (JACS) launched the JACS Twitter feed @JAmCollSurg to promote featured articles, JACS in the news, and important articles in press. Two new applications have been developed to provide easy access to JACS on handheld devices, and a mobile-friendly JACS CME website has launched. The JACS impact factor remains 4.5, ranking it seventh out of 198 surgery journals. The number of original scientific articles submitted to the journal has doubled since 2008, and accepted but not yet published manuscripts are posted on the JACS website within two weeks of acceptance.

ACS Foundation

Unrestricted gifts to the ACS Foundation increased by 65 percent in FY 2013, and total contributions increased more than 68 percent. Current contributions combined with past philanthropy from ACS restricted funds provide nearly $4 million to the College for current needs as well as for meritorious programs and emerging opportunities.

In FY 2013, 25 ACS chapters and affiliated societies made donations. ACS Foundation volunteer representatives attended 25 chapter meetings as well as the Southeastern and Southwestern Surgical Congress meetings. The ACS Foundation has undertaken an initiative to recruit local volunteers who can promote and explain the role of philanthropy in the College.

Milestones achieved this year include securing funding for the following:

- The Jameson L. Chassin, MD, FACS, Fund for Professionalism in General Surgery
- The Olga M. Jonasson, MD, FACS, Lectureship
- The Thomas R. Russell, MD, FACS Scholarship
- The Carlos A. Pellegrini Fellowship of the China-Hong Kong Chapter
- The Kankuben B. Gelot Scholarship
- Patient education, scholarly opportunities for international surgeons, and a CoC Scholar-in-Residence

A highlight of the last year was establishment of the 1913 Legacy Campaign in honor of the College’s Centennial and to benefit The Surgeon, The Profession, and The Societal Good.

During the past fiscal year, several major bequests were received, and total enrollment in the Mayne Heritage Society is now at 57. The goal is “100 by 100” by October 2014 in recognition of the ACS Centennial.

With the goal of expanding the engagement of Fellows as partners with the Foundation and raising the profile of philanthropy, the Chapter and Affiliate Relations Committee has recruited 32 volunteers from 24 chapters to act as Philanthropic Champions and promote the Foundation at chapter meetings.

The Foundation has created a Young Fellows Leadership Circle—a donor recognition program to encourage giving among members of the YFA. Nearly 50 Young Fellows have made entry-level gifts.

The June Bulletin featured an article on past recipients of ACS scholarships, showing the return on philanthropic investments. Five Fellows who received ACS research scholarships attested that ACS awards help set them on a path toward discovering surgical breakthroughs.
A significant amount of planning and work has gone into the redevelopment of the College’s Web properties. The process began with more than a dozen stakeholder meetings with consultants and staff to assess the background, goals, and expectations for the project.

PI/HR
Many areas of the ACS are engaged in performance improvement (PI) activities. One major College-wide undertaking involved establishing and training staff in the ACS Values of Professionalism, Excellence, Innovation, Introspection, and Inclusion.

In addition, we put together a yearlong leadership training initiative that includes five two-day sessions with analysis of behavioral characteristics and emotional intelligence, personal development, and personal coaching. This effort will conclude next June.

We launched a Change Acceleration Process (CAP), training 92 staff members in the concepts and strategies of creating change. We also trained five Master Change Agents who will work with the PI Professionals (PIPs) to facilitate projects and PI training and developed a two-hour CAP orientation for all ACS staff. Furthermore, we have designed CAP/PI sharing sessions for sharing PI success stories and peer project problem solving and are planning to offer CAP tool refreshers for Change Agents.

Additional movement in this area is as follows:

- Conducted a strategic planning session to establish ACS objectives and projects that align with those goals
- Identified 258 projects to undertake; 189 are under way, and 25 have been completed
- Began 12 projects facilitated by the PIPs and the PI Director; three have been completed, nine are under way
- Conducted monthly UConnect sessions with Human Resources (HR) for managers/supervisors, which center on employee benefits and policy discussions, CAP tool tips, and presentations from project teams for ACS managers and supervisors
- Developed index of expectations of volunteer PI professionals and the PI team is reviewing the PIP curriculum to train another cohort of PIPs

HR has been working with consultants and the PI team to develop new job pillars and is benchmarking approximately 200 positions. The College has developed new recruitment tools. We have created a new employment brand for the ACS, launching a LinkedIn recruiting page, posting staff videos on YouTube, and developing a new benefits summary sheet.

Convention and Meetings
Convention and Meetings had a productive year. As of August, the exhibits team was responsible for 12 internal and external client meetings, and the Association Management Services program had contracts with 17 clients. Registration Services managed 24 meetings and approximately 32,000 registrations, and Travel Services booked 3,863 tickets. Meeting Services successfully coordinated more than 1,500 internal meetings, 73 external meetings, and 10 client association meetings.

The 20 F Street NW Conference Center in Washington, DC, hosted 183 meetings from August 2012 to August 2013—a 20 percent increase from the previous year. Roof Terrace bookings for the property doubled from last year due to the installation of the South Terrace tent.

Conclusion
The ACS continues to undergo transformative changes aimed at ensuring the College Fellows can continue to provide optimal care to their patients now and for the next 100 years. As always, the staff and leadership of this organization welcome your ideas for how we can help you better serve your patients and grow professionally. ♦
This year was an exceptionally busy one for the state legislatures. As January 2013 trundled in, the majority of state legislatures went to work almost immediately on a host of issues related to state budgets, state finances, health care, and an array of other issues. In an average year, state legislatures may consider a combined total of anywhere from 150,000 to 180,000 pieces of legislation, which is significantly more than the number of bills that are introduced in the U.S. Congress.

The American College of Surgeons (ACS) uses an online service to identify and monitor state legislation that affects surgical care. ACS State Affairs follows the overall legislative priorities of the College, which include medical liability reform, quality/patient safety (scope of practice, injury prevention), workforce/surgical practice (Uniform Emergency Volunteer Health Practitioners Act [UEVHPA], trauma system funding and development), and physician payment (physician/cosmetic surgery taxes). Legislation of interest may also be communicated to State Affairs by Fellows, chapter members, and representatives of national surgical specialty societies that also are interested in a particular issue. In 2013, more than 1,900 such bills were introduced in the states, although most of them stalled early on in the legislative process.

This article gives readers a sense of the spectrum of state legislation, regulation, and judicial rulings from across the country by providing highlights of actions taken in certain issue categories.

**Medical liability reform**

The legislature considered a number of resolutions that would amend Arkansas’ constitution to address various elements of tort reform. One resolution included the following requirements: individuals who file a lawsuit that is dismissed as frivolous must pay court costs up to a certain amount; expert witnesses must be of the same specialty as the defendant; a certificate of good faith must be filed with the complaint; a suit cannot commence until at least 60 days after written notice of claim for medical injury has been served; and punitive damages are limited to no more than nine times the amount of compensatory damages. Proving that liability reforms are difficult to enact, none of the resolutions went forward but will likely be reintroduced in 2014.

**California’s Medical Injury Compensation Reform Act (MICRA),** which has helped to keep liability premiums in check since 1975, is under threat with the introduction of California Ballot Initiative 13-0011, the Troy and Alana Pack Patient Safety Act of 2014. The proposal was filed in late July by Robert S. Pack and Consumer Watchdog and calls for raising the cap on noneconomic damages to $1.1 million from the current $250,000—the same amount as the original limit. In addition, this initiative would require physicians to do the following:

- Check a prescription drug tracking database before prescribing controlled substances
• Undergo mandatory drug and alcohol testing after an unexpected death or injury occurs

• Report any witnessed medical negligence or substance misuse by other physicians

• Undergo random drug and alcohol testing

• Be placed on automatic suspension if testing positive for alcohol or drugs while on duty

The Consumer Attorneys of California supports this measure whereas the California Medical Association, California Hospital Association, and Civil Justice Association of California oppose it. More than 504,000 valid signatures will be required for the initiative to qualify for the 2014 ballot. Since its inception, MICRA has been under attack from legal and attorney groups. Should this measure make the ballot, it is expected to be expensive to defeat.

In May, Georgia became the first state to enact provider shield legislation. Under the new statute, a barrier is created between physicians and public or private payor guidelines that could be used as evidence in medical liability lawsuits. Evidence related to the public and private payor guidelines will be inadmissible in court and cannot be used as the standard of care or as a presumption of negligence in a medical liability lawsuit.

Plaintiff attorneys received a substantial pay increase under legislation that Illinois Gov. Patrick Quinn (D) signed in January. H.B. 5151 eliminated the sliding scale fee structure in medical liability cases and replaced it with a flat 33.33 percent fee on the entire award. Formerly, the sliding scale was 33.33 percent of the first $150,000, 25 percent of the next $850,000, and 20 percent of anything more than $1 million.

The Michigan legislature adopted liability reforms before adjourning the lame-duck session in January. S.B. 1115 and S.B. 1118 helped to clarify a number of existing liability statutes, including the definition of noneconomic damages to clearly denote what damages or losses are subject to the cap and when it may be applied to ensure that judges are unable to circumvent the legal restrictions on awards.

The New Jersey Supreme Court issued a ruling in a medical liability case pertaining to expert witness qualifications. Under New Jersey law, the plaintiff’s expert witnesses must be board certified in the same specialty as the defendant. In this case, the court ruled that an internist who specializes in hyperbaric medicine, critical care medicine, and pulmonary diseases is ill-qualified to testify against an emergency physician and a family physician. The court found that plaintiffs cannot establish the standard of care through an expert who practices outside of the defendant physicians’ medical specialties and barred the expert from testifying to the standard of care.

A number of medical liability bills were introduced in New York that would have likely increased liability insurance premiums in the state. The bills and their related provisions were as follows:

• S. 554: remove contingency fee limitations in medical liability claims

• S. 744/A.1056: change the medical liability statute of limitations

• S. 551/A.1001: expand damages in wrongful death actions

• S. 1046/A.2365: prohibit ex parte interviews of plaintiff’s treating physician

• S. 887/A. 1085: change allocation of damages rules in cases involving multiple defendants

None of the bills passed this session, but they are likely to be reintroduced next session. The ACS is keeping close watch and will notify New York Fellows in the event that happens.

On June 4, the Oklahoma Supreme Court ruled that several comprehensive medical liability reforms, such as certificate of merit requirements, caps on noneconomic damages, and joint and several liability, are unconstitutional. The justices found that the tort reform legislation passed in 2009 violated the single subject rule of the state’s constitution. The court did not rule on the merits of the policies in the statute, with the exception of the certificate of merit requirements, which the court ruled unconstitutional because
this law is a “special law” applied to professional negligence cases and not all negligence cases, thereby creating undue financial burdens. However, the cap on noneconomic damages remains in place because the legislature enacted it under a separate cap in 2011, and the court only addressed the 2009 law.

**Oregon** Gov. John Kitzhaber (D) signed S.B. 483, Early Discussion and Resolution legislation, into law on March 18. The new law offers health care providers and patients the opportunity to voluntarily resolve notices of adverse events without litigation. It is anticipated that open discussion of adverse events ultimately will enhance patient safety. Under the legislation, discussions are initiated by filing a notice of an adverse health care incident with the Oregon Patient Safety Commission. A health care provider, health care facility, or patient may file this notice. Other steps in the resolution process include early, confidential discussion of what happened during the delivery of care; any necessary mediation; and an opportunity to make a compensation offer, if warranted. If an offer is made and accepted, the physician or facility extending the offer may require that the patient sign a release of future liability.

S.B. 129, introduced in April and assigned to the **Wisconsin** Senate Committee on Judiciary and Labor, would enact an “I’m Sorry” statute for medical liability actions. According to the bill, an expression of apology, benevolence, compassion, condolence, fault, liability, remorse, responsibility, or sympathy to a patient or relative/representative would be inadmissible into evidence or subject to discovery in any civil action or administrative hearing regarding the health care provider as evidence of liability. Similar bills were introduced in the Assembly, but no final action was taken, and Wisconsin remains one of the few states without an “I’m Sorry” statute.

**UEVHPA**

The adage “third time’s a charm” rings true for one **Texas** bill, as it took three legislative sessions to pass the UEVHPA. After clearing the House and the Senate, Gov. Rick Perry (R) signed the law June 14, and it became effective September 1. The purpose of this ACS-endorsed legislation is to improve the ability of out-of-state surgeons and other physicians to provide care in Texas during a declared emergency.

J. Patrick Walker, MD, FACS, a general surgeon from Crockett, TX, was the surgeon champion for this legislation. He closely worked with his local state legislator to get the bill introduced, and visited Austin on a number of occasions to present testimony. This instance is an excellent example of how grassroots advocacy can help legislation get enacted at the state level. When individual surgeons take the time to contact their elected officials to get legislation introduced, commit to presenting testimony in committee hearings, and coordinate requests for information, sound legislation gets enacted.

**Injury prevention**

S.B. 374, legislation to strengthen existing **California** law relating to assault weapons, passed both legislative chambers and was ultimately vetoed by Gov. Jerry Brown (D). It was part of a package of firearm safety bills; those bills that did achieve enactment called for the following:

- Ban the use of lead ammunition in hunting by no later than 2019
- Prohibit businesses from getting assault weapons permits
- Add criminal liability for firearm storage that endangers a child
- Require all gun purchasers to take a firearm safety class and earn a safety certificate

Current California law already has strict background checks and waiting periods for all gun purchases. Multiple physician organizations in the state supported these bills, with the Northern California Chapter of the ACS taking a position of support for S.B. 374 early on in the legislative process.

At the start of this year, youth concussion education and distracted driving proved to be the two most active injury prevention issues. More than 43 states and the District of Columbia have youth concussion edu-
cation statutes in place, typically requiring concussion education of youth, coaches, and athletic trainers, and medical clearance before an injured athlete may return to practice or play. During 2013, 18 bills were introduced—some to amend existing statutes, and others to implement youth concussion education requirements. Of those few states without such a statute, Montana and South Carolina enacted one.

Nineteen states saw activity that would restrict distracted driving. Of these bills, 11 related to texting while driving and eight required hands-free use of mobile devices. A Connecticut bill would have required insurance discounts for consumers who download apps on their phone that prevent texting while driving.

Scope of practice
Recent activity in the California Assembly on S.B. 491 brought nurse practitioners one step closer to independent practice. Under the terms of the bill, which did not achieve passage, nurse practitioners would have been able to order durable medical equipment without physician supervision and, in consultation with a physician and surgeon, approve, sign, modify, or add to a plan of treatment or plan for an individual receiving home health services or personal care services. Additionally, nurse practitioners would have been able to furnish or prescribe drugs or devices, establish patient diagnoses, and delegate tasks to medical assistants. However, nurse practitioners would have been required to carry an appropriate level of liability insurance. Although this legislation did not pass, it did receive stronger support than in previous years.

Following a few years of optometrists making intense attempts to be permitted to practice surgery in Florida, ophthalmologists and their surgical and medical colleagues succeeded in achieving the enactment of legislation that would clearly define surgery and clarify what optometrists may do as part of their scope of practice. Optometrists would also be required to report adverse incidents to the Florida Department of Health, and a patient-specific written protocol between an ophthalmologist and an optometrist would be required for the provision of postoperative care. The governor signed the law in April.

The Louisiana legislature considered a bill to significantly increase the scope of practice of optometrists to prescribe controlled substances and perform ophthalmic surgery, as well as be called ophthalmic physicians. The bill passed out of committee, and a major grassroots effort was launched by the Louisiana Chapter of the ACS with assistance from the College, the Louisiana State Medical Society, and the Louisiana Academy of Ophthalmology. Surgeons sent more than 60 letters to Louisiana legislators and the Speaker of the House stating their opposition to this legislation, which helped to ensure the withdrawal of the bill from consideration.

Following months of negotiation between physicians, advanced practice nurses, and physician assistants, the Texas legislature passed legislation creating a team-based, physician-led collaborative model of practice. Under the new law, physicians will enter into prescriptive authority agreements with advanced practice nurses or physician assistants, delegating to them the ability to prescribe under the supervision of the physician. Periodic in-person meetings are required between the physician and the advanced practice nurse/physician assistant.

Surgical practice
Florida Gov. Rick Scott (R) approved legislation creating the Cancer Center of Excellence Award to recognize hospitals, treatment centers, and other providers in the state that demonstrate excellence in patient-centered coordinated care for individuals receiving cancer treatment and therapy. To be considered for the award, the hospital, treatment center, or other provider must have ACS Commission on Cancer accreditation, and the state Surgeon General will appoint a team of independent evaluators to determine award eligibility.

A recent hot topic in the state legislatures has to do with follow-up imaging for women who have dense breast tissue. A total of 26 bills were introduced around the country in 2013 mandating that coverage be provided for an additional imaging test, whether it be another mammogram or some other appropriate test. Hawaii, Illinois, Indiana, Maryland, Nevada, Oregon, Tennessee, and Virginia enacted this legis-
When individual surgeons take the time to contact their elected officials to get legislation introduced, commit to presenting testimony in committee hearings, and coordinate requests for information, sound legislation gets enacted.

State advocacy

Although keeping up with the many bills introduced at the state level over the course of a year is an important part of advocacy, there is much more to the entire process. It is vital that surgeons and ACS chapters play an active role in advocating for or against legislation that is of concern to them. One excellent way to do this is through a lobby day at the state capital.

As noted in the October issue of the Bulletin of the American College of Surgeons, the College’s Chapter Lobby Day Grant Program continues to be popular with many ACS chapters.* A total of 16 lobby days took place this year, providing opportunities for active grassroots advocacy as well as building relationships with legislators and learning the do’s and don’ts of advocacy.

For the third year in a row, the Connecticut Chapter had an extremely successful lobby day as co-host of the Connecticut State Medical Society’s Doctor’s Day. This program draws numerous state specialty societies to the capitol for an opportunity to present a unified voice to legislators. Major issues from the perspective of the chapter included advocating for adoption of a definition of surgery and defeat of a bill that would weaken Connecticut’s certificate of merit statute. The Connecticut Surgical Quality Collaborative also received top billing as part of the briefings held before legislative visits.

One big item on the day of the event was the signing of Connecticut’s new firearms legislation, which was developed in response to the tragedy at Sandy Hook Elementary School.

The North Carolina Chapter met in Raleigh on February 5–6 for their first lobby day. On February 5, lobby day participants and invited representatives attended a cocktail reception, enjoying a casual atmosphere and a preview of what was to come in the legislative appointments the following day. On February 6, surgeons met with the North Carolina Medical Society lobbyist to discuss the key issues to be addressed in their meetings with legislators and reviewed talking points, then met with their respective legislators as well as key committee members.

Surgeons joined with their Tennessee Medical Association (TMA) colleagues for the TMA Physicians Involved at Tennessee’s Capitol Hill lobby day. Issues raised with legislators included the importance of requiring helmets for motorcycle riders, trauma funding, cancer care, rural access to general surgeons, scope of practice, and state Medicaid funding.

The Virginia Chapter participated in its third White Coats on Call Day in conjunction with the Medical Society of Virginia on February 6 in Richmond. This took place on “crossover day,” which is the deadline for bills to be passed from one chamber to the other. Holding a lobby day at this time reduces the number of committee hearings being held, which makes it more likely that surgeons will be able to meet with individual legislators.

Surgeons who participate in these lobby days gain valuable advocacy experience and leave the event with a sense of accomplishment and excitement about participating in the democratic process. They also build and/or enhance relationships with their legislators, making future interactions more productive on issues important to surgeons and to the physician community at large.

For advocacy to be effective at the state level, it is important that Fellows and their chapters actively engage with their state legislators. Many ACS resources are available to assist with these efforts and are available at http://www.facs.org/ahp/statelegislation.html. In addition, the State Affairs staff is available at 202-337-2701 and are always glad to hear from Fellows regarding legislation in their state.

Acknowledgment

The author acknowledges the assistance that Charlotte Grill, ACS Member Services Administrator for the Young Fellows Association, Chicago, IL, provided in compiling the information in this article when she was in her previous position of State Affairs Associate, Division of Advocacy and Health Policy.

Get some rest:
Minimizing the effects of sleep deprivation on patient care

by Edwin W. Shearburn III, MD, FACS

Editor’s note: The following is the second in a series of excerpts from Being Well and Staying Competent: Challenges for the Surgeon, a guidebook issued earlier this year by the Board of Governors’ Committee on Physician Competency and Health. The complete document is posted on the American College of Surgeons members-only Web portal at www.efacs.org.

To the best of the knowledge of the members of the Board of Governors of the American College of Surgeons (ACS), no surgeon has ever woken up in the morning thinking, “How can I harm a patient today?” Yet, as we look at the effects of sleep deprivation upon ourselves and upon our surgical colleagues, we may unwittingly be causing harm to the patients we serve. Historically, sleep deprivation among surgeons was not viewed as a serious problem; however, the topic has been receiving more serious consideration since 1988 in the aftermath of the 1984 Libby Zion case, which is discussed later in this article.

In years past, surgeons were taught to care for patients even if they had little sleep and were fatigued. Before the mandatory 80-hour residency workweek, surgical residents and attending surgeons were trained to ignore the effects of sleep deprivation and to care for their patient’s needs at the expense of obtaining renewing and invigorating sleep. Anecdotes and memories of physicians falling asleep during rounds or while driving home are well-known. For most surgeons, it has been a point of pride to be able to work long hours and still provide good care.

Over the last several decades, the effects of sleep deprivation have been studied in several nonmedical occupations and professions.¹ Sleep deprivation-related impairments in cogni-

HIGHLIGHTS

• Explains why sleep deprivation among surgeons and residents has become an issue of growing concern
• Outlines aspects of the problem that require further study
• Offers guidelines for all inhospital health care professionals to apply to improve patient safety by limiting contact between patients and sleep-deprived surgical clinicians
tive and motor performance have been equated to alcohol intoxication in multiple studies showing 24 hours without sleep to be equivalent to a blood alcohol level of 0.1 percent, or the standard for legal intoxication. Additionally, evidence of the deleterious health effects of sleep deprivation continues to increase. Included in this ever-lengthening list are the enhanced risks of diabetes, impaired cognitive function and mood, weight gain, endocrine alterations, and so on. Sleep deprivation has been studied extensively among long-distance drivers and airline pilots; these studies have led to mandatory federal regulations and oversight limiting duty hours in those professions. Several major national and international catastrophes have been attributed to poor cognitive function in sleep-deprived workers, specifically the Three Mile Island and Chernobyl nuclear power plant catastrophes, as well as the space shuttle Challenger disaster.

**Heightened awareness**
The effects of sleep deprivation upon health care professionals were essentially ignored until “the Libby Zion case in 1984 triggered the formation of a commission to investigate supervision and work hours of residents in New York hospitals.” This particular medical catastrophe resulted in New York State guidelines and subsequent Accreditation Council for Graduate Medical Education (ACGME) requirements for medical and surgical house staff work hours and rest periods. These ACGME limits were subsequently revised and made more restrictive in 2011 (see table, this page). The work-hour limits were mandated after significant study looking at the effects (or lack thereof) of sleep deprivation upon medical and surgical residents in the U.S. Although this article focuses on the effects of sleep deprivation on the practicing surgeon, not surgical residents, the ACGME work-hour restrictions are worth mentioning to frame the issue in a historical context. It is counterintuitive to think that attending surgeons are any less susceptible to the negative consequences of sleep deprivation than surgeons in training. Therefore, it is surprising that few studies have been conducted to evaluate the results of sleep deprivation on attending surgeons. The effects on judgment, mood, hand-eye coordination, and so on are equally likely to affect the practicing surgeon as the resident surgeon. Most studies analyzing technical performance of surgical skills have demonstrated more errors, longer times for task completion, and less efficiency in using instruments when a surgeon has gotten too little sleep. In fact, it is arguable that as the practicing surgeon ages, the effects of sleep deprivation may be more pronounced.

**More study needed**
Although anecdotal reports exist of fatigued health care workers causing specific harm to patients, most often these incidents have been viewed as isolated events that are not reflective of a widespread problem within the health care system. In late 2002, an article by Gaba and colleagues in *The New England Journal of Medicine* contrasted and compared the effects of sleep deprivation and the potential harm to patients between resi-
dent physicians and attending clinicians. Even in this study, it was noted that “no study has proved that fatigue on the part of healthcare personnel causes errors that harm patients.” Moreover, a subsequent 2009 article addressing operative complications in both the surgical and obstetrical disciplines demonstrated that “procedures performed the day after attending surgeons and obstetricians/gynecologists worked at some point during the night were not associated with significantly increased complication rates compared with control cases that were not preceded by nighttime work.”

Although the surgical literature contains minimal reference to actual objective complications occurring as a result of sleep deprivation among practicing surgeons, perhaps more surprising is the paucity of information pertaining to the effects of fatigue on surgical judgment. Understandably, no objective measuring tools are available to evaluate surgical judgment when the surgeon is well-rested versus sleep-deprived. Clinical judgment is a subtle skill, and fatigue may contribute to errors in interpretation of radiologic studies or perhaps a decision to delay operative intervention rather than immediately take the patient to the operating room. Further, in the present system, any effects of fatigue that result in bad outcomes would be self-reported.

Gaba and colleagues also note the lack of pressure from “market forces to address the issue of fatigue among clinicians.” The authors state, “The problem of fatigue-related risks in medicine will not be solved simply by limiting residents’ work hours. A comprehensive strategy should include changes in organizational culture and operational safeguards, as well as provisions for ensuring that the workload of clinicians is acceptable. Although residents have been the focus of the debate, the strategy should ultimately apply to experienced clinicians as well, especially since older persons are more likely than younger persons to be adversely affected by sleep deprivation.”

With the ongoing changes in market forces (more employed clinicians, decreasing reimbursement, increased patient expectations, and mandates for comprehensive use of the electronic health record) health care systems and hospitals currently have no incentive to limit surgical clinicians’ work hours. Many hospitals and many surgeons have left the issue of sleep deprivation to the individual surgeon. However, the individual surgeon may be conflicted and unable to rationally evaluate his or her level of sleep deprivation. Indeed, “competing interests...self-image, peer pressure, and financial pressure...can be difficult to weigh in a state of fatigue.”

Other authors have suggested that the patient should make the decision as to whether a surgeon “without adequate sleep” should perform an elective scheduled procedure the day after that surgeon has been on call. Some leaders of the ACS rightfully question whether each and every patient scheduled for surgery can make an informed decision on the day of surgery as to whether the surgeon is capable of proceeding with the proposed procedure after being up all night caring for other patients. As with the surgeon, multiple competing factors (scheduled work time off, child care arrangements, financial issues, and so on) may color the surgical patient’s judgment.

**Systematic approach needed**

Fatigue-related risks of harm to the surgical patient will not be eradicated by simply limiting surgeons’ work hours or by leaving this issue to the individual surgeon, who may be incapable of making a rational decision in a fatigued state and, although there may be exceptions, generally, the individual patient should not be placed in the position of deciding whether to proceed with surgery under circumstances that are out of his or her control. Rather, a coordinated and systematic approach to the issue of surgical sleep deprivation will provide the best set of safeguards for the surgical patient. This line of attack should include...
the individual surgeon, the surgical department, the medical staff, and the hospital administration. Furthermore, given the regional variations of surgical practice within our country, solutions to the issue of sleep-deprived surgeons should be adaptable to the institutional needs and constraints.

The following guidelines are intended to be general and adaptable to the various models of surgical practices in all communities. However, the goal is to address and reform potentially unsafe work practices and to safeguard the surgical patient as well as protect the individual surgeon’s well-being. Enforcement of these practices should be a cooperative non-punitive effort between the individual surgeon, the surgical department, the medical staff, and the hospital administration.

**Hospital administration:** Whereas the hospital administration has the authority and the responsibility to provide a safe environment for both the surgical patient and for all surgical health care workers within their institution, it should provide an objective means to evaluate each surgeon’s level of sleep deprivation, depending on the situational circumstances. The hospital and the operating room nurse manager should institute a method of identifying significant sleep deprivation among operating surgeons. Although this method will vary depending on the clinical situation, it should ensure that a surgeon performing elective surgery has had, at a minimum, four hours of uninterrupted sleep before commencing elective surgery. Furthermore, the hospital should establish operational safeguards to prevent a fatigued surgeon from commencing surgery and mandating that the operation be delayed or rescheduled.

If an elective operative procedure must be delayed, it should be rescheduled as soon as possible to minimize the inconvenience to the patient, the patient’s family, and the operating surgeon. Ideally, a prospectively established mechanism agreed to by each individual member of the department of surgery, the chief of surgery, and the hospital administration should be in place to ensure that the surgical procedure is performed as soon as possible after the original delay. Furthermore, the surgeon should not be penalized for postponement of a case due to fatigue.

If a fatigued surgeon, either self-reported or identified by the operating room staff, is asked to perform an emergent procedure, a prospectively established procedure should be in place to rapidly provide a replacement surgeon. The specifics of such an organizational mechanism for surgeon replace-
If a fatigued surgeon, either self-reported or identified by the operating room staff, is asked to perform an emergent procedure, a prospectively established procedure should be in place to rapidly provide a replacement surgeon.

...
are not practical for clinical measurement of sleep deprivation effects, each surgeon must be able to evaluate his or her capacity to safely and effectively complete a surgical procedure.

While further study is indicated to evaluate the scope of sleep deprivation among surgeons and potential harm to surgical patients, the surgical community must assume the responsibility for reforming surgical attitudes and surgical work practices “…so that exhaustion is considered as posing an unacceptable risk [to both patient and surgeon] rather than as a sign of dedication.”13 This cultural change in surgical practice will have far-reaching consequences. However, without self-remediation it is foreseeable that additional governmental regulation will be imposed upon the surgical community, just as it has been upon pilots, long-distance truck drivers, and surgical residents.

As mentioned previously, because of situational and geographical differences, the guidelines need to be broad and variable. What may be right for a well-staffed regional hospital may be inapplicable to a small critical care unit. Situational and geographical differences, the workload, and surgical drivers, and surgical residents.


The Medicare EHR Incentive Program in 2014

Begning in 2014, the Medicare Electronic Health Records (EHR) Incentive Program will offer different reporting options than in years past to eligible professionals (EPs) who meaningfully use EHR technology. EPs will be required to report using the new 2014 criteria regardless of whether they are participating in Stage 1 or Stage 2 of the EHR Incentive Program.

The program was established under the Health Information Technology for Economic and Clinical Health (HITECH) Act, which authorizes the U.S. Department of Health and Human Services to provide financial incentives to EPs and hospitals that “meaningfully use” EHR technology. HITECH is part of the American Recovery and Reinvestment Act of 2009 (ARRA).

This column responds to questions that surgeons may have regarding the 2014 reporting options, important deadlines, and penalties associated with noncompliance and nonparticipation.

What are the 2014 Medicare EHR Incentive Program reporting criteria?

As mentioned previously, EPs who participate in the EHR Incentive Program will have different reporting options in calendar year (CY) 2014 than in previous years. Regardless of the reporting stage, EPs participating in the program will have the option of reporting on a quarterly basis. The Centers for Medicare & Medicaid Services (CMS) implemented the reporting change to allow EPs sufficient time to upgrade or adopt EHR that meet the Office of the National Coordinator’s (ONC’s) 2014 certification criteria, which will allow EHR technology to be more efficient as well as provide improved security, interoperability, data portability, and other features.

EPs who began their first year of reporting in CY 2011, 2012, or 2013 may report quarterly in 2014. CMS has designated dates for the 2014 EHR Incentive Program quarters, which are shown in Table 1 on page 43.

CY 2014 marks a pivotal point in the EHR Incentive Program, as it will be the first year some EPs will begin or continue participating in Stage 1 of the program and others will begin participating in Stage 2 of the program.
First-year program participants should report on any 90-day period. EPs have until July 3, 2014, to begin reporting and should submit their data by October 1, 2014, to avoid being penalized in 2015. EPs who begin reporting after July 3, 2014, are still eligible to receive up to the 2014 incentive payment of $24,000. However, they will also receive the 2015 program penalty of –1 percent.

What are the EHR incentive payments and penalty amounts?
The Medicare EHR Incentive Program payments began in CY 2011. EPs who began meeting the Stage 1 meaningful use requirement in 2011 or 2012 may earn an incentive payment totaling $44,000 over five years.

- If EPs began reporting in 2013, they may earn a total incentive payment of $39,000 over a four-year period.
- If EPs begin reporting in 2014, they may receive a total incentive payment of $24,000 over a period of three years. No incentives are scheduled for EPs who first become meaningful users in 2015 and beyond.

Although program penalties are not applied until CY 2015, the performance period for this penalty will occur before the payment penalty year. In other words, surgeons will need to be able to achieve Stage 1 of meaningful use before 2015 to avoid the payment penalty in 2015. And even though the incentive payments are set to end by 2016 for EPs who participate

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**TABLE 1.**  
**2014 QUARTERLY REPORTING TIMELINE FOR EPS**

<table>
<thead>
<tr>
<th>2014 quarterly reporting for EPs beyond year one reporting (choose only one)</th>
<th>Submission period for meaningful use (Stages 1 and 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 1–March 31, April 1–June 30, July 1–September 30, or October 1–December 31</td>
<td>Two months following the end of the reporting period (January 1–February 28)</td>
</tr>
</tbody>
</table>

**TABLE 2.**  
**MAXIMUM TOTAL AMOUNT OF EHR INCENTIVE PAYMENTS FOR A MEDICARE EP**

<table>
<thead>
<tr>
<th>CY†</th>
<th>FIRST CY IN WHICH THE EP RECEIVES AN INCENTIVE PAYMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>2012</td>
</tr>
<tr>
<td>2011</td>
<td>$18,000</td>
</tr>
<tr>
<td>2012</td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>8,000</td>
</tr>
<tr>
<td>2014</td>
<td>4,000</td>
</tr>
<tr>
<td>2015</td>
<td>2,000</td>
</tr>
<tr>
<td>2016</td>
<td></td>
</tr>
<tr>
<td>2017</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>$44,000</td>
</tr>
</tbody>
</table>

Note: Medicare EHR incentive payments are subject to the mandatory reductions in federal spending known as sequestration. This 2 percent reduction will be applied to any Medicare EHR incentive payment for a reporting period that ended on or after April 1, 2013. If the final day of the reporting period occurred before April 1, 2013, those incentive payments will not be subject to the reduction. Maximum incentive amounts do not reflect the 2 percent cut.

†A CY equals a payment year.

**Note:**
Medicare EHR incentive payments are subject to the mandatory reductions in federal spending known as sequestration. This 2 percent reduction will be applied to any Medicare EHR incentive payment for a reporting period that ended on or after April 1, 2013. If the final day of the reporting period occurred before April 1, 2013, those incentive payments will not be subject to the reduction. Maximum incentive amounts do not reflect the 2 percent cut.


†A CY equals a payment year.

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*Any changes that CMS may make to the 2014 deadlines will be reported in ACS NewsScope, the ACS Advocate, and the Bulletin.
How can I determine my reporting stage in 2014?

CY 2014 marks a pivotal point in the EHR Incentive Program, as it will be the first year some EPs will begin or continue participating in Stage 1 of the program and others will begin participating in Stage 2 of the program.

Use the checklist found in Table 3 on this page to determine when to begin reporting, or visit http://www.facs.org/ahp/ehr/ehr_reporting.html.

What steps do I need to take to begin or continue reporting Stage 1 in 2014?

To begin Stage 1, EPs should first register with the CMS registration and attestation system at https://ehrincentives.cms.gov/hitech/login.action. EPs may enroll in this system even before they have certified EHR technology. To meet the meaningful use objectives, EPs must use certified EHR technology that has been approved by the ONC and is certified as meeting 2014 requirements. View a list of the ONC-certified EHR systems at http://onchpl.force.com/ehrcert.

An EP must meet the following objectives to begin reporting:

- 15 core objectives
- Five out of 10 menu set objectives
- Three core clinical quality measures (CQMs) or three alternative core clinical quality measures if the three core are inapplicable and three additional CQMs

For the three additional CQMs, EPs may choose any measures that are appropriate to their specialty or practice. The 2014 CQMs are available at http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/EP_MeasuresTable_Posting_CQMs.pdf.

What steps do I need to take to begin reporting Stage 2 in 2014?

CY 2014 is the first year of Stage 2 of the EHR Incentive Program. Only EPs who began reporting in 2011 or 2012 will be allowed to begin reporting for Stage 2 in 2014. As in Stage 1, EPs must register with the CMS registration and attestation system. For Stage 2, EPs must report:

- 17 core objectives
- Three menu set measures
- Nine CQMs, of which at least three should be from one of the six National Quality Strategy domains

Refer to the following website to obtain a list of core objectives and menu set objectives available for Stage 2: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/Stage2_MeaningfulUseSpecSheet_TableContents_EPs.pdf.


I want to report Physician Quality Reporting System (PQRS) and EHR CQMs simultaneously. Are the reporting requirements different?

In 2013, CMS offered EPs the option of reporting on certain measures through the PQRS-Medicare EHR Incentive Pilot program, which allows EPs to report on specific EHR measures available in the PQRS program.
through their PQRS-qualified and ONC-certified EHR system. By reporting through this program, EPs can satisfy two requirements: the CQM component of the Medicare EHR Incentive Program and the requirements for satisfactory reporting under the 2013 PQRS. For 2014, EPs beyond their first year of meaningful use who wish to streamline efforts and electronically submit CQMs to receive credit for both the PQRS and EHR Incentive programs should report for one full CY for the EHR Incentive Program instead of a quarter.


### How do I qualify for an exception for this program?

If an EP claims an exception and it is approved by CMS, the EP will become ineligible to receive an incentive payment and will be exempt from any penalties. An exception must be filed by July 1, 2014, to avoid the 2015 penalty; EPs may need to reapply for most of these exceptions on an annual basis. CMS is in the process of updating its website to provide information on how to apply for the exceptions and the specific requirements to qualify for the exceptions. Refer to Table 4 on this page for a list of the exceptions.

### What resources are available to help me begin reporting?

The ACS and CMS offer several resources pertaining to the EHR Incentive Program, including the following:

- **ACS EHR Web page**: [http://www.facs.org/ahp/ehr/index.html](http://www.facs.org/ahp/ehr/index.html)
- **CMS PQRS Web page** for more information on the PQRS-EHR streamlined reporting option: [www.cms.gov/PQRS/](http://www.cms.gov/PQRS/)

The College has partnered with AmericanEHR Partners: [http://www.americanehr.com/Home.aspx](http://www.americanehr.com/Home.aspx). ACS Members may register with the AmericanEHR Partners to receive additional information on EHR vendor ratings, listen to podcasts, request proposals from vendors, receive e-newsletters, and more. •

### TABLE 4: EXCEPTIONS AVAILABLE FOR EHR INCENTIVE PROGRAM*

<table>
<thead>
<tr>
<th>EXCEPTION</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insufficient Internet access</td>
<td>EPs must demonstrate that they are in an area without sufficient Internet access or face insurmountable barriers to obtaining the necessary infrastructure (such as lack of broadband)</td>
</tr>
<tr>
<td>New EP</td>
<td>Newly practicing EPs who would not have had time to become meaningful users may apply for a two-year limited exception to payment adjustments</td>
</tr>
<tr>
<td>Extreme circumstances outside of the EP’s control</td>
<td>Examples include a natural disaster or another unforeseeable barrier</td>
</tr>
</tbody>
</table>
| Lack of patient interaction | EPs must demonstrate that they meet the following criteria:  
  - Lack of face-to-face or telemedicine interaction with patients  
  - Lack of follow-up need with patients |
| Lack of control over availability of certified EHR technology (CEHRT) | Lack of control over availability of CEHRT for more than 50 percent of patient encounters |

The Medicare program: Enrollment and participation options
by Jenny J. Jackson, MPH, CPC

Physicians, nonphysician health care professionals, and other health care providers must be enrolled in the Medicare program to receive payment for covered services provided to Medicare beneficiaries. As the new calendar year approaches, many physicians are considering their options with respect to Medicare participation and the implications of their decision. This column answers some of the questions surgeons may have regarding their enrollment and participation options.

What is Medicare participation?
Medicare participating physicians agree to always accept assignment for all services furnished to Medicare beneficiaries. Agreeing to always accept assignment means the surgeon agrees to the Medicare-allowed amounts as full payment for a service and to collect no more than the Medicare deductible and coinsurance from the beneficiary.

How do I enroll in Medicare?
To enroll in Medicare, physicians and nonphysician providers must have a National Provider Identifier (NPI). Covered health care providers and all health plans and health care clearinghouses must use the NPIs in the administrative and financial transactions adopted under the Health Insurance Portability and Accountability Act (HIPAA). To apply for an NPI, go to https://nppes.cms.hhs.gov/NPPES/Welcome.do.

HIPAA-covered providers also must share their NPI with other providers, health plans, clearinghouses, and any entity that may need it for billing purposes. Access the following link to apply for an NPI: https://nppes.cms.hhs.gov/NPPES/Welcome.do.

Once an NPI is issued, a health care professional may apply for enrollment in the Medicare program or make a change in enrollment information using the paper application process (form CMS-855) or the Internet-based Provider Enrollment, Chain, and Ownership System (PECOS).

Should I use the paper enrollment form or the Internet?
The Medicare enrollment application form (CMS-855) may be completed using a computer, but signatures must be handwritten. Completed paper applications and all supporting documentation must be mailed to the Medicare fee-for-service contractor serving the surgeon’s state or geographic area. To find the Medicare fee-for-service contractor for your state or geographic location, go to http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/contact_list.pdf. Completed applications should not be mailed to the Centers for Medicare & Medicaid Services in Baltimore, MD.

PECOS may be used instead of the Medicare enrollment application (CMS-855). Physicians
and nonphysician providers can access PECOS by using the user IDs and passwords established when they applied online to the National Plan and Provider Enumeration System (NPPES) for their NPIs. For additional information regarding Medicare enrollment in PECOS, go to http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/medenroll_physother_factsheet_icn903768.pdf.

What are my options for participation in Part B Medicare?
The only options are participation or nonparticipation. Both options require the provider to file claims with Medicare. Participating (PAR) providers agree to accept Medicare payment for services rendered to program beneficiaries, who have 80 percent of each service covered by Medicare with the remaining applied to the patient copayment. The patient (or possibly the patient’s secondary insurer) is responsible for the 20 percent copayment. The provider cannot bill the patient for amounts in excess of the Medicare-allowed amount.

Nonparticipating (non-PAR) providers may determine on an individual claim basis whether to accept assignment. Medicare-approved amounts for services provided by non-PAR providers (including the 80 percent from Medicare plus the 20 percent copayment) are set at 95 percent of Medicare-approved amounts for PAR providers. However, non-PAR providers may charge more than the Medicare-approved amount.

The maximum amount that non-PAR providers may charge for unassigned claims is called the “limiting charge.” The limiting charge for a service is an amount equal to 115 percent of the Medicare-approved amount for non-PAR providers. See the table on this page for a list of Medicare participation options.

What does it mean to “opt out” of Medicare?
Opting out of Medicare means that a provider (physician, osteopath, and selected nonphysician providers, such as a clinical psychologist, physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, and so on) have decided not to participate...

What is the deadline for Medicare participation in 2014?
Typically, physicians have from November 15 to December 31 of each year to change their Medicare participation or nonparticipation status, and any changes would take effect January 1 of the following year. However, due to the 17-day government shutdown in October, CMS delayed the release of the Medicare physician fee schedule final rule, which lists payment rates for services covered under Medicare Part B. Appropriately, the ACS sent a letter to CMS in November, urging them to extend the period of time during which physicians may modify their Medicare participation status. At press time, the final rule had not been released, and CMS had not issued a response. Physicians who want to continue their current PAR or non-PAR status do not need to take any action.
in the Medicare program. Providers who opt out may enter private contracting agreements with Medicare beneficiaries and charge patients without being subject to the Medicare physician fee schedule, which can be found at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PFSlookup/index.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PFSlookup/index.html).

Health care professionals are prohibited from opting out on a claim-by-claim or patient-by-patient basis. Once providers have opted out of Medicare, they cannot submit claims to Medicare for any of their patients for a two-year period. Nonetheless, a provider who opts out may order, certify, or refer a beneficiary for Medicare-covered items and services as long as the provider is not reimbursed for the services, except for emergency and urgent care services. For example, if a physician who has opted out of Medicare refers a patient for services, such as durable medical equipment or inpatient hospitalization, those services would be covered by Medicare.

**Is it possible to opt out of the Medicare program in the middle of the calendar year?**

PAR providers may opt out at the beginning of each calendar quarter (January, April, July, or October). A valid affidavit postmarked 30 days before the first day of each new quarter must be submitted. Those providers who provide services to Medicare beneficiaries but who have non-PAR status may opt out at any time. However, the date on which the opt out becomes effective must be after the date on which the provider signs the affidavit.

**If I participate in Medicare am I required to accept new patients?**

No. Medicare participation does not require a physician’s practice to accept new Medicare patients. The Medicare participation agreement only directs how much physicians may charge Medicare patients for services.

**What if I have opted out of Medicare but provide emergency or urgent care services to a Medicare beneficiary?**

Physicians who have opted out of Medicare may provide emergency or urgent care services to a Medicare beneficiary even if they have not previously entered into a private contract with the patient, if the provider:

- Submits a claim in accordance with Medicare payment requirements and other instructions, including but not limited to complying with proper coding of emergency or urgent care services furnished by physicians who have opted out of Medicare
- Collects no more than the Medicare charge

**If I opt out of Medicare and then join a new practice a year later and need to start participating in Medicare again, is it possible to opt back in?**

No. After the initial 90-day effective period a provider may not participate in the Medicare program until the two-year opt-out period has ended.

For additional information, review the Medicare Enrollment for Physicians, Nonphysician Practitioners, and Other Health Care Suppliers fact sheet at [http://www.cms.gov/Medicare/Provider-Enrollment-andCertification/MedicareProviderSupEnroll/downloads/suppliers.pdf](http://www.cms.gov/Medicare/Provider-Enrollment-andCertification/MedicareProviderSupEnroll/downloads/suppliers.pdf).

**Editor’s note**

The College is not recommending or offering legal advice on any of the options discussed.
New data reported by Joint Commission-accredited hospitals show significant progress in compliance with evidence-based care processes that have been linked to improved outcomes for surgical patients. The results are presented in Improving America’s Hospitals: The Joint Commission’s Annual Report on Quality and Safety 2013, which also includes the overall performance of Joint Commission-accredited hospitals on quality of care core measures relating to heart attack, heart failure, pneumonia, children’s asthma, inpatient psychiatric services, venous thromboembolism (VTE), stroke, perinatal care, and immunization. These measures were chosen because they provide concrete data about evidence-based care processes closely linked to positive patient outcomes.

**Surgical measure improvements**
The new annual report shows that the 2012 surgical care composite accountability measures result is 98.3 percent, compared with 97.6 percent in 2011. The 2012 result is up from 82.1 percent in 2005 when The Joint Commission first began compiling results for this measure set. This change represents an improvement of 16.2 percentage points.

The surgical care composite includes:

- Antibiotics within one hour before the first surgical incision
- Appropriate prophylactic antibiotics
- Stopping antibiotics within 24 hours
- Beta-blocker patients who received beta-blocker perioperatively
- Cardiac patients with controlled postoperative blood glucose
- Patients with appropriate hair removal
- Prescribing VTE medicine/treatment
- Receiving VTE medicine/treatment
- Urinary catheter removed

The surgical care measures target key areas of perioperative care to reduce the risk of surgical complications. These evidence-based processes are important means of preventing infections and cardiovascular and thromboembolic complications. The nine measures are significant because they address a very large number of different types of patients who undergo a range of surgical procedures with a focus on major operations.

The percentage of hospitals achieving composite rates greater than 95 percent for the accountability measures related to surgical care also has improved dramatically; this threshold was 90 percent in previous years but was increased to 95 percent to better reflect the overall higher performance of the majority of accredited hospitals. In 2012, 91.6 percent of hospitals achieved surgical-related composite rates greater than 95 percent, in contrast with 38.2 percent of hospitals that achieved surgical-related composite rates greater than 90 percent in 2008. Composite measures combine the results of related measures into a single percentage rating calculated by adding up the number of times recommended evidence-based care was provided to patients and dividing this sum by the total number of opportunities to provide this care.

**Surgical care measure results**
In the table on page 50, the overall measure and rates are indicated in bold; the stratified measures (by specific surgical procedures) are indicated in regular type. The first three measures listed—antibiotics within one hour before the

*continued on page 51*
SURGICAL CARE MEASURE RESULTS

The overall measure and rates are indicated in **bold**; the stratified measures (by specific surgical procedures) are indicated in regular type. The first three measures listed (antibiotics within one hour before the first surgical cut, appropriate prophylactic antibiotics, and stopping antibiotics within 24 hours) report rates on seven specific surgical procedures, as well as the overall measure rate.

<table>
<thead>
<tr>
<th>Performance measure</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>Improvement since inception in 2005 (percentage points)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical care component</td>
<td>93.1%</td>
<td>95.8%</td>
<td>96.4%</td>
<td>97.6%</td>
<td>98.1%</td>
<td><strong>16.2%</strong></td>
</tr>
<tr>
<td>Antibiotics within one hour before the first surgical cut</td>
<td>93.5%</td>
<td>96.2%</td>
<td>97.4%</td>
<td>98.2%</td>
<td>98.0%</td>
<td><strong>16.4%</strong></td>
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<tr>
<td>For CABG surgery</td>
<td>94.0%</td>
<td>96.8%</td>
<td>97.8%</td>
<td>98.0%</td>
<td>98.5%</td>
<td><strong>13.7%</strong></td>
</tr>
<tr>
<td>For carotid surgery (other than CABG)</td>
<td>93.9%</td>
<td>96.6%</td>
<td>97.0%</td>
<td>98.8%</td>
<td>98.0%</td>
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<td>For colostomy surgery</td>
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<td>97.2%</td>
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<tr>
<td>For hip joint replacement surgery</td>
<td>93.4%</td>
<td>96.3%</td>
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<td>98.7%</td>
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<td>97.5%</td>
<td>98.3%</td>
<td>98.0%</td>
<td><strong>16.2%</strong></td>
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<tr>
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<td>98.0%</td>
<td>99.0%</td>
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<td>91.0%</td>
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<td>91.0%</td>
<td>97.6%</td>
<td><strong>22.1%</strong></td>
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<tr>
<td>Appropriate prophylactic antibiotics</td>
<td>96.8%</td>
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<td>98.3%</td>
<td>98.9%</td>
<td><strong>5.9%</strong></td>
</tr>
<tr>
<td>For CABG surgery</td>
<td>94.4%</td>
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<td>97.5%</td>
<td>98.0%</td>
<td>98.4%</td>
<td><strong>21.7%</strong></td>
</tr>
<tr>
<td>For carotid surgery (other than CABG)</td>
<td>92.9%</td>
<td>94.3%</td>
<td>95.4%</td>
<td>97.0%</td>
<td>98.2%</td>
<td><strong>35.2%</strong></td>
</tr>
<tr>
<td>For colostomy surgery</td>
<td>90.9%</td>
<td>92.4%</td>
<td>95.0%</td>
<td>94.7%</td>
<td>95.0%</td>
<td><strong>13.7%</strong></td>
</tr>
<tr>
<td>For hip joint replacement surgery</td>
<td>93.0%</td>
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<td>98.0%</td>
<td>98.4%</td>
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<tr>
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<td>97.8%</td>
<td>98.1%</td>
<td><strong>24.1%</strong></td>
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<td>For vascular surgery</td>
<td>83.0%</td>
<td>88.2%</td>
<td>91.0%</td>
<td>93.0%</td>
<td>93.9%</td>
<td><strong>25.8%</strong></td>
</tr>
<tr>
<td>Stopping antibiotics within 24 hours</td>
<td>90.5%</td>
<td>93.5%</td>
<td>95.2%</td>
<td>97.0%</td>
<td>97.6%</td>
<td><strong>24.2%</strong></td>
</tr>
<tr>
<td>For CABG surgery</td>
<td>95.6%</td>
<td>95.5%</td>
<td>97.5%</td>
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<td>98.4%</td>
<td><strong>25.7%</strong></td>
</tr>
<tr>
<td>For carotid surgery (other than CABG)</td>
<td>92.0%</td>
<td>94.8%</td>
<td>95.4%</td>
<td>97.0%</td>
<td>98.2%</td>
<td><strong>35.2%</strong></td>
</tr>
<tr>
<td>For colostomy surgery</td>
<td>90.0%</td>
<td>94.8%</td>
<td>95.0%</td>
<td>94.7%</td>
<td>95.0%</td>
<td><strong>13.7%</strong></td>
</tr>
<tr>
<td>For hip joint replacement surgery</td>
<td>89.8%</td>
<td>93.6%</td>
<td>95.0%</td>
<td>97.0%</td>
<td>97.8%</td>
<td><strong>28.6%</strong></td>
</tr>
<tr>
<td>For hysterectomy surgery</td>
<td>92.9%</td>
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<td>95.3%</td>
<td>97.2%</td>
<td>97.8%</td>
<td><strong>28.6%</strong></td>
</tr>
<tr>
<td>For knee joint replacement surgery</td>
<td>91.3%</td>
<td>93.7%</td>
<td>97.3%</td>
<td>97.8%</td>
<td>98.1%</td>
<td><strong>28.1%</strong></td>
</tr>
<tr>
<td>For vascular surgery</td>
<td>83.0%</td>
<td>88.2%</td>
<td>91.0%</td>
<td>93.0%</td>
<td>93.9%</td>
<td><strong>25.8%</strong></td>
</tr>
<tr>
<td>Beta-blocker patients who received beta-blocker postoperatively</td>
<td>92.8%</td>
<td>91.5%</td>
<td>94.4%</td>
<td>96.4%</td>
<td>97.3%</td>
<td><strong>5.2%</strong></td>
</tr>
<tr>
<td>Cardiac patients with controlled postoperative blood glucose</td>
<td>89.9%</td>
<td>92.7%</td>
<td>94.1%</td>
<td>95.3%</td>
<td>96.4%</td>
<td><strong>6.5%</strong></td>
</tr>
<tr>
<td>Patients with appropriate hair removal</td>
<td>97.4%</td>
<td>99.2%</td>
<td>99.7%</td>
<td>99.8%</td>
<td>99.9%</td>
<td><strong>2.4%</strong></td>
</tr>
<tr>
<td>Prescribing VTE medicine/treatment*</td>
<td>92.1%</td>
<td>93.7%</td>
<td>95.2%</td>
<td>97.8%</td>
<td>98.5%</td>
<td><strong>11.3%</strong></td>
</tr>
<tr>
<td>Receiving VTE medicine/treatment*</td>
<td>89.6%</td>
<td>91.9%</td>
<td>93.7%</td>
<td>96.9%</td>
<td>97.9%</td>
<td><strong>14.6%</strong></td>
</tr>
<tr>
<td>Urinary catheter removed</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

Since implementation in 1995, the average number of hospitals reporting data was 1,884 and ranged from 258 to 2,760. *Retired as of December 31, 2012.*
Currently, The Joint Commission requires most hospitals to select four measure sets. As of January 1, 2014, the required number of selected measure sets will increase to six.

first surgical cut, appropriate prophylactic antibiotics, and stopping antibiotics within 24 hours—report rates on seven specific surgical procedures, as well as the overall measure rate.

Since implementation in 2005, the average number of hospitals reporting data was 1,884 and ranged from 258 to 2,766.

Raising the measurement bar
Currently, The Joint Commission requires most hospitals to select four measure sets. As of January 1, 2014, the required number of selected measure sets will increase to six. Four of the six measure sets will be mandatory for all general medical/surgical hospitals that serve specific patient populations addressed by the measure sets and related measures. The measure sets address acute myocardial infarction, heart failure, pneumonia, and the Centers for Medicare & Medicaid Services’ Surgical Care Improvement Project. For hospitals with 1,100 or more births per year, the perinatal care measure set will become the mandatory fifth measure set. Hospitals that do not have 1,100 or more births may elect to submit data on the perinatal care set as the fifth or sixth discretionary set. The sixth measure set (or fifth and sixth measure sets for hospitals with fewer than 1,100 births per year) will be chosen by all general medical/surgical hospitals from the approved complement of core measure sets. Hospitals submit monthly data on a quarterly basis on all measures of performance within specific sets of their choosing to third-party vendors, which compile and provide data to The Joint Commission. Hospitals may obtain feedback reports through The Joint Commission’s extranet. This year’s results on the surgical measure set, the other eight measure sets, and all individual measures reported both this year and last year show improvement. These results reflect the collective performance of more than 3,300 Joint Commission-accredited hospitals working to improve quality and safety. Although this improvement is supported by numerous Joint Commission efforts, including accreditation itself, the accountability measures, and the structured and audited data process, The Joint Commission also provides a Core Measure Solution Exchange®, which promotes the sharing of success stories among hospitals. This database helps hospitals to learn how peers have achieved excellent performance on core measures. To date, more than 200 core measure solutions have been posted by hospitals that have dramatically improved and sustained their performance. These solutions are available to Joint Commission-accredited organizations on the secure Joint Commission Connect extranet. Hospitals that have found solutions are encouraged to post them to the exchange.

Movies have become very graphic over the years, and often a modern action adventure movie will portray the use of a sleeper hold, either used by or against the hero. Applied from behind, a grip around the neck compresses both carotid arteries, and within a matter of seconds unconsciousness results from the reduction in cerebral blood flow. This maneuver has its roots in judo, initially termed shime-waza (constriction technique), and over time has been referred to as a chokehold, stranglehold, blood choke, mugger’s yoke, and the carotid choke.¹ Use of the sleeper hold has its risks.

A recent report describes bilateral blunt carotid artery injury in a young man due to strangulation. He arrived at the hospital with a normal Glasgow Coma Scale but computed tomography (CT) angiography revealed injuries to both carotid arteries. Fortunately, after six weeks of conservative management with anticoagulation, a repeat CT study showed complete resolution of an intimal flap.²

The website dictionary.com defines the carotid (also called carotid artery) as “either of the two large arteries, one on each side of the head, that carry blood to the head.”³ The word has its origin from “Greek karōtides neck arteries, equivalent to karōt (ikós) soporific (kár (os) stupor + -ōtikos -otic) + -ides -id; so called by Galen, who found that their compression causes stupor.”³ Blunt carotid artery injury has been an enigma, but over the past 15 years, it has come to the forefront. As trauma system development spread throughout the country bringing larger numbers of injured patients to trauma centers, diagnostic algorithms with screening protocols were developed and patterns of injury were recognized. As technology improved along with the availability and use of multi-slice CT angiography, most institutions now report blunt cerebrovascular injuries occurring in 1 percent to 2 percent of trauma admissions.⁴

Occurrence of injury

To examine the occurrence of blunt carotid artery injuries in the National Trauma Data Bank® (NTDB®) research dataset for 2012, admissions medical records with a blunt mechanism of injury were searched using the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis codes. Specifically searched were injury codes 900.0, carotid artery unspecified; 900.01, common carotid artery; 900.02, external carotid artery; and 900.03, internal carotid artery. A total of 957 records was uncovered. Of these records, 921 contained a discharge
status, including 372 patients discharged to home, 250 to acute care/rehab, and 135 sent to skilled nursing facilities; 164 died. Of these patients, 65 percent were male, on average 39.2 years of age, had an average hospital length of stay (LOS) of 15.2 days, an intensive care unit (ICU) length of stay of 10.3 days, an average injury severity score (ISS) of 28.3, and were on the ventilator for an average of 9.1 days. Emergency department disposition resulted in only 11 percent going to a general surgical floor, while 62 percent went to the ICU, another 21 percent went directly to the operating room, and 6 percent went to telemetry. This group had significant injuries based upon the high average ISS, the majority requiring ICU admission, and the high average hospital and ICU LOS (see figure, this page).

Most blunt carotid artery injuries are unilateral and the result of motor vehicle crashes; however, other mechanisms have been implicated, as mentioned previously in this column.

**Play it safe**

Horseplay is a rite of passage, especially among siblings close in age or among friends that may have had a few drinks and try and relive their earlier days wrestling around on the floor. Just remember that the sleeper hold is not an innocent maneuver and may cause arterial injury and put you to sleep permanently.

Throughout the year, we will be highlighting data through brief reports in the *Bulletin*. The NTDB Annual Report 2012 is available on the ACS website as a PDF file and as a PowerPoint presentation at [www.ntdb.org](http://www.ntdb.org). In addition, information regarding how to obtain NTDB data for more detailed study is available on the website. If you are interested in submitting your trauma center’s data, contact Melanie L. Neal, Manager, NTDB, at mmeal@facs.org.

**Acknowledgement**

Statistical support for this article has been provided by Chrystal Caden-Price, data analyst, NTDB.

**REFERENCES**

Andrew L. Warshaw, MD, FACS, surgeon-in-chief emeritus, Massachusetts General Hospital (MGH), and the W. Gerald Austen Distinguished Professor of Surgery at Harvard Medical School, Boston, MA, was elected President-Elect of the American College of Surgeons (ACS) during the Annual Business Meeting of Members. In addition, the First and Second Vice-Presidents-Elect were elected, along with a new ACS Treasurer and Secretary.

Eminent researcher, educator, clinician

Dr. Warshaw, who also is senior consultant for international and regional clinical relations at MGH and Partners Healthcare, became a Fellow of the ACS in 1974. Since then, he has served the College in various leadership capacities, including in his current role as Chair of the Health Policy and Advocacy Group and as ACS Treasurer (2007–2013).

An eminent surgical researcher, educator, and clinician, Dr. Warshaw has made important contributions to the diagnosis, treatment, and understanding of the pathogenesis of inflammatory and malignant lesions of the pancreas. He is the director of the Andrew L. Warshaw Institute for Pancreatic Cancer Research at MGH, which was established in 2008 to develop innovative and comprehensive diagnostic and treatment options for all forms of pancreatic cancer. The institute’s core faculty works closely with dozens of clinicians and scientists at the MGH Cancer Center, which has one of the nation’s largest clinical pancreatic cancer programs and offers treatment options available at few other hospitals.

Dr. Warshaw is a graduate of Harvard College and Harvard Medical School and trained at MGH. He spent two years as a clinical associate in the section on gastroenterology of the National Institutes of Health and was a research fellow in medicine (gastroenterology) at MGH. Since 1972, he has been on the staff at MGH and on the faculty of Harvard Medical School. In 1987, he became professor of surgery at Harvard and, in 1997, the W. Gerald Austen Professor of Surgery, surgeon-in-chief, and chairman of the department of surgery at MGH.


He also is a former member of the ACS Board of Governors (1997–2003). In that capacity, Dr. Warshaw chaired the Governors Committee on Socioeconomic Issues (1999–2003) and continues to serve as an ex officio member of that panel. As chair, he was responsible for initiating the ACS volunteerism program (Operation Giving Back) and the American College of Surgeons Professional Association’s political action committee (ACSPA-SurgeonsPAC). Additionally, he served on the Governors’ Nominating Committee (1999–2000) and Committee on Surgical Practice (1997–1998) and has been an ex officio member of the Governors’ Committee to Study the Fiscal Affairs of the College since 2007.

Dr. Warshaw is a Past-President of the Massachusetts Chapter of the ACS (1991–1992) and has been an active member of the College’s Women in Surgery Committee (2001–2004), the Surgical Research Committee (1988–1993), the Committee...
on Video-Based Education (1983–1993), and the Medical Motion Pictures Committee (1985–1989). Dr. Warshaw also served as Chair of the ACS Finance Committee’s Investment Subcommittee (2007–2013).

In addition to his leadership within the ACS, Dr. Warshaw has been president of several other surgical societies, including the Society for Surgery of the Alimentary Tract, the International Association of Pancreatologists, the New England Surgical Society, the Halsted Society, the Boston Surgical Society, the Society of Surgical Chairs, and the American Pancreatic Association. He served on the board of directors of the American Board of Surgery (1985–1993) and as its chairman in 1993. Dr. Warshaw received the Lifetime Achievement Award of the American Pancreatic Association (2011), the Ewing Medal from the Society of Surgical Oncology (2002), and the Master Educator Award from the Society for the Surgery of Alimentary Tract (2011).

His bibliography lists more than 420 original reports as well as 240 book chapters, reviews, and monographs and 13 books. Presently, he is editor-in-chief of *Surgery.*

**Vice-Presidents-Elect**

The Vice-Presidents-Elect also were elected during the Annual Meeting. The First Vice-President-Elect is **Jay L. Grosfeld, MD, FACS,** Lafayette F. Page Professor Emeritus of Pediatric Surgery, Indiana University School of Medicine, Indianapolis. He served as chairman of the department of surgery at that institution (1984–2003) and as director of pediatric surgery and surgeon-in-chief, Riley Hospital for Children, Indianapolis (1972–2005). The Second Vice-President-Elect is **Kenneth L. Mattox, MD, FACS,** Distinguished Service Professor, Michael E. DeBakey Department of Surgery, Baylor College of Medicine; and chief of staff and chief of surgery, Ben Taub General Hospital, Houston, TX.

A Fellow of the ACS since 1973, Dr. Grosfeld has served on the ACS Advisory Council for Pediatric Surgery (1996–2001) and on the Advisory Councils for Surgical Specialties (1989–1994). An ACS Governor from 1985 to 1991, he was a member of the Board of Governors’ Committees on Chapter Relations (1989–1992) and Physician Competency (1987–1992). He also served as a senior member of the Committee on Continuing Education (1981–1991) and on the Nominating Committee of the Fellows (1991–1992). He has been the president of many surgical associations, including the American Surgical Association and the American Pediatric Surgical Association, and, like Dr. Warshaw, is a former chairman of the American Board of Surgery. Dr. Grosfeld also is editor-in-chief of the *Journal of Pediatric Surgery and Seminars in Pediatric Surgery.* Dr. Grosfeld has received the William E. Ladd Medal from the American Academy of Pediatrics, the Denis Browne Gold Medal from the British Association of Paediatric Surgeons, and the Fritz Rehbein Medal from the European Pediatric Surgeons Association. He recently received a Distinguished Service Award from the American Pediatric Surgical Association and a Lifetime Achievement Award from the World Federation of Associations of Pediatric Surgeons.

Dr. Mattox has been a Fellow of the ACS since 1975. A dedicated trauma surgeon, he has played a particularly active role on the College’s Committee on Trauma (COT). He has served on the COT’s Executive Committee (1986–1989) and chaired the COT’s Emergency Services-Hospital Subcommittee (1983–1990). He also was a member of the ACS’s Committee on Video-Based Education (1983–1993), and the Medical Motion Pictures Committee (1985–1989). Dr. Warshaw also served as Chair of the ACS Finance Committee’s Investment Subcommittee (2007–2013).
of the COT’s Verification and Consultation Committee (1990–2000) and an ex officio member of the Education Subcommittee (1993–present). He delivered the Scudder Oration on Trauma at the 2000 Clinical Congress and is Program Director of the Trauma, Critical Care, and Acute Care Surgery Course and the Disaster Medical Response Course, both of which are sponsored by the ACS and presented each spring in Las Vegas, NV.

In addition, Dr. Mattox has served on the ACS Board of Governors (1985–1991, 1997–2003), playing an active role on the following Governors’ committees: the Committee on Surgical Infections as both Vice-Chair (2002–2003) and as a member (1998–2002), the Nominating Committee (2002–2003), and the Committee on Ambulatory Surgical Care (1986–1991). Dr. Mattox also has been a member of the College’s Pre- and Postoperative Care Committee (1988–1994), the Committee on Video-Based Education (1986–1990), the Program Committee (1982–1986), and the Committee on Medical Devices (1980–1986), which he chaired (1983–1986). Dr. Mattox has co-authored or co-edited several prominent surgical texts, including Trauma, Top Knife: The Art and Craft of Trauma Surgery, and the Sabiston Textbook of Surgery: The Biological Basis of Modern Surgical Practice.

**Secretary and Treasurer**

Also elected during the Annual Business Meeting were the ACS Secretary and Treasurer. Edward E. Cornwell III, MD, FACS, FCCM, LaSalle D. Leffall, Jr., MD, Professor and Chairman of Surgery, Howard University College of Medicine, and surgeon-in-chief, Howard University Hospital, Washington, DC, replaces Courtney M. Townsend, Jr., MD, FACS, as ACS Secretary. An ACS Fellow since 1992, Dr. Cornwell serves on the ACS Legislative Committee and is Past-Chair and member of the Nominating Committee of the Fellows (2003–2004 and 2001–2003, respectively). Dr. Cornwell has served on several other ACS committees, including the COT (2004–2010 as a member and 2010–2012 as a special member), the COT’s Committee on Trauma Systems (2004–2010), the Pre-and Postoperative Care Committee (2000–2002), and the Committee on Diversity Issues (2002–2005).

Replacing Dr. Warshaw as ACS Treasurer is William G. Cioffi, Jr., MD, FACS, J. Murray Beardsley Professor and Chairman, department of surgery, Alpert Medical School of Brown University, and surgeon-in-chief, Rhode Island Hospital and The Miriam Hospital, Providence. A Fellow of the College since 1990, Dr. Cioffi completed his service as Secretary of the Board of Governors at this year’s Clinical Congress. He began serving on the Board of Governors in 1999. After serving as member of the Governors’ Committee to Study the Fiscal Affairs of the College (2001–2002, 2004–2005), he was elected Vice-Chair and Chair of that committee (2002–2004 and 2011–2013, respectively). Dr. Cioffi also served as Vice-Chair of the Governors’ Committee on Chapter Relations (2009–2011), and the Ad Hoc Committee to Restructure the Board of Governors’ Committees. He has been an active member of the Pre-Operative and Postoperative Care Committee (1995–2002), the COT (2004–2010), and the Program Committee (2007–2013). Additionally, he has served on the Regents’ Finance Committee (2011–2013) and the Executive Compensation Committee (2011–2013). ◆
One new member of the Board of Regents was elected during the Annual Business Meeting of Members at the 2013 American College of Surgeons (ACS) Clinical Congress in Washington, DC. The new Regent, James Gigantelli, MD, FACS, is professor of ophthalmology, vice-chair of clinical affairs, and assistant dean of government affairs at the University of Nebraska Medical Center, Omaha. A Fellow since 1999, Dr. Gigantelli served on the Board of Governors (2005–2011) and, in that role, on the Governors’ Committee on Socioeconomic Issues (2008–2011). He also has been a member of the Advisory Council for Ophthalmic Surgery since 2005, most recently serving as the Council Chair (2009–2013). He first became a member of the Advisory Council for Ophthalmic Surgery in 2005. In addition, Dr. Gigantelli is a member of the ACS Health Policy Advisory Council (2011–present).

Reelected to additional three-year terms on the Board of Regents were: Margaret M. Dunn, MD, FACS, a general surgeon, Dayton, OH; Howard M. Snyder III, MD, FACS, a urological surgeon, Philadelphia, PA, and Michael J. Zinner, MD, FACS, a general surgeon, Boston, MA.

Julie A. Freischlag, MD, FACS, a vascular surgeon, Baltimore, MD, will continue her service as Chair of the Board of Regents, and Mark C. Weissler, MD, FACS, an otolaryngology surgeon, Chapel Hill, NC, will continue to serve as Vice-Chair.

The Board of Governors elected Gary L. Timmerman, MD, FACS, a general surgeon, Sioux Falls, SD, to assume the role of Chair of its Executive Committee; Fabrizio Michelassi, MD, FACS, a general surgeon, New York, NY, as Vice-Chair; and Lorrie Langdale, MD, FACS, a general surgeon, Seattle, WA, as Secretary. Newly elected to serve on the Executive Committee Board of Governors are Karen Brasel, MD, FACS, a general surgeon, Milwaukee, WI; and Joseph H. Tepas III, MD, FACS, a pediatric surgeon, Jacksonville, FL. In addition, James C. Dennen III, MD, FACS, an otolaryngology surgeon, Columbia, MO, and Sherry M. Wren, MD, FACS, a general surgeon, Palo Alto, CA, have been reappointed to the Board of Governors Executive Committee.
The American College of Surgeons (ACS) Commission on Cancer (CoC) responded to the Institute of Medicine (IOM) report, *Delivering High-Quality Cancer Care: Charting a New Course for a System in Crisis*, released on September 10. CoC Chair Daniel P. McKellar, MD, FACS, clinical professor of surgery at Wright State University, Dayton, OH, and director of the cancer program at Wayne HealthCare, Greenville, OH, called the IOM document a “thought-generating committee report” but noted that the CoC does “not view our current cancer care system as one ‘in crisis.’”

“We think the report is well-constructed and provides an excellent framework for improving the delivery of quality cancer care in the future,” Dr. McKellar said. “However, many of the quality issues addressed in the IOM report are already active initiatives of our organization and have been for many years.

“Since 2005, the CoC has provided its accredited cancer programs with an annual Cancer Program Practice Profile Report, which assists cancer programs in monitoring compliance with quality measures and benchmarking,” Dr. McKellar continued. “The CoC also provides immediate feedback on quality measure compliance through our Rapid Quality Reporting System that tracks outcomes in ‘real time’ for clinicians and cancer programs and provides reminders when a quality measure is not met for individual patients.”

More than 1,500 accredited cancer programs follow CoC standards. These standards “set a high bar—one that the CoC has found accredited programs are eager to meet,” according to the CoC response statement. “Cancer is a multifaceted disease, and its complexity makes it challenging to treat,” said David P. Winchester, MD, FACS, Medical Director, ACS Cancer Programs. “The CoC has been a leader in the development and monitoring of quality measures for cancer care and for holding cancer programs accountable for compliance with standards and measures of quality.”

As noted in the IOM report, the CoC has incorporated the National Quality Forum-endorsed measures into the CoC quality reporting tools. Quality measures reported in the *Cancer Program Practice Profile Report* have been incorporated into the CoC Standards as either Quality Accountability or Quality Improvement measures. The CoC requires accredited cancer programs to comply with these measures.

In addition, the CoC’s Quality Integration Committee approves quality measures to be used for reporting to CoC-accredited programs. Measures for esophageal, gastric, rectal, and non-small cell lung cancer were passed by the Quality Integration Committee in May 2013. These measures will be reported starting in 2014.

The CoC also has formed a full committee that addresses advocacy and health policy issues that affect cancer patients. The CoC has addressed such matters as payment systems, quality tracking systems, cancer disparities, and the challenges of workforce shortages and training needs.

View the full CoC statement online at http://www.facs.org/cancer/coc-iom-response.html.
Members of the Fellows Leadership Society (FLS) met October 7 during the American College of Surgeons (ACS) Clinical Congress in Washington, DC, for the group’s 25th anniversary luncheon. During the program, Amilu Stewart, MD, FACS, Chair of the ACS Foundation Board of Directors, and Andrew Warshaw, MD, FACS, ACS President-Elect, publicly announced the launch of the 1913 Legacy Campaign fundraising initiative.

**1913 Legacy Campaign officially launched at FLS luncheon**

While also recognizing the Centennial and looking forward to the next 100 years, Campaign gifts will invest in the three pillars of the College’s mission: The Surgeon, The Profession, and The Societal Good.

Dr. Stewart said at the time of the luncheon that the Foundation had received $825,000 of its $5 million goal. “This is only the beginning of this transformative campaign,” Dr. Warshaw said, asking attendees for their support. He noted that donors may direct their campaign donations to a number of funds, including the Rural Surgery Initiative, chapter programs, education, scholarships, and the Codman Quality and Safety Fund established in honor of the pioneering work of Ernest A. Codman, MD, FACS.

**Donors recognized**

Drs. Stewart and Warshaw recognized donors who have given at several levels to the campaign. William Sternfeld, MD, FACS, Toledo, OH, and Pon Satipunwaycha, MD, FACS, Houston, TX, have donated at the Leadership level with gifts of $100,000 and up. W. Gerald Austen, MD, FACS, and his wife, Patricia, Boston, MA; Raghuvir Gelot, MD, FACS, and his wife, Carolyn, Ahoskie, NC; Mary McGrath, MD, FACS, San Francisco, CA; and Dr. Warshaw and his wife Brenda are Champion gift donors ($50,000 to $99,999). Richard Reiling, MD, FACS, and his wife, Elizabeth, Charlotte, NC; William Bernie, MD, FACS, Naples, FL; and Dr. Stewart are Distinguished gift donors ($25,000 to $49,999).

After the FLS luncheon, many new donors came forward to contribute to the 1913 Legacy Campaign, including Danny Robinette, MD, FACS, and his wife Paula, Fairbanks, AK, who gave at the Leadership Gift level. At press time, more than $1 million had been raised.

For more information on how to participate in the 1913 Legacy Campaign, contact the ACS Foundation at 312-202-5338 or acsfoundation@facs.org.
Outcomes key to ACA mission of reducing health care costs

Several health care experts, including Clifford Y. Ko, MD, MS, MSHA, FACS, Director of the American College of Surgeons (ACS) Division of Research and Optimal Patient Care, examined the complex political, medical, and business ramifications of the Affordable Care Act (ACA) at a half-day forum sponsored by the National Journal on October 3 in Washington, DC. For the ACA to achieve its mission of curbing the cost of health care, accurate, risk-adjusted data must be collected, Dr. Ko said at the forum.

“We need good, rigorous, and believable data that physicians on the front line will trust and buy into,” Dr. Ko, Director of the ACS National Surgical Quality Improvement Program (ACS NSQIP®), said. “And we need to be able to collect the data without a lot of burden.” College databases such as the National Cancer Data Base and ACS NSQIP have focused on collecting robust data. The ACS, which has led a number of initiatives to improve quality in such areas as trauma and cancer, subscribes to four key principles: set the standards, build the right infrastructure, use robust patient data, and verify.

“What we need is more and better metrics,” Dr. Ko said. “We continually need to accurately and appropriately measure the care we’re delivering.”

The forum examined the complex political, medical, and business ramifications of the ACA. Participants included key decision-makers from areas impacted by the new law. View the ACS press release regarding the National Journal forum at http://www.facs.org/news/2013/ko1013.html.

CMS recognizes ACS Surgeon Specific Registry as a PQRS-Qualified Registry

The American College of Surgeons (ACS) Surgeon Specific Registry (SSR), previously the case log, has been recognized as a qualified registry for the Centers for Medicare & Medicaid Services’ (CMS) Physician Quality Reporting System (PQRS). Eligible professionals may submit 2013 PQRS Perioperative Care Measures Group data through the SSR.

In addition, the ACS has worked closely with CMS to submit additional PQRS measures. Once the measures are approved, surgeons may submit measure-specific variables to CMS through the SSR.

The American Board of Surgery’s and American Board of Colon and Rectal Surgery’s Maintenance of Certification (MOC) Part IV requirements previously accepted the SSR to fulfill reporting mandates.

For more information on the SSR, MOC, and PQRS participation, visit the ACS website at http://www.facs.org/members/pbils.html or contact SSR@facs.org.

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Chapter news
by Donna Tieberg

Policy, advocacy, and health care access focus of Utah Chapter meeting

The Utah Chapter of the American College of Surgeons met September 13-14, 2014, at the Little America Hotel in Salt Lake City. An enthusiastic 34 members and guests were in attendance for a Friday night poster competition and dinner, and for a Saturday program. In addition, 12 chapter officers convened to discuss preliminary planning for the upcoming year.

Highlights of the Utah Chapter annual meeting included the poster competition, featuring the work of 14 pre-med and medical students and residents. The winner of the Michael Collins Research Award was Huizhong Li, graduate research assistant at the University of Utah, Salt Lake City, working with Jay Agarwal, MD, FACS, on a project titled A New Vascular Coupling Device for End-to-End Anastomosis. Second prize was awarded to Alice Chung, MD, and third prize to Jeffrey Redshaw, research assistant, both of the University of Utah School of Medicine.

The chapter dinner speaker was Douglas Grey, MD, FACS, co-founder of Operation Access. The mission of Operation Access is to provide health care professionals in the San Francisco, CA, Bay area with opportunities to donate vital surgical and specialty care to people in need.

The theme of Saturday’s program was “Policy, Advocacy, and Access to Healthcare.” Brian Stagg, MD, University of Utah, described the work of the Moran Eye Center, which is providing for the eye care needs of the homeless and underserved in both Salt Lake City and Park City. Christina Gallop, MD, medical director of the Fourth Street Clinic in Salt Lake City, spoke of the surgical needs of the homeless community in that city.

Amalia Cochran, MD, FACS, Utah Chapter President and a member of the American College of Surgeons Professional Association’s Political Action Committee (ACSPA-SurgeonsPAC) Board of Directors, provided a legislative overview of surgery-related issues that are currently being debated in Congress and discussed the importance of ACSPA-SurgeonsPAC membership. Dr. Cochran also updated the group on SurgeonsVoice, a greatly enhanced grassroots advocacy program aimed at recruiting, educating, and motivating ACS Fellows to use their influence with decision makers in Washington, DC.

U.S. Rep. Jim Matheson (UT) participated in a question-and-answer session centered on current health care legislation. Representative Matheson is the lead sponsor of the Good Samaritan Bill (H.R. 36), which would ensure that physicians and other providers who volunteer across state lines in response to a federally declared disaster receive the same liability protection currently offered to those who volunteer in-state.

State Rep. Rebecca Chavez-Houck offered advice on how surgeons can get involved in health care reform at the state level. Rep. Chavez-Houck encouraged audience members to educate members of the Utah Health Services Reform Taskforce about the provision of charity care in Utah.

Sam Finlayson, MD, FACS, chair of the department of surgery at the University of Utah, closed the annual meeting with a talk on surgeon supply and physician workforce issues and how future models of collaborative care may affect them.

For additional information on the Utah Chapter, contact Dr. Cochran at amalia.cocharan@hsc.utah.edu.

DEC 2013 BULLETIN American College of Surgeons
Scholarships for 2014 Heller School Executive Leadership Program in Health Policy and Management now available

The American College of Surgeons (ACS) is offering scholarships to subsidize attendance and participation in the Executive Leadership Program in Health Policy and Management at the Heller School for Social Policy and Management at Brandeis University, Waltham, MA (http://heller.brandeis.edu/academic/execed/index.html). The 2014 course will take place June 8–14, and the closing date for receipt of all application materials is February 3, 2014. The $8,000 award must be used toward the cost of tuition, travel, housing, and subsistence during participation in the course and the post-course follow-up period.

The ACS fully funds two scholarships, reserved for general surgeons, and has partnered with several surgical organizations to cosponsor a scholarship for a member in good standing of both the College and their specialty society. (See sidebar for list of participating specialty societies.) All applicants will be notified of the outcome of the selection process by March 31, 2014.

Questions may be directed to the ACS Scholarships Administrator at kearly@facs.org or 312-202-5281. Requirements for the scholarships are posted on the ACS website at http://www.facs.org/memberservices/research.html.

PARTICIPATING SOCIETIES

- American Association of Neurological Surgeons
- American Academy of Otolaryngology-Head and Neck Surgery
- American Association for the Surgery of Trauma
- American College of Surgeons
- American Pediatric Surgical Association
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- American Society of Colon and Rectal Surgeons
- American Society of Plastic Surgeons
- American Surgical Association
- American Urogynecologic Society
- American Urological Society (via Gallagher Scholarship program)
- Eastern Association for the Surgery of Trauma Foundation
- New England Surgical Society
- Society for Surgery of the Alimentary Tract
- The Society of Thoracic Surgeons
- Society for Vascular Surgery

Connect with the College via social media!

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Event Hashtag: #ACS100 identifies tweets related to the College’s centennial celebration, as well as highlights people and events from our 100-year history.

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Social media questions?
For more assistance or if you have questions or comments about the American College of Surgeons’ social media sites, send an e-mail to socialmedia@facs.org.
Being selected to serve as the 2012 American College of Surgeons Traveling Fellow to Australia and New Zealand (ANZ) has been the highlight of my professional career. I was thrilled to have the opportunity to meet and interact with my wonderful colleagues Down Under.

My goals for the Traveling Fellowship included exchanging with ANZ surgeons ideas and solutions for patients with vascular disease. Specifically, I wanted to accomplish the following:

- Share my expertise in vascular surgery, endovascular therapies, and vascular biology with surgeons in Australia and New Zealand
- Discuss and directly observe complex surgical and endovascular techniques
- Understand new training paradigms for the next generation of vascular specialists

I believe I achieved all of these goals and much more.

First stop, Malaysia
One of the requirements of the Traveling Fellowship is to address the Royal Australasian College of Surgeons (RACS) Scientific Congress. For the first time in many years, this meeting was not held in Australia or New Zealand, but in Kuala Lumpur, Malaysia, which proved to be a fantastic choice of venues.

Traveling to Malaysia and then to Australia and New Zealand did create some time and cost challenges for one trip, so I actually made two trips. I want to thank Stephen Deane, MD, MB, BS, FACS, FRACS, FRCS(C), Chair of the ACS International Relations Committee, for helping to orchestrate the trips.

I went to Kuala Lumpur in May 2012, where I interacted with multiple ANZ and Malaysian surgeons (see photo, this page). Ian Civil, MB, ChB, FACS, PRACS, a general and...
trauma surgeon at Auckland City Hospital, NZ, introduced me to several ANZ vascular surgeons. Despite his multiple time pressures as President of the RACS, Dr. Civil graciously attended my lectures and discussed my research regarding endothelial dysfunction. Of note, he had trained at the Cleveland Clinic where I spent eight years of my professional career, and we traded many stories. His partner at Auckland City Hospital, Andrew Hill, MB, ChB, FACS, FRACS, is a widely recognized endovascular surgeon. Dr. Hill and Andrew Holden, MB, ChB, FRANZCR, have written extensively on cutting-edge endovascular therapies that are being incorporated into surgical practice worldwide. We exchanged ideas and debated visceral and mesenteric endovascular strategies. Ravi Huilgol, MB, BS, FRACS, from Sydney coordinated the vascular sessions and organized an outstanding program.

During my week in Malaysia, I participated in multiple forums regarding the current state of vascular surgery and intervention. An added benefit was hearing Malaysian surgeons’ approaches to vascular care.

Back to Australia
I returned to Australia in October 2012 and traveled to Melbourne and Sydney. During my visit to Melbourne, I attended the ANZ Society for Vascular Surgery meeting. Prof. Robert Fitridge, MB, BS, MS, FRACS, from Adelaide invited me to give multiple presentations. He and his colleague, Peter Subramaniam, MB, BS, FRACS (Surgery), FRACS (Vascular Surgery) run a highly reputed limb salvage program. Similar to the worldwide epidemic, diabetes is rampant in ANZ, especially in the Aborigine community. Geoff Cox, MB, BS, FRACS, has a large aortic practice in Melbourne. He was a gracious host and took some American visitors on a boat ride down the Yarra River (see photo, this page).

Domenic Robinson, MB, BS, PGDipSurgAnat, a vascular trainee at the Austin Hospital, asked me to present Reflections at Mid-Career to ANZ residents, trainees, and students during a dinner meeting in Melbourne. In Melbourne, I visited the Alfred Hospital and the Baker IDI Heart and Diabetes Institute. At the Alfred, I observed a thoracic endovascular repair for thoracic aortic pathologies, among other operations.

In Sydney, I visited Dr. Huilgol; Prof. James May, AC; and their colleagues at St. Vincent’s Hospital, a prominent private institution. We spent time on the wards and reviewing cases. Raffi Qasabian, MB, BS, BSc, FRACS, allowed me to scrub in on some endovascular cases (see photo, page 65). He performed endovascular therapy for patients with critical limb ischemia. Despite the recent evolution of this therapy, the actual techniques are remarkably similar to those approaches that we use in the U.S.

Lessons learned
I learned a great deal as the ANZ Traveling Fellow. Vascular surgeons in that region have been at the forefront of open...
surgical and endovascular procedures for many years. The opportunity to visit surgeons at their institutions, to engage in personal interchanges, and to directly observe procedures was invaluable. Examples of the lessons I learned are as follows:

- Endovascular therapies are used routinely throughout Australia and New Zealand. ANZ surgeons have high-level endovascular skills, and variance of endovascular capability may be less than in other regions, possibly due to a smaller pool of vascular surgeons and training programs. There is rapid dissemination of new endovascular techniques throughout the ANZ vascular surgery community. However, like many U.S. surgeons, vascular surgeons in ANZ are debating the indications and long-term benefits of endovascular procedures.

- In ANZ, practices often are defined by whether the surgeon works at a public versus a private hospital, although many surgeons have appointments at both types of institutions. Public hospitals largely provide care to patients with government-sponsored medical insurance and house most of the training programs. Private hospitals treat patients with supplemental private insurance who may seek care without the delays inherent in the public system. Despite the patients’ impression that private hospitals may provide higher-quality care, most surgeons confide that sometimes their most challenging cases are done in the public hospital, given the intraoperative assistance and postoperative vigilance trainees can provide.

- Vascular surgery training in ANZ is undergoing marked change similar to what we are experiencing in the U.S. Many vascular training programs in the U.S. are adopting “0–5” programs in which medical students go directly into vascular training for five years after medical school. This system is in contradistinction to the traditional “5–2” program in which one finishes a five-year general surgery residency before starting a two-year vascular fellowship. Similarly, vascular surgery training is being streamlined in ANZ. The RACS plays a large role in training paradigms in ANZ, and fellowship status in RACS is a milestone for ANZ surgeons.

- Given ANZ’s relatively small population, staff positions are also limited and highly competitive. Many trainees seek additional “super fellowships” to make themselves more attractive for top spots. Travel throughout ANZ and abroad is common. Interest in vascular disease and the highly competitive vascular surgical field appears to be high among medical students and junior trainees.

- Many vascular surgeons are on the cutting edge of vascular innovation in ANZ. Stent-grafts for complex aneurysm pathology, advanced endovascular techniques for occlusive disease, treatment of arteriovenous malformations, and minimally invasive techniques for venous disease are advanced by many ANZ surgeons.
• Like other surgeons around the world, ANZ vascular surgeons are critically examining their results with audits in which most surgeons participate.

Friendships formed
The Traveling Fellowship led to multiple social interactions. In Melbourne, John Michael Quinn, MB, BS, FACS, FRACS, executive director for surgical affairs at the RACS, hosted a fabulous dinner at the Melbourne Club. The history of Australia appeared on the walls with multiple murals of famous explorers and settlers of the continent. John (Jack) Harris, MB, BS, FACS, FRACS, head of the department of surgery at the University of Sydney, hosted another memorable meal at the opulent Australia Club.

During my multiple visits Down Under over the last two decades, I have found that the culture in ANZ is open, friendly, and welcoming, which spills over to the surgical community. The collegiality among surgeons, often at competing hospitals, is striking. The discourse at both the medical meetings and hospital rounds is educational with a typically jovial tone—an attitude that we all likely could benefit from adopting.

During my travel to ANZ, I also enjoyed meeting many American vascular surgeons as well. Jon Matsumura, MD, FACS, chief of vascular surgery at the University of Wisconsin, Madison; Melina Kibbe, MD, FACS, Edward G. Elcock Professor of surgical research, Northwestern University Feinberg School of Medicine, Chicago, IL; Manju Kalra, MB, BS, FRCS(Ed), of the Mayo Clinic, Rochester, MN; Scott Lemaire, MD, FACS, professor of surgery, Baylor College of Medicine, Houston, TX; James Valentine, MD, FACS, Alvin Baldwin Jr. Chair in Surgery, University of Texas, Southwestern Medical School, Dallas; and many other surgeons were traveling to meetings in the area as well. Meetings with ANZ and American surgeons led to interchanges regarding novel therapies to enhance patient care. Comparing and contrasting care delivery with surgeons from different settings was illuminating.

On a personal note, my wife, Sangeeta R. Kashyap, MD, an academic endocrinologist, joined me for some of the travel. Our ANZ hosts treated us like royalty, and we had a chance to visit some vineyards in the Mornington Peninsula near Melbourne, and the sights in Sydney (see photo, this page).

It was a privilege for me to participate in a very exciting dialogue with our Australian and New Zealand colleagues as the Traveling Fellow. This was truly a tremendous opportunity to learn and share ideas and techniques that may profoundly affect patient care. This experience has helped me grow as a surgeon and will have a lasting impact on my surgical career. I cherish the professional and personal connections that I made. This Fellowship has been the highlight of my career. I thank my ANZ hosts and I humbly thank the American College of Surgeons for this singular honor. ♦
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Mandating the use of motorcycle helmets: What are the issues? (Satkoske, Horner, Polack, Kappel, Mattson), 98, 9:28
Surgeons put planning, preparation, past experience to work in efforts to save Boston Marathon bombing victims (Schneidman), 98, 9:9

VALUE-BASED CARE (see also: QUALITY OF CARE)
Looking forward (Hoyt), 98, 7:7
Outcomes key to ACA mission of reducing health care costs, 98, 12:60
Replacing the SGR: The latest developments in the ACS Value-Based Update proposal, 98, 6:72
Surgical leadership in the era of quality-based payment (White, Young, Mahal-van Brenk, Peters), 98, 5:22

VOLUNTEERISM (see also: EDUCATION and GLOBAL HEALTH CARE)
ACS Fellows provide surgical leadership and service in India (Savarise, Como), 98, 4:30
Dr. Brendan C. Brady serves “invisible population” of migrant workers in upstate New York (Glickson), 98, 4:22
Fellows honored for volunteerism (Casey, Kodera), 98, 9:68
Surgeons bring RRT to patients in Guyana (Babakhani, Guy, Falta, Elster, Jindal, Jindal), 98, 6:17
Surgeons lead educational program to improve kidney care in Vietnam (Slakey, Davidson), 98, 10:34

WORKFORCE ISSUES (see also: AMERICAN COLLEGE OF SURGEONS: Health Policy Research Institute)
From residency to retirement: Is medicine still a good profession? Reflections of a retired surgeon (Jordan, Jr.), 98, 1:58

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YOUNG SURGEONS (see: AMERICAN COLLEGE OF SURGEONS: Resident and Associate Society of the American College of Surgeons (RAS-ACS); and EDUCATION AND TRAINING)
Calendar of events

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

**DECEMBER**

**Brooklyn-Long Island Chapter**
December 4
Uniondale, NY
Contact: Teresa Barzyz, acsteresa@aol.com, http://www.bliacs.org/

**Massachusetts Chapter**
December 7
Boston, MA
Contact: Crystal Beatrice, cheatrice@prri.com, http://www.mcacs.org/

**New Jersey Chapter**
December 14
Iselin, NJ
Contact: Andrea Donelan, njsurgeons@aol.com, http://www.nj-acs.org/index.html

**JANUARY 2014**

**Southern California Chapter**
January 17–19
Santa Barbara, CA
Contact: Jim Dowden, jdowden@prodigy.net, http://www.socalsurgeons.org/acs/index.html

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

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

**FEBRUARY**

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

**South Texas Chapter**
February 20–22
Austin, TX
Contact: Janna Pequet, janna@southtexasacs.org, http://www.southtexasacs.org/

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

**Montana, Wyoming, and Idaho Chapters**
February 21–23
Jackson, WY
Contact: Janis Black, jblack@wyoSurgeons.com

**MARCH**

**Metropolitan Washington, DC, Chapter**
March 8
Washington, DC
Contact: Jennifer Starkey, Jennifer@acschapters.com, http://www.dcfacs.org/

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

**Medical Disaster Response**
March 30
Las Vegas, NV
Contact: Mary Allen, redstart@aol.com

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

**FUTURE CLINICAL CONGRESSES**

2014
October 26–30
San Francisco, CA

2015
October 4–8
Chicago, IL