## Contents

### FEATURES

**COVER STORY:** Presidential Address: Achieving our personal best—
Back to the future of the American College of Surgeons  
Andrew L. Warshaw, MD, FACS, FRCSEd(Hon)

<table>
<thead>
<tr>
<th>Executive Director’s annual report</th>
<th>19</th>
</tr>
</thead>
<tbody>
<tr>
<td>David B. Hoyt, MD, FACS</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Georgia coalition develops bariatric surgery pilot project</th>
<th>35</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kathryn Drake Browning</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Liability reform, scope of practice, trauma topped state legislative agendas in 2014</th>
<th>37</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tara Leystra Ackerman, MPH</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hugh Agnew Gamble, MD, FACS: A legacy to the College</th>
<th>43</th>
</tr>
</thead>
<tbody>
<tr>
<td>Michael C. Trotter, MD, FACS</td>
<td></td>
</tr>
</tbody>
</table>

---

**Connect with the College via social media!**

- **Twitter:**
  - Twitter.com/AmCollSurgeons
  - Twitter.com/ACSTrauma

- **Facebook:**
  - Facebook.com/AmCollSurgeons
  - Facebook.com/ACSTrauma
  - Facebook.com/RASACS

**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.
COLUMNS

Looking forward 6
David B. Hoyt, MD, FACS

A look at The Joint Commission: Updated compendium offers strategies to prevent health care-associated infections 49

NTDB® data points: Go before you go: Bladder injuries 51
Richard Joseph Fantus, MD, FACS, and Richard Jacob Fantus, MD

NEWS

J. David Richardson, MD, FACS, next President-Elect of the ACS 53

Submit 2015 ACS Surgical Volunteerism and Humanitarian Award nominations, January 1–February 28 55

Regents reelected and new Board of Governors Executive Committee installed 56

ACS presents Lifetime Achievement Award posthumously to Dr. Russell 57
Carlos A. Pellegrini, MD, FACS, FRCSI(Hon)

ACS hosts Inspiring Quality Forum in Utah 59

ACS loans ancient Irish deer antlers to Art Institute of Chicago exhibit 60

Chapter news 61
Donna Tieberg

ACS in the news 65

INDEX

Bulletin index: Volume 99, numbers 1–12 67

MEETINGS CALENDAR

Calendar of events 92

SAVE THE DATE

April 18–21, 2015

MAKE A DIFFERENCE. JOIN US IN WASHINGTON, DC.

- Advocate for health care improvements
- Engage influential decision makers
- Connect with ACS leaders and learn how to get involved
- Lead discussions on innovative ways to face leadership and surgical challenges
- Enhance your leadership skills by attending professional development sessions

Visit www.facs.org/advocacy/participate/summit for schedule of events, registration, hotel, and contact information.
The American College of Surgeons is dedicated to improving the care of the surgical patient and to safeguarding standards of care in an optimal and ethical practice environment.

Craig Miller, MD, FACS, researched and wrote this engaging account of the impressive life and career of Robert M. Zollinger, MD, FACS. The narrative is a compelling read for anyone interested in the story behind one of the legends of the surgical profession.

Praise for
The Big Z: The Life of Robert M. Zollinger, MD
“…a magnificent piece of prose. This is a surgical sequel to The Greatest Generation. A superb effort.”
—Hiram C. Polk, Jr., MD, FACS
Professor Emeritus, University of Louisville

“A very easy read about an authoritarian giant in a time of giants. The inherent message—complete care of the patient and the patient’s cares—remains. Dr. Zollinger would like this book; Dr. Dunphy would say he wasn’t that good! I enjoyed it immensely.”
—Murray Brennan, MD, FACS
Benno C. Schmidt Chair in Clinical Oncology, Memorial Sloan-Kettering Cancer Center

“Driven, devoted, dedicated, accomplished. Dr. Zollinger was all of these and much more. Herein learn how greatness was forged and how the impact continues. If you like a good tale—an inspiring, richly told story—you will find it here. This is the stuff that made American surgery and America what it is.”
—LaMar McGinnis, Jr., MD, FACS
Senior Medical Advisor and Liaison, American Cancer Society

Ordering Information
To order online, visit www.facs.org/publications/catalog
To order by phone, call 312-202-5474
Price: $14.95, plus sales tax, shipping, and handling

Dr. Miller is in private practice in Indiana and is a Scholar-in-Residence at The Ohio State University Medical Heritage Center.

Published by the American College of Surgeons.
Officers and Staff of the American College of Surgeons

Officers
Andrew L. Warshaw, MD, FACS
President
Carlos A. Pellegrini, MD, FACS
Immediate Past-President
Jay L. Grosfeld, MD, FACS
First Vice-President
Kenneth L. Mattox, MD, FACS
Second Vice-President
Edward E. Cornwell III, MD, FACS, FCCM
Vice-Chair

*Mark C. Weissler, MD, FACS
Atlanta, GA

Andrew L. Warshaw, MD, FACS
Washington, DC

Walter J. Pories, MD, FACS
Greenville, NC

William G. Cioffi, Jr., MD, FACS
Seattle, WA

Officer-Elect
J. David Richardson, MD, FACS
Louisville, KY

Ronald V. Maier, MD, FACS
Indianapolis, IN

First Vice-President-Elect
John L. D. Atkinson, MD, FACS
Rochester, MN

Second Vice-President-Elect
David A. Hoyt, MD, FACS
Chicago, IL

Governor/Trustee
Gay L. Vincent, CPA

*Executive Committee

Board of Governors/Executive Committee

Fabrizio Michelassi, MD, FACS
New York, NY
Chair

Karen Brasel, MD, FACS
Portland, OR
Vice-Chair

James C. Denny III, MD, FACS
Alexandria, VA
Secretary

Kevin E. Behrens, MD, FACS
Gainesville, FL

Diana L. Farmer, MD, FACS
Sacramento, CA

Steven C. Stain, MD, FACS
Albany, NY

Joseph J. Tepas III, MD, FACS
Jacksonville, FL

Advisory Council to the Board of Regents

(Past-Presidents)

Kathryn D. Anderson, MD, FACS
Boston, MA

W. Gerald Austen, MD, FACS
Boston, MA

L. D. Britt, MD, MPH, FACS, FCCM
Norfolk, VA

John L. Cameron, MD, FACS
Baltimore, MD

Edward M. Copeland III, MD, FACS
Gainesville, FL

A. Brent Eastman, MD, FACS
Rancho Santa Fe, CA

Gerald B. Healy, MD, FACS
Wellesley, MA

R. Scott Jones, MD, FACS
Charlottesville, VA

Edward R. Laws, MD, FACS
Boston, MA

LaSalle D. Leffall, Jr., MD, FACS
Washington, DC

Lloyd D. MacLean, MD, FACS
Montreal, QC

LaMar S. McGinnis, Jr., MD, FACS
Atlanta, GA

David G. Murray, MD, FACS
Syracuse, NY

Patricia J. Numann, MD, FACS
Syracuse, NY

Carlos A. Pellegrini, MD, FACS
Seattle, WA

Richard R. Sabo, MD, FACS
Bozeman, MT

Seymour I. Schwartz, MD, FACS
Charlottesville, VA

Frank C. Spencer, MD, FACS
New York, NY

Executive Staff

EXECUTIVE DIRECTOR
David B. Hoyt, MD, FACS

DIVISION OF ADVOCACY AND HEALTH POLICY

Frank G. Opelka, MD, FACS
Medical Director of Quality and Health Policy

Patrick V. Bailey, MD, FACS
Medical Director of Advocacy

Christian Shalgian
Director

AMERICAN COLLEGE OF SURGEONS FOUNDATION
Martin H. Wojcik
Executive Director

ALLIANCE/AMERICAN COLLEGE OF SURGEONS
CLINICAL RESEARCH PROGRAM
Kelly Hunt, MD, FACS
Chair

CONVENTION AND MEETINGS
Felix Niespodziewanski
Director

DIVISION OF EDUCATION
Ajit K. Sachdeva, MD, FACS, FCCM
Director

EXECUTIVE SERVICES
Jane J. Lee-Kwon, MPS
Director

FINANCE AND FACILITIES
Gay L. Vincent, CPA
Director

HUMAN RESOURCES AND TALENT MANAGEMENT
Michelle McGovern
Director

INFORMATION TECHNOLOGY
Howard Tanzman
Director

DIVISION OF INTEGRATED COMMUNICATIONS
Lynn Kahn
Director

JOURNAL OF THE AMERICAN COLLEGE OF SURGEONS
Timothy J. Eberlein, MD, FACS
Editor-in-Chief

DIVISION OF MEMBER SERVICES
Patricia L. Turner, MD, FACS
Director

PERFORMANCE IMPROVEMENT
Will Chapleau, RN, EMT-P
Director

DIVISION OF RESEARCH AND OPTIMAL PATIENT CARE
Clifford Y. Ko, MD, MS, FACS
Director

Cancer:
David P. Winchester, MD, FACS
Medical Director

Trauma:
Michael F. Rotondo, MD, FACS
Medical Director

Legal
Christian Shalgian
Director
**Author bios***

*Titles and locations current at the time articles were submitted for publication.

**MS. ACKERMAN** (a) is State Affairs Associate, American College of Surgeons (ACS) Division of Advocacy and Health Policy, Washington, DC.

**MS. BROWNING** (b) is Executive Director, Georgia Society of the ACS, Stockbridge.

**DR. RICHARD JACOB FANTUS** (c) is a first-year urology resident at the University of Chicago, IL, and Resident Member of the ACS.

**DR. RICHARD JOSEPH FANTUS** (d) is vice-chairman, department of surgery; medical director, trauma services; and chief, section of surgical critical care, Advocate Illinois Masonic Medical Center. He is clinical professor of surgery, University of Illinois College of Medicine, Chicago, and Past-Chair, ad hoc Trauma Registry Advisory Committee, ACS Committee on Trauma.

**DR. HOYT** (e) is Executive Director of the ACS.

**DR. PELLEGRINI** (f) is The Henry N. Harkins Professor and chair, department of surgery, University of Washington, Seattle. He is Immediate Past-President of the ACS.

**MS. TIEBERG** (g) is Manager of Chapter Services, ACS Division of Member Services, Chicago, IL.

**DR. TROTTER** (h) is a cardiovascular and thoracic surgeon at Delta Regional Medical Center, Greenville, MS.

**DR. WARSHAW** (i) is surgeon-in-chief emeritus, Massachusetts General Hospital, and the W. Gerald Austen Distinguished Professor of Surgery, Harvard Medical School, Boston, MA. He is President of the ACS.
Looking forward

by David B. Hoyt, MD, FACS

As the Executive Director’s report on page 19 demonstrates, the American College of Surgeons had another successful year. The full report provides a detailed account of these accomplishments, but for those of you who are interested in a briefer overview, this column highlights the key activities of each of the ACS divisions and support areas.

Advocacy and Health Policy
The ACS Division of Advocacy and Health Policy got a boost in June when Frank Opelka, MD, FACS, and Patrick Bailey, MD, FACS, joined the Washington Office team as Medical Directors of Quality and Advocacy, respectively. These surgeons will play a leading role in helping to position the ACS as a leader in the health policy, legislative, and regulatory arenas.

To address surgeons’ ongoing concerns regarding Medicare physician payment, the ACS worked closely with members of Congress to develop legislation that would repeal the broken sustainable growth rate (SGR) formula and replace it with a more equitable model. More than 200 ACS members from 44 states participated in 229 meetings on Capitol Hill April 1 in conjunction with the 2014 Leadership & Advocacy Summit in Washington, DC. The SGR was a key topic of discussion at those meetings. Unfortunately, passage of the SGR Repeal and Medicare Provider Payment Modernization Act of 2014 was derailed due to funding challenges. At press time, the College continued to call upon lawmakers to revisit the bill before adjourning this year.

The SurgeonsVoice grassroots advocacy program is proving to be a most valuable tool for developing relationships with legislators. We now have SurgeonsVoice Region Chiefs and Councilors throughout the country to heighten our grassroots presence.

Education
Many of the College’s recent education efforts have centered on assisting surgeons—particularly young surgeons—in career transitions. To address ongoing concerns regarding surgical training, the ACS has appointed a Committee on Residency Training (“Fix the Five”), which meets regularly and has identified several areas of focus.

To help young surgeons transition from residency to practice, the ACS has developed the Transition to Practice in General Surgery Program, which provides individuals who have completed five years of general surgery training with the opportunity to serve as a junior partner of a surgical practice. In 2014–2015, the program is being pilot-tested at 10 sites.

In addition, the ACS has partnered with the Association of Program Directors in Surgery and the Association for Surgical Education to create a Surgery Resident Prep Curriculum for medical students transitioning to residency. Pilot testing of the curriculum modules began in 2013–2014, and we anticipate the final curriculum will launch in 2015.

Furthermore, the College has launched a nationwide ACS Education and Training Campaign, similar to the Inspiring Quality Campaign, to communicate the following messages:

- ACS Education and Training are the cornerstones of excellence
- ACS Education and Training transform possibilities into realities
- ACS Education and Training instill the joy of lifelong learning

Research and Optimal Patient Care
This year marked the 10th anniversary of the launch of ACS National Surgical Quality Improvement Program (ACS NSQIP®). In July, ACS NSQIP presented its annual conference in New York, NY, and a record-breaking 1,200 representatives from nearly 600 hospitals attended. The College is now working with the surgical specialties to develop specialty-specific modules for ACS NSQIP.

Furthermore, the College completed three years of working with a broad-based task force to develop comprehensive guidelines that define the resources needed to perform safe, effective pediatric operations.
To address surgeons’ ongoing concerns regarding Medicare physician payment, the ACS worked closely with members of Congress to develop legislation that would repeal the broken SGR formula and replace it with a more equitable model.

The standards for optimal resources for operations on infants and children were published in the March issue of the Journal of the American College of Surgeons.

The Advanced Trauma Life Support® (ATLS®) app has been downloaded by 66,900 users, and an eLearning project is under way. An interactive eBook has been developed, featuring flash cards, text highlighting, video links, and self-check questions.

The Committee on Trauma (COT) is pursuing a closer relationship with the Department of Defense (DoD) that would enable military trauma centers to participate in the National Trauma Data Bank®/Trauma Quality Improvement Program and thus meet that requirement for ACS verification.

The COT also has been actively involved in government efforts to establish guidelines for emergency medical services in mass-casualty events. In a related effort, the Hartford Consensus, led by ACS Regent Lenworth Jacobs, Jr., MD, FACS, articulated a framework for increasing survivability in mass shootings, which promotes the use of THREAT: (1) Threat suppression, (2) Hemorrhage control, (3) Rapid Extrication to safety, (4) Assessment by medical providers, and (5) Transport to definitive care.

One of the Commission on Cancer’s (CoC’s) most significant accomplishments this year involved working with consultants to develop a framework for oncology medical home standards. We have requested grant funding from the Center for Medicare & Medicaid Innovation to support development of the model.

In addition, the CoC held its first legislative briefing in February and issued a written response to the Institutes of Medicine report, Delivering High-Quality Cancer Care: Charting a New Course for a System in Crisis.

The National Accreditation Program for Breast Cancer has now awarded accreditation to more than 560 U.S. breast centers, and the ACS Clinical Research Program (ACS CRP) has completed the manuscript for Operative Standards for Cancer Surgery. The ACS CRP also received funding for three studies from the Patient-Centered Outcomes Research Institute.

**Member Services**

This year’s Initiates class—one of the largest ever—totaled 1,640. To further attract younger members, we have launched a Young Surgeons Marketing Campaign—Realize the Potential of Your Profession—and a Show Your Pride campaign.

More than 425 ACS leaders, chapter officers, and young surgeons participated in the leadership portion of the 2014 Leadership & Advocacy Summit. In addition to providing information on best practices for chapter administration, mentoring, and other topics of general interest, a session on emotional intelligence and its relevance to surgical leadership was presented.

A new Archivist, Adam Carey, has been hired to develop a strategic plan to make the Archives more accessible to Fellows. To this end, he is creating a Web-based Master Finding Aid that lists all ACS archival holdings, and specific ACS records are being digitized.

**Integrated Communications**

The ACS Communities launched in July, providing an interactive platform for surgeons to share their views, interests, and concerns. Shortly thereafter, the College launched its new public website, facs.org. The site is organized around the College’s core pillars: Member Services, Quality, Education, and Advocacy. Password-protected areas have been established for the conduct of College-related business.

The ACS Inspiring Quality tour made stops in Northern California, North Carolina, Ohio, South Carolina, Iowa, and Utah. At these meetings, we continued to demonstrate how ACS Quality Programs reduce spending and improve outcomes.

The ACS enjoyed prominent news coverage in 2014 and expanded its social media presence. For example, the College now has 7,863 “Likes” on Facebook, 16,366 followers on Twitter, and 811 subscribers on YouTube.
NATIONAL STEERING COMMITTEE FOR 1913 LEGACY CAMPAIGN

Suresh Agarwal, MD, FACS  
John L.D. Atkinson, MD, FACS  
Charles M. Balch, MD, FACS  
Ruth L. Bush, MD, FACS  
James G. Chandler, MD, FACS  
William G. Cioffi, Jr., MD, FACS  
Christopher J. Daly, MD, FACS  
Barbara L. Dean  
Daniel L. Dent, MD, FACS  
E. Christopher Ellison, MD, FACS  
James K. Elsey, MD, FACS  
James W. Fleshman, Jr., MD, FACS  
Donald E. Fry, MD, FACS  
Enrique Hernandez, MD, FACS  
David B. Hoyt, MD, FACS  
Tyler G. Hughes, Sr., MD, FACS  
Mark Kuhnke, MD, FACS  
Charles A. Lucas, MD, FACS  
Richard A. Lynn, MD, FACS  
LaMar S. McGinnis, Jr., MD, FACS  
Mary H. McGrath, MD, MPH, FACS  
Fabrizio Michelassi, MD, FACS  
Patricia J. Numann, MD, FACS  
Richard B. Reiling, MD, FACS  
Layton F. Rikkers, MD, FACS  
Danny R. Robinette, MD, FACS  
Hilary Sanfey, MB, BCh, FACS,  
William F. Sasser, MD, FACS  
Kenneth W. Sharp, MD, FACS  
David A. Spain, MD, FACS  
Steven C. Stain, MD, FACS  
Steven M. Steinberg, MD, FACS  
Aamilu Stewart, MD, FACS  
Ronald M. Stewart, MD, FACS  
Jon A. van Heerden, MB, BCh, FACS, FRCS  
Andrew L. Warshaw, MD, FACS

Other accomplishments

The ACS Foundation’s 1913 Legacy Campaign, which launched in conjunction with the ACS Centennial, is nearing completion. At press time, Fellows, friends, and corporations had donated more than $2.4 million through the campaign. Nearly half of the ACS Fellows who donated gave $5,000 or more in honor of the Centennial.

I’d like to give special thanks and recognition to the members of the 1913 Legacy Campaign National Steering Committee (see roster, this page). In addition to making their own philanthropic contributions to the campaign, these dedicated individuals have inspired other generous donors to do the same. The committee members are making a meaningful impact through their own College networks. For example, Fabrizio Michelassi, MD, FACS, engaged members of the Board of Governors Executive Committee; Kenneth W. Sharp, MD, FACS, reached out to attendees at the Advocacy and Leadership Summit; Richard A. Lynn, MD, FACS, and Jon van Heerden, MD, FACS, worked with ACS Chapters; Mary H. McGrath, MD, MPH, FACS, and Charles Balch, MD, FACS, advocated for ACS programs during meetings with corporations; Richard Reiling, MD, FACS, recruited loyal donors through his long association with ACS philanthropic efforts; and Aamilu Stewart, MD, FACS, and Andrew L. Warshaw, MD, FACS, FRCSEd(Hon), sought the support of ACS Past-Presidents.

The committee’s combined efforts are increasing current philanthropy while planting the seeds for future support. The 1913 Legacy Campaign will help the College fulfill its mission of equipping surgeons with the tools they need to meet the demands of an evolving medical environment. I am truly thankful to have such talented individuals actively engaged in the College.

Internally, nearly one-third of College staff has been trained in the Change Acceleration Process, and we are designing a curriculum to train all staff in leadership skills. Almost all staff have completed the DiSC and emotional intelligence training courses.

Finally, at this year’s Clinical Congress, we presented the ACS Lifetime Achievement Award posthumously to Thomas R. Russell, MD, FACS, former Executive Director of the ACS, and hosted a “Celebration of Life” service in his memory.

In short, the College has entered its next 100 years ready to address the challenges of the future. With your support and input, I anticipate that this upward trajectory will continue. ♦

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

Back to the future of the American College of Surgeons

by
Andrew L. Warshaw, MD, FACS, FRCSEd(Hon)
Editor’s note: The following is an edited version of the Presidential Address that Dr. Warshaw delivered at the Convocation ceremony during the 2014 American College of Surgeons (ACS) Clinical Congress in San Francisco, CA.

It is with both pride and awe that I welcome you to this 100th Convocation of the Clinical Congress of the ACS, which is truly an international society of nearly 80,000 members. My journey to this podium has been propelled by talented colleagues and trainees, valued collaborators, and invaluable mentors. President [Carlos A.] Pellegrini, you have been a leader worthy of being followed. I hope I have learned from you and our predecessors as ACS Presidents and that I will represent our College wisely, as you have done.

I owe much to my family, who tolerated and supported my absences in the interest of my patients, and especially to Brenda, my wife of three decades, on whose constant support I have depended. Brenda, thank you.

But this is your night, new Fellows. I know that your family, teachers, and mentors are justly proud of you, just as I take personal pride in those among you in whose progress I have had a hand. Now is your time to put your hard work and preparation to use, to become your personal best. The door is opening to your future.

**Visionary surgeon**

In this first year of the second century of the ACS, let us revisit our beginnings. I want to share a story about an extraordinary man, profoundly influential but flawed, visionary but, in his own words, quixotic—a surgeon whose story is woven into the fabric of our College through a century of improving the care of the surgical patient.

Ernest Amory Codman, MD, FACS, who preferred to be called “Emory,” had a privileged upbringing in Boston, MA. He was what some term a “Preparation H.” He was a graduate of Harvard College and Harvard Medical School (HMS), trained at a Harvard institution, Massachusetts General Hospital (MGH), and had an appointment at HMS and MGH—at least for a while.

As a medical student in 1895, Dr. Codman and his classmate, Harvey Cushing, MD, FACS, later a renowned neurosurgeon, witnessed a fatal outcome from the administration of ether anesthesia, which had been introduced at MGH 50 years earlier. To provide data to ensure the safety of their patients, they began to record pulse, respiratory rate, and blood pressure when this anesthesia was used. These “ether charts,” now residing in the HMS Countway Library of Medicine, were the first anesthesia records and have contributed to saving many thousands of lives.

The following year, Dr. Codman began to experiment with the newly introduced X rays to study anatomy. This experience led to his appointment in 1899 as “skiagrapher” (radiologist) at Boston Children’s Hospital and was the foundation of his extensive studies of bone and joint diseases, which culminated in his classic book, *The Shoulder: Rupture of the Supraspinatus Tendon and Other Lesions In or About the Subacromial Bursa*, in 1934.

Dr. Codman’s biggest contribution, however, was what he called “The End Result Idea.” This concept centered on the common-sense notion that every hospital and every surgeon should follow every patient
long enough to determine whether the treatment was successful, and to inquire, “If not, why not?” with a view to preventing similar failures in the future and to improving the efficiency of care—his term for effectiveness and quality.

Applying the End Result Idea
In 1911, he opened the tiny 12-bed Codman Hospital in Boston, near the MGH, to test his ideas. He kept records on every patient on 3 x 5 cards for a year. He rated the outcomes with absolute honesty: error in diagnosis, error in judgment, error in treatment, and so on. This process is the basis for the modern morbidity and mortality conference. In 1917, Dr. Codman published another book, A Study in Hospital Efficiency: As Demonstrated by the Case Report of the First Five Years of a Private Hospital—which contained the records of all 337 cases treated over five years at the Codman Hospital, good and bad results alike—and made it available free of charge to any member of the ACS. The book is a marvel of public reporting that would be difficult to replicate in today’s litigious environment. It is noteworthy that although these end results were for an individual surgeon, they were intended to serve as building blocks for improving the surgical profession. Presciently, he stated that “insurance companies, large industrial plants, and even the state may find that it will be less expensive in the long run to send patients...
• All results of surgical treatment which lack perfection may be explained by one or more of these causes:
  – E-s: Lack of knowledge or skill
  – E-j: Lack of surgical judgment
  – E-c: Lack of care or equipment
  – E-d: Lack of diagnostic skill
  – P-d: Patient’s unconquerable disease
  – P-r: Patient’s refusal of treatment
• Acknowledged that mistakes or “calamities of surgery” occur and need to be studied to be prevented

Dr. Codman’s end-result system
scrutiny and criticism. Recounting that time, Dr. Codman wrote,

In order to attract the attention of the trustees of the MGH, I resigned from the staff in 1914 as a protest against the seniority system of promotion, which was obviously incompatible with the End Result Idea. On the day on which I received acceptance of my resignation, I wrote again asking to be appointed Surgeon-in-Chief on the ground that the results of treatment of my patients during the last 10 years had been better than theirs. Naturally, my letter was ignored, and I was not appointed Surgeon-in-Chief.1

An offensive act

On January 6, 1915, Dr. Codman used his position as chairman of the surgical section of the local medical society to push his End Result Idea. At the conclusion of a slate of speakers on hospital efficiency, accurate measurement of outcomes, and standardization, Dr. Codman unveiled an six-foot cartoon drawn on brown paper. It depicted the medical community and the leaders of Harvard and MGH as caring only about the golden eggs being kicked to them by an ostrich with its head in the sand, and not about the facts that support optimal patient care.

Dr. Codman managed to offend just about everyone in the surgical and education community. He was forced to resign his chairmanship of the surgical
section and was dropped from the Harvard Medical School faculty. Later that year, his reputation marred, he resigned his chairmanship of the Hospital Standardization Committee of the ACS. Despite these setbacks, he persisted and continued to speak out in support of the End Result Idea.

On December 6, 1917, there was a mammoth explosion of an ammunitions ship in Halifax Harbor, QC. The explosion leveled much of Halifax, killed 3,000 people, and left more than 20,000 injured. Dr. Codman immediately responded by closing his hospital and leaving Boston the next day with nurses and another surgeon to help those in need. Of course, he kept his end result cards on every patient over the succeeding months. Each year since, the City of Halifax remembers Dr. Codman’s humanitarian help by sending an enormous Christmas tree to decorate a public plaza in Boston.

It strikes me that his action presaged another ACS program, Operation Giving Back, through which surgeons selflessly volunteer their skills in times of disaster as well as to address other unmet needs for surgical care among the medically underserved at home and abroad. Today, increasing numbers of medical students, surgical residents, surgeons, and surgical institutions like the ACS are recognizing and responding to these calls for help, not only for direct provision of treatment, but also for sustaining benefits through helping to develop the skills of local caregivers.

Shortly after that time in Halifax, Dr. Codman went off to serve in the U.S. Army during World War I. On returning to Boston in 1919, he was deeply in debt, had no hospital appointment, and was unable to reopen the Codman Hospital. In subsequent years, he struggled to make a living and support his family.

**The ACS’ first registry**

In 1920, Dr. Codman became interested in the treatment of bone sarcoma, a condition about which little was then known. He circulated a letter to ACS Fellows requesting information about their cases for a clinical research database. Again ahead of his time, he explained, “By grouping cases into series large enough to favor comparative study and by observing definite previously determined points, a rational and clinical science can be developed.” Initially disappointed with the lack of responses, he joined with James Ewing, MD, a New York, NY, pathologist, and Joseph Bloodgood, MD, FACS, a pathologist at Johns Hopkins University, Baltimore, MD, to develop a Registry of Bone Sarcoma, which was adopted as a standing committee of the ACS in 1921. This registry, the first cancer registry in this country, was a precursor to later ACS databases, such as the National Trauma Data Bank® and the National Cancer Data Base. Characteristically, Dr. Codman scolded the ACS Fellows for their apathy in a journal article in which he wrote, “The American College of Surgeons expects something more of its
Fellows than annual dues. It expects any Fellow who has undertaken the care of a case of bone sarcoma to give the other members of the College, and through them to the rest of the profession, the benefits of the experience gained."

Fellows, take heed of that injunction. We owe it to each other and to our patients to improve our profession actively and continuously, to increase knowledge, and to innovate when we can. Be involved in shaping the changes in health care delivery, in advocacy, and in giving back to society for the opportunities we have been given.

In subsequent years, Dr. Codman was slowly accepted back into the fold. The soil—organized medicine—was finally prepared to nurture the seed he had planted. He was reinstated at the MGH in 1929, and when he died in 1940 from melanoma, the MGH trustees paid Dr. Codman this tribute: “Champion of truth; original in thought; firm in his convictions and willing to sacrifice personal place and standing to achieve what he believed to be right. Mankind, medicine, and the Massachusetts General Hospital are his debtors.”

Dr. Codman’s ashes were interred in his wife’s family plot in Mount Auburn Cemetery, Cambridge, MA. His wife, Katherine (Katy) Bowditch, part of a prominent Boston and MGH family, was active in the women’s suffrage movement and nursing education. Because of difficult financial circumstances at the time of his death, he instructed Katy not to spend money on a headstone, and for 74 years his ashes had lain in...
an unmarked grave. I am pleased to report to you that our College, along with The Joint Commission, The American Shoulder and Elbow Society, and the Massachusetts General Physicians Organization, among others, led a successful campaign to design and create a fitting headstone for Dr. Codman. It was installed July 22 with appropriate recognition of his significant achievements on behalf of surgical standards.

**Dr. Codman's legacy**

So, what can we learn from Dr. Codman’s career and his contributions—his end results? With a century’s hindsight we see the strength of his pioneering ideas on quality based on a record of scientific truth, as he put it—on evidence, not eminence (see table, page 17). He asked if it was possible to standardize the treatment of disease or the work of individual members of hospital staffs. He answered, “Such standards can be established. The object of standards is to raise them.”

Good enough is not good enough. Dr. Codman can be considered the father of outcomes research, of process improvement in surgery, and, in fact, of quality as the driving force of ACS programs today. But Dr. Codman’s flaw was his tendency to excess and his intentionally disruptive personality. It is not sufficient to have a good idea. You must apply leadership to get others to buy into new concepts and programs. He failed to recognize that leading change requires developing consensus rather than demanding it, and that change management should be rooted in the very data he collected, not blunt force. The cartoon he presented at a regional medical society meeting was simply the wrong way to achieve the change he desired. His lifelong friend, Dr. Edward Martin, wrote to him that “the wheels of progress must hurt and bruise someone, but the chariot should be drawn with some thought as to reducing to its minimum the crop of the crippled.”

Dr. Codman came to peace with his failings in the end. He said, “If the prophet is confident of the value of his service, he may keep his equanimity in spite of the jeers of his contemporaries. Although the End Result Idea may not achieve its entire fulfillment for several generations, I hope to be as content when dying as any soldier of the battlefield.”

He added, “The man who may be called unselfish works for the next generation and necessarily cannot be paid for it—except in honor.” Yogi Berra, the baseball star and humorist philosopher, said, “It’s tough to make predictions, especially about the future.” Dr. Codman did predict the future—fought for it and paid for it.

**Is a Codman among you?**

But Dr. Codman’s vision has not yet been fully reached. We have registries, such as the ACS National Surgical Quality Improvement Program; guidelines for efficient and appropriate care; and statistics...
on outcomes for hospitals, practices, and disciplines. However, measurement science is still short of an established methodology to assess the outcomes of most individual surgeons, as Dr. Codman did piecemeal for himself.

To that end, the ACS has initiated the Surgeon Specific Registry (SSR) for each surgeon to record and assess the outcomes of his or her cases, which is a step in the right direction. I urge each of you to use the SSR to gain insights into your own practices. In addition, evaluations by patients, such as the Consumer Assessment of Healthcare Providers and Systems survey tool for surgery, assess those outcomes that are important to these individuals, which is a key component in determining appropriate care.

In the end, it is up to each of us to measure, track, and improve our own end results and to achieve our personal best. This should be our message to legislators, insurers, the public, and especially to ourselves. In Dr. Codman’s words, “If not, why not?” If not us, who?

Unbeknownst to us when my class of Initiates, the class of 1974, sat in your seats, there were six future ACS Presidents among us, as well as innovators, scientists, and great clinical surgeons. There are those among you who will be tomorrow’s contributors and leaders. Every one of you will bring lifesaving and health-restoring care to patients around the world. You will bring new ideas, new techniques, new skills, and new compassion to those who need your help.

The Stone Age did not end because they ran out of stones. Something better replaced it. The field of surgery is changing. In this class of 1,640—one of the largest groups of Initiates ever—more are women (22 percent) and more are international medical graduates (26 percent) from 61 countries, than in any previous class. Most of you are likely to be employed by a hospital, group practice, medical school, or health care system. Teams and multidisciplinary care are superseding the lone surgeon. Minimally invasive surgical technologies are changing how surgery is practiced, while simulation is changing how surgery is taught. Health care delivery systems are coalescing rapidly. New organs are being tissue engineered, and DNA is being rebuilt to cure and prevent disease. The potential to heal is ever growing.

### DR. CODMAN’S “END RESULTS”

<table>
<thead>
<tr>
<th>Year</th>
<th>Codman’s contributions</th>
<th>An “end result”</th>
<th>Institution</th>
</tr>
</thead>
<tbody>
<tr>
<td>1895</td>
<td>Ether charts</td>
<td>Anesthesiology</td>
<td>[American Society of</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Anesthesiologists]</td>
</tr>
<tr>
<td>1896</td>
<td>X-rays of anatomy</td>
<td>Radiography</td>
<td></td>
</tr>
<tr>
<td>1910</td>
<td>Plan for 1913 Clinical Congress</td>
<td>American College of Surgeons</td>
<td></td>
</tr>
<tr>
<td>1911–1917</td>
<td>Codman Hospital</td>
<td>Outcomes research</td>
<td>Codman Center</td>
</tr>
<tr>
<td>1912</td>
<td>Committee on Standardization of Hospitals</td>
<td>JCAHO</td>
<td>[Massachusetts General Hospital]</td>
</tr>
<tr>
<td>1917</td>
<td>Halifax explosion response</td>
<td>Operation Giving Back</td>
<td>[Operation Giving Back]</td>
</tr>
<tr>
<td>1921</td>
<td>Registry of Bone Sarcoma</td>
<td>ACS Registries</td>
<td>[ACS NSQIP]</td>
</tr>
</tbody>
</table>

DEC 2014 BULLETIN American College of Surgeons
Change is the only constant. Don’t be afraid of it. Embrace and foster change. Take risks—thoughtfully.

You are accomplished surgeons today. You have studied, struggled, and worked to wear the robes you have on, the robes of an ACS Fellow. But if you don’t continue to improve and evolve, tomorrow you will remain the surgeon you are today—no better. Good enough is not good enough. Is there a Codman among you?

I wish for you good luck and success, but I wish from you clear sight for your future excellence, hard work for your patients and our profession, and forthright leadership on whatever path you choose. My generation will be passing the baton—symbolized by this Great Mace of the American College of Surgeons—to yours. Carry it forward proudly. Be your best.

REFERENCES

1. Codman EA. The Shoulder: Rupture of the Supraspinatus Tendon and Other Lesions In or About the Subacromial Bursa. Boston, MA: Thomas Todd Co; 1934.
Executive Director’s annual report

by David B. Hoyt, MD, FACS
In 2013–2014, the ACS worked closely with members of Congress to develop legislation that would repeal the SGR and replace it with an alternative.

Each year, the Bulletin publishes an update on the major activities carried out by the American College of Surgeons’ (ACS) staff and volunteers over the course of the last year. This report points to our accomplishments and to the areas in which we are striving to better meet the needs of surgeons and their patients.

Advocacy and Health Policy

In June, Frank Opelka, MD, FACS, and Patrick Bailey, MD, FACS, began serving as Medical Directors of Quality and Advocacy, respectively, in the Division of Advocacy and Health Policy. Given their backgrounds, we believe these surgeons will play a leading role in positioning the ACS as a leader in the health policy, legislative, and regulatory arenas.

One issue that continues to be of great concern to Fellows is Medicare physician payment. The ACS has been working for the last decade to persuade Congress to repeal the broken sustainable growth rate (SGR) formula used to calculate Medicare payment. In 2013–2014, the ACS worked closely with members of Congress to develop legislation that would repeal the SGR and replace it with an alternative.

On February 6, Congress reached a bipartisan, bicameral agreement on The SGR Repeal and Medicare Provider Payment Modernization Act of 2014. This legislation was the product of a yearlong collaborative effort between Congress and key stakeholders, including the ACS. Final passage of the bill, however, was derailed due to funding challenges.

The College played an influential role in efforts to repeal and replace the SGR due to:

• Solid policy recommendations
• Reputation as a quality leader
• Media contacts
• Coalition support
• A strong advocacy team
• Grassroots advocates and a political action committee (PAC)

In addition, more than 200 ACS members from 44 states participated in 229 meetings on Capitol Hill April 1 in conjunction with the 2014 Leadership & Advocacy Summit in Washington, DC. The SGR was a key topic of discussion at those meetings.

Other payment issues that the ACS addressed in 2014 included the repeal of the 96-Hour Rule on discharge of inpatients from critical access hospitals; and the Centers for Medicare & Medicaid Services (CMS) proposed rules pertaining to the Inpatient Prospective Payment System, the Medicare physician fee schedule, and the Outpatient Prospective Payment System/Ambulatory Surgical Centers.

With regard to medical liability reform, the ACS has sought to advance targeted bills, including the Good Samaritan Health Professions Act, the Health Safety Net Enhancement Act, and the Saving Lives, Savings Costs Act. The College also has developed both a primer and a surgeons’ guide to liability reform. In addition, the College is working to avert any changes to California’s Medical Injury Recovery and Compensation Act.

The Institute of Medicine recently released a report on the financing and governance of graduate medical education (GME), and the ACS is developing recommendations. We will hold a summit on GME in 2015 to evaluate proposals for change.

As noted previously, the ACS Professional Association’s SurgeonsPAC and the SurgeonsVoice grassroots program continue to be our most valuable tools in terms of developing relationships with legislators. We now have SurgeonsVoice Region Chiefs and Councilors throughout the country to boost our grassroots presence. Furthermore, we have a completely redesigned SurgeonsVoice website (www.surgeonsvoice.org) with tools to make getting involved in advocacy easier than ever.
Finally, the ACS continues to lead an active coalition of surgical societies that work together on issues of mutual concern.

**Education**

In light of widespread concerns regarding the training of surgery residents, the ACS has appointed a Committee on Residency Training (“Fix the Five”). This committee includes leaders of the ACS, American Board of Surgery (ABS), Residency Review Committee for Surgery (Surgery RRC), Accreditation Council for Graduate Medical Education (ACGME), and Association of Program Directors in Surgery (APDS). In addition, representatives of the Royal College of Physicians and Surgeons of Canada and several surgical educators serve on the committee.

The committee meets regularly and has identified the following areas of focus:

- Organizational commitment
- Transitions in residency
- Structured curricula
- Sufficient autonomy for residents
- Residency education environment, including duty hours, financing, and support systems
- Best practices in faculty development and support
- End product of surgical training

A survey of surgery program directors will be conducted to gather more information on these matters and to identify best practices.

The ACS Committee to Enhance Peak Performance in Surgery through Recognition and Mitigation of the Impact of Fatigue (Peak Performance Committee) crafted an ACS statement, which was published in the August Bulletin.

The ACS continues to play a preeminent role in advancing simulation-based surgical education and training and has been recognized for its contributions to this field. Examples of related activities include:

- The ACS plays an important part in the Council of Medical Specialty Societies (CMSS) workgroup on simulation. The workgroup’s activities will culminate in the Second CMSS Simulation Summit, November 19, 2015, in Washington, DC.

- The College is active in a coalition of national surgical specialty societies, Veterans Affairs, Department of Defense (DoD), and other stakeholders interested in simulation-based surgical education.

- The Consortium of ACS-Accredited Education Institutes (ACS-AEIs) continues to advance the field of simulation-based surgical education and training.

- In October 2013, the U.S. Patent and Trademark Office issued a patent (U.S. 8,562,357 B2) for the “Interactive Educational System and Method” of the ACS Fundamentals of Surgery Curriculum®.

- In April 2014, the Association for Surgical Education (ASE) presented an Excellence in Innovation in Surgical Education Award to Ajit K. Sachdeva, MD, FACS, FRCSC, Director, ACS Division of Education, for the ACS/ASE Medical Student Simulation-based Surgical Skills Curriculum.

The ACS seeks to help surgeons smoothly transition through each stage of their career. Over the last year, we have focused on early-career transitions. The ACS Transition to Practice in General Surgery (TTP) Program Steering Committee has defined the model for the program: provision of a one-year advanced experience as a junior partner (TTP Associate) for a surgeon who has completed five years of training. The focus is on general surgery and practice management. In 2014–2015, the program is being pilot-tested at 10 sites.

The Eighth Annual Residents As Teachers and Leaders Course was offered in May 2014. The demand for the course exceeded capacity, and course participants gave the course high ratings.

The ACS/APDS/ASE Surgery Resident Prep Curriculum is aimed at graduating medical students to help them transition to residency and to ensure that training programs receive individuals with appropriate knowl-
The ACS continues to play a preeminent role in advancing simulation-based surgical education and training and has been recognized for its contributions to this field.

edge and skills. Pilot testing of the curriculum modules commenced in 2013–2014 at 38 U.S. medical schools. To date, 55 medical schools have expressed interest in joining the 2015–2016 pilot. We anticipate the final curriculum will launch in 2015.

The Clinical Congress program continues to address the evolving needs of practicing surgeons and other ACS members. The Program Committee convened two strategic planning retreats in 2014. Participants included members of the Program Committee, three ACS Regents, and representatives of the ACS Board of Governors, Young Fellows Association, Resident and Associate Society, and key ACS divisions.

To prepare for the retreats, seven task forces were charged with reviewing the Clinical Congress program and providing recommendations for further enhancements. One task force was charged with addressing overall content; the others were to address specific aspects of the program, including Panel Sessions, Scientific Sessions, Didactic Courses, Skills Courses, Town Hall Meetings, and Meet-the-Expert Luncheons. A task force also was appointed to address Communications and Marketing. The retreats resulted in several recommendations that will help improve Clinical Congress.

The 2014 Clinical Congress comprised 25 tracks and 11 Named Lectures, 114 Panel Sessions, 16 Didactic Courses, and 12 Skills Courses. Approximately 1,800 speakers and faculty participated in the program. A total of 1,286 abstracts were received for the Papers and Poster Sessions; 871 were received for the Forum on Fundamental Surgical Problems, and 424 submissions were received for the Video-based Education Sessions. All Scientific and Surgical Forum abstracts will be published in the Journal of the American College of Surgeons (JACS).

Self-Assessment credits were offered for all Panel Sessions, Didactic Courses, Skills Courses, and Video-Based Education Courses. Special certificates were offered for participation in sessions on Patient Safety, Trauma and Critical Care, Ethics, and Palliative Care.

The 2014 Clinical Congress Webcast package includes 113 Panel Sessions with opportunities to earn Self-Assessment credits. Webcasts include all Panel Sessions and Didactic Courses.

Plans to expand the Skills Courses offered at the Clinical Congress and at regional sites are under way. A new Committee on Surgical Skills Training for Practicing Surgeons has been appointed to develop a strategic plan.

The ACS continues to evaluate new procedures and technologies and to design training programs that address the acquisition and maintenance of skills in these areas. The College has established a relationship with the Australian Safety and Efficacy Register of New Intervventional Procedures–Surgical to conduct systematic reviews of the literature; 17 reviews have been developed and posted on the Committee on Emerging Surgical Technology and Education Web page.

The ACS Comprehensive General Surgery Review Course helps practicing surgeons to fulfill Part 2 of MOC requirements and to prepare for the Recertification Examination in Surgery to fulfill the requirements for Part 3 of MOC. The 2014 course attracted 150 attendees.

Evidence-Based Decisions in Surgery includes concise, focused modules derived from practice guidelines. Modules are developed based on diagnoses that are relevant to the 20 most common general surgery operations. The modules are intended for use at point-of-care and are accessible through electronic devices. The first 10 modules were released in October 2013, and the next 20 were released in October 2014.

Other developments in educational opportunities for practicing surgeons include:

- The liver volume of the ACS Multimedia Atlas of Surgery was released in October.
- The Third Edition of the Ultrasound for Surgeons: The Basic Course launched in October.
The 10th Annual Surgeons As Leaders Course took place in May with demand exceeding capacity.

The Committee on Ethics conducted a strategic planning session in April. The following action items emerged:

- Author a book that defines surgery ethics as it has evolved in the last decade
- Develop educational programs for surgeons who are committed to advanced study of ethics, as well as for those seeking to apply fundamental principles in surgical practice
- Expand the committee’s membership for better integration across the organization

The ACS also offers educational programs and products that address the core content for surgery residents. For example, ACS Fundamentals of Surgery Curriculum® (ACS FSC) is a simulation-based, interactive, online program that focuses on cognitive skills and is primarily directed at first-year residents. Enrollment has progressively increased; in fiscal year (FY) 2013–2014, 235 programs and 1,884 trainees were enrolled. Many program directors recommend or require entering residents to complete modules of ACS FSC before residency training begins.

The Fundamentals of Laparoscopic Surgery (FLS) program is a collaborative venture between the Society of American Gastrointestinal and Endoscopic Surgeons (SAGES) and the ACS. Version 3.0 of FLS is in development. To accommodate the increased demand for FLS testing, SAGES is accepting FLS Test Center applications from programs outside the U.S. and Canada. FLS International Test Center Standards and Criteria have been developed to help ensure standardized testing, and the feasibility of translating FLS into Spanish is being pursued.

The Ultrasound for Residents course has been reformatted to include the Ultrasound for Surgeons: The Basic Course and Ultrasound for Residents: A Skills Companion DVDs.

The ACS presented two resident education awards at Clinical Congress: the Resident Award for Exemplary Teaching and the Jameson L. Chassin Award for Professionalism in General Surgery, which is presented to a chief resident in general surgery who exemplifies the values of compassion, technical skill, and devotion to science and learning.

The ACS offers a number of programs to address the core content for medical students, including the ACS/APDS/ASE Resident Prep Curriculum described previously. Other examples include the ACS/ASE Medical Student Simulation-Based Surgical Skills Curriculum, which addresses core clinical and basic surgical skills. The curriculum was released in April 2013 and has been viewed nearly 3,200 times. A multi-institutional study is being planned to examine the effectiveness of the curriculum; approximately 30 medical schools have expressed interest in participating.

Efforts to develop the ACS/ASE Medical Student Core Surgery Curriculum are proceeding. This curriculum will address the educational needs of all medical students rotating through the core surgery clerkship. In addition, hundreds of aspiring surgeons participated in the three-day Medical Student Program at Clinical Congress.

The College presents several faculty-development programs, including the successful six-day Surgeons As Educators Course. Furthermore, the Division of Education and the International Relations Committee jointly sponsor International Guest Scholarships for faculty at institutions outside of the U.S. and Canada.

The College’s Surgical Patient Education Program is intended to support inclusion of patients and their families in health care decisions and to engage them to fully participate in the perioperative period. Key components of the program include Home Skills Training Kits, Education for Better Recovery, Informed Surgical Prep brochures and e-learning materials, and a new Professional Training Program. Major grants have been secured in collaboration with the ACS Foundation to support development of additional resources.

The ACS-AEI program is considered the gold standard for accreditation of simulation centers. The total number of ACS-AEIs is now 82, including 70 Compre-
The number of surgeons participating in the SSR continues to rise. Surgeons use the registry to fulfill PQRS and MOC requirements; more than 200 surgeons used SSR for PQRS last year.

Comprehensive (Level I) Institutes, and 12 Focused (Level II) Institutes. New accreditation standards and criteria for AEIs have been developed based on experience with the program since its inception and advances in the fields of simulation and educational accreditation. The designations were changed from Level I to Comprehensive Education Institute and from Level II to Focused Education Institute. The new accreditation standards, implemented in 2013, are as follows:

I. Learners and Scope of Educational Programs
II. Curriculum Development, Delivery of Effective Education, and Assessment
III. Administration, Management, and Governance
IV. Advancement of the Field

In addition, a special committee was appointed to develop standards and criteria for ACS-AEI Fellowships based on experiences in the field, expert consensus, and input from Consortium members. The standards are as follows:

I. Curriculum Requirements
II. Assessment Requirements
III. Operational Requirements
IV. Resource Requirements
V. Governance Requirements
VI. Advancement of the Field Requirements

Following review, four Fellowship Programs were approved in December 2013.

The Sixth Annual Postgraduate Course of the Consortium of ACS-AEIs took place in August 2013. The Centre for Excellence for Simulation and Innovation at the University of British Columbia hosted the program, which featured didactic sessions and discussion of topics of interest to members of the consortium.

The Seventh Annual Meeting of the Consortium of ACS-AEIs took place in March. A total of 184 representatives from 61 of the 79 ACS-AEIs participated in this meeting.

Committees of the Consortium of ACS-AEIs are engaged in the following activities:

- Developing a textbook on simulation and surgery
- Writing a manual on the principles and practice of simulation-based surgical education research
- Developing a toolkit for directors and administrators of simulation centers
- Creating a taxonomy for surgical simulation and education
- Designing the Program for ACS-AEI Consortium Meetings
- Collecting information on best practices
- Pursuing efforts to address current and emerging needs

The online My CME (continuing medical education) system awards and tracks CME credits. From July 2013 to April 2014, My CME provided approximately 12,000 CME certificates, approximately 9,000 Self-Assessment CME certificates, nearly 2,700 Patient Safety certificates, and more than 2,000 Trauma Certificates.

The ACS provides Category 1 CME Credits for many educational programs presented by the College and other surgical organizations. In 2013, the ACS accredited 2,147 activities, providing more than 26,000 credits to approximately 147,000 physicians.

The College is launching a nationwide ACS Education and Training Campaign, similar to the Inspiring Quality Campaign, to communicate the following messages:

- ACS Education and Training are the cornerstones of excellence
- ACS Education and Training transform possibilities into realities
- ACS Education and Training instill the joy of lifelong learning

The number of surgeons participating in the SSR continues to rise. Surgeons use the registry to fulfill PQRS and MOC requirements; more than 200 surgeons used SSR for PQRS last year.
Continuous Quality Improvement (CQI)

This year marked the 10th anniversary of the launch of ACS National Surgical Quality Improvement Program (ACS NSQIP®). In July, ACS NSQIP presented its annual conference in New York, NY. Approximately 1,200 representatives from nearly 600 hospitals attended. More hospitals from more locations are enrolling in ACS NSQIP, and new collaboratives are being formed. The College is working with the surgical specialties to develop specialty-specific modules. For example, a new transplant module is under development. In addition, we are working with CMS to continue the public reporting (Hospital Compare) contract with ACS NSQIP hospitals.

Furthermore, over the last three years, we have been working with a broad-based task force to develop comprehensive guidelines that define the resources needed to perform safe, effective operations in infants and children. Early next year, the ACS will start evaluating participating hospitals’ level of pediatric surgical care. The guidelines were published in the March 2014 issue of JACS in an article titled “Optimal Resources for Children’s Surgical Care in the U.S.” The Wall Street Journal also published a favorable article about the program.

More than 700 hospitals now participate in the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP). The MBSAQIP recently issued new standards for accreditation, which are now being used. Site visitors have been trained, and verification site visits are being performed. Hospitals are using the MBSAQIP registry for quality improvement. The registry is a certified CMS Quality Clinical Data Registry, which means surgeons may use the bariatric registry to report outcomes instead of participating in the Physician Quality Reporting System (PQRS).

The number of surgeons participating in the Surgeon Specific Registry (SSR) continues to rise. Surgeons use the registry to fulfill PQRS and MOC requirements; more than 200 surgeons used SSR for PQRS last year. The College continues work on a Quality Manual. Many chapters have been completed and are being evaluated, revised, and aligned. The target date for release is summer 2015.

A one-day Leading Quality Course was piloted at Clinical Congress. The course was oversubscribed within a few days of an e-mail announcing its presentation; the ACS sees this program developing into a more comprehensive course with initial presentation in spring 2015.

Finally, the ACS continues to provide opportunities for residents to work on ACS Quality Programs through the Clinical Scholars in Residence Program.

Trauma

Sharon Henry, MD, FACS, has been selected to chair the Advanced Trauma Life Support® (ATLS®) Committee, and ACS Governor Karen Brasel, MD, FACS, will lead international ATLS efforts.

The ATLS app continues to be successful with more than 66,900 unique downloads and more than 4,320 in-app purchases from 164 countries. The eLearning project is under way, with staff conducting webinars for coordinators across the nation to ensure appropriate planning and application of ATLS requirements.

An interactive eBook has been developed for ATLS. It will include flashcards, text highlighting, video links, and self-check questions.

The Committee on Trauma (COT) continues to review alternate models of international promulgation and is working with region chiefs to promote their independence in adopting course sites. International ATLS activity continues to outstrip North American activity.

The COT is pursuing a more in-depth relationship with the DoD that would allow military trauma centers to participate in the National Trauma Data Bank (NTDB®)/Trauma Quality Improvement Program (TQIP) and thus meet that requirement for verification. The intent would be for an agreement to be reached whereby non-combat data would continue to be sent from each military trauma center to the DoD Trauma Registry, which would then forward records to NTDB/TQIP.

An electronic version of the Resources for the Optimal Care of the Injured Patient 2014 launched this summer; the print version was released in mid-fall. The new guide features streamlined and simplified criteria, and...
an evidentiary base has been established. The guidelines take effect July 1, 2015.

The COT is working to establish a Future Trauma Leaders Program to engage young trauma and acute care surgeons. The COT Membership Committee will select two individuals for a two-year program under the guidance of a COT mentor; participants will be expected to complete specific projects, train to be COT course instructors, and receive advocacy/leadership training.

The COT has been actively involved in government efforts to establish guidelines for emergency medical services (EMS), including hemorrhage control. COT leaders participated in a federal stakeholder meeting to address the response to mass shootings and improvised explosive devices and discuss protocols for EMS personnel to provide timely care to victims. There was enthusiasm for greater integration of EMS and law enforcement personnel.

The Hartford Consensus, led by ACS Regent Lenworth Jacobs, Jr., MD, FACS, and numerous consensus partners, articulated a framework for increasing survivability in mass shootings, which promotes the use of THREAT: (1) Threat suppression, (2) Hemorrhage control, (3) Rapid Extrication to safety, (4) Assessment by medical provider, and (5) Transport to definitive care. The document also calls upon uninjured or minimally injured victims to act as rescuers, law enforcement to be trained in hemorrhage control, EMS personnel to be more fully integrated into the response process, and surgeons and trauma systems to be used to optimize seamless care.

The Regents approved three injury prevention statements: Statement on Bicycle Safety and the Promotion of Bicycle Helmet Use, Statement on Intimate Partner Violence, and Statement on Older Adult Falls and Falls Prevention.

The COT TQIP team is developing a pilot of an Emergency General Surgery Registry, and is leading an effort to align the COT’s processes with other major ACS quality improvement programs. The goal is to standardize the processes, guidelines, and reports of these programs.

The COT’s Advocacy Pillar conducted a successful day on Capitol Hill, which preceded the COT Annual Meeting in March. Improved processes have reduced the trauma center verification reporting process to approximately seven to eight weeks. A total of 426 sites have been verified to date, and the COT is already scheduling visits into FY 2016.

More than 6 million records have been deposited in the NTDB since its inception; the most recent call for data yielded more than 814,660 records from the following:

- 230 Level I centers
- 265 Level II centers
- 205 Level III or Level IV centers
- 32 Level I or Level II pediatric-only centers

The NTDB training course for 2014 was released to assist registrars. Staff has conducted de-identification reviews to ensure that data released comply with the Health Insurance Portability and Accountability Act.

A total of 208 trauma centers participate in TQIP—131 Level I and 80 Level II, with 40 more centers in the pipeline. Of the Level I centers, 65 percent are ACS-verified, as are 71 percent of the Level II facilities. State participation has continued to grow, and we have been asked to help in the formation of state collaboratives.

The pilot for Pediatric TQIP is complete. A total of 25 centers are participating:

- 15 Level I, eight state-designated and 12 ACS-verified
- Six Level II, three state-designated and four ACS-verified
- 39 centers are in the process of joining pediatric TQIP

The first Pediatric TQIP report was released this fall.

Cancer Programs

The CoC has accredited more than 1,500 programs that provide care to 71 percent of all newly diagnosed cancer patients in the U.S. and Puerto Rico. The CoC conducted 502 cancer program surveys this past year, and 31 new cancer programs joined the accreditation program. A total of 74 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 standards.
op a framework for oncology medical home standards. We have requested grant funding from the Center for Medicare & Medicaid Innovation to support development of the model.

CoC leadership and other stakeholders have developed rectal cancer standards, which will form the basis of a rectal cancer accreditation model. In addition, the CoC established a cross-functional pediatric workgroup to evaluate existing standards and develop an enhanced set of performance measures and will explore possible linkage with the pediatric surgical accreditation program.

The LIVESTRONG Foundation, the Cancer Support Community, the American Cancer Society, and the National Coalition for Cancer Survivorship joined with the CoC to create a Continuum of Care Readiness Survey distributed to all CoC-accredited programs to gauge their preparedness for 2015 phase-in standards: Patient Navigation, Distress Screening, and Survivorship Care Plans. The CoC drew on the survey results to develop clarifications to the requirements for these standards, which were released in September.

More than 300 staff from CoC-accredited programs and programs seeking accreditation attended the two sessions of the new Accreditation 101 workshop in March and September and the advanced Strengthening Your Cancer Program... Enriching the Coordinators’ Role workshop in June.

The National Cancer Data Base (NCDB) has grown over the last year, adding 8.6 million new and updated reports; 1.2 million were newly diagnosed cases in 2012. The NCDB is approaching 26.8 million cases diagnosed.

The Cancer Program Practice Profile Reports (CP3R) has been expanded to include two new sets of quality measures. Three breast-related measures were released in March. Three additional measures will be included in the next data release—two for non-small cell lung and one for gastric cancer—bringing the total released measures to 12. In March 2013, the CoC and the Pennsylvania Health Care Quality Alliance (PHCQA) began working together to post CP3R performance measures on the PHCQA website at www.PAHealthCareQuality.org. The purpose of this project is to provide more comparable information to patients. Presently, 56 of the 72 programs have agreed to participate in public reporting through the PHCQA Web page.

The first Cancer Quality Improvement Program Annual Report (CQIP 2013) was released in February and was well received. This year’s CQIP includes comparative performance on six new quality measures—three breast, two lung, and one gastric. The CQIP 2013 included 30-day mortality rates for selected, complicated surgical procedures. The CQIP 2014 will be expanded to include 90-day mortality rates for complicated operations. One additional cancer disease site will include melanoma of the skin along with risk-adjusted survival rates for breast, colon, and non-small cell lung cancer.

Feedback from the inaugural year of the Participant User File (PUF) program was positive, and interest grew in 2014.

The Rapid Quality Reporting System (RQRS) is a Web-based reporting and quality improvement tool that provides real clinical time assessment of hospital adherence to National Quality Forum-endorsed quality measures for breast and colon cancers and prospectively tracks the progress of individual patients within each measure. Approximately 71 percent of CoC-accredited programs participate in RQRS.

The Prospective Payment System-exempt contract completed its second year. Data are submitted by the 11 members of the Alliance of Dedicated Cancer Centers to the RQRS system. Quarterly data files containing quality measure rates for three measures (two for breast cancer, one for colon) are generated and submitted to CMS for public reporting. CMS met with representatives of the facilities and contractors in June discuss progress to date.

The Cancer Liaison Program engaged in the following activities:

- Presented a State Chair Town Hall session before Clinical Congress and presented awards for outstanding service to three State Chairs
- Hosted a Cancer Liaison Program Breakfast for approximately 250 attendees at Clinical Congress
To boost membership, we have launched a Young Surgeons Marketing Campaign, called Realize the Potential of Your Profession, and a Show Your Pride campaign to reinforce use of the FACS insignia.

- Discussed the State Chair role in chapters at the annual meeting of Chapter Executives in December
- Encouraged State Chairs to participate in ACS advocacy efforts

The 2013 CoC Paper Competition winner delivered a 15-minute presentation on “Gastrointestinal Cancers in Young Survivors of Lymphoma: Implications for Earlier Screening” at the 2013 CoC Annual Meeting in Washington, DC. The 2014 Paper Competition winner will present next year.

The American Cancer Society/CoC Collaborations Meeting took place in December 2013. The agenda set the stage for future collaboration between the two organizations. Additionally, American Cancer Society and CoC leaders met to discuss the possibility of ACS Survivorship Care Program Certification.

The Annual Advocacy Committee Planning Meeting took place in Washington, DC, February 10–11, and the CoC held its first legislative briefing at this time. The CoC has been actively engaged in several legislative and regulatory issues, including:

- Support of the One Voice Against Cancer appropriation requests for the National Institutes of Health and Centers for Disease Control (CDC)
- Sign on to H.R. 1666: Patient Centered Quality Care for Life Act
- Sign on to H.R. 1339/S. 641: Palliative Care & Hospice Education and Training Act
- Support H.R. 1070: Removing Barriers to Colorectal Cancer Screening Act
- Support CAG-00439N: National Coverage Analysis Tracking Sheet for Lung Cancer Screening with Low-Dose Computed Tomography
- Comment on recommendations from the National Patient Navigation Consortium
- Sign on to American Medical Association Resolution on Genetic Testing
- Sign on to biomedical research legislation

Other CoC advocacy activities include:

- Issued a written response to the Institutes of Medicine report, Delivering High-Quality Cancer Care: Charting a New Course for a System in Crisis
- Prepared a Statement on Cooperative Cancer Clinical Research Groups and the National Clinical Trials Network System

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

The NAPBC Board held a Strategic Leadership Retreat, January 29–30. Leadership from the CoC and the Division of Research and Optimal Patient Care attended. The retreat resulted in eight specific areas of focus, with an emphasis on improving the value to accredited centers and developing new quality tools.

An international pilot survey occurred November 11 at the Tawam Hospital in the United Arab Emirates. The survey immediately preceded the Emirates Oncology Conference; the two surveyors were invited speakers. A presentation on the NAPBC was delivered at the conference. International interest remains strong, and two additional pilot surveys are planned for 2015.

An Ohio law took effect in March that incorporates the NAPBC standards relating to mastectomy and reconstructive surgery. The Lizzie B. Byrd Act requires that a surgeon, or a health care professional designated by a surgeon, who performs a mastectomy
in a hospital must guide the patient through provided or referred services in a manner consistent with NAPBC standards.

A new episode of National Public Radio’s *Recovery Room* highlighted mammographic screening issues. Rick Greene, MD, FACS, interviewed two NAPBC leaders who discussed common concerns with mammography, the role of insurance companies, magnetic resonance imaging, and a high-profile Canadian study that casts doubt on the effectiveness of mammograms.

The *ACS Clinical Research Program (ACS CRP)* sponsored several sessions at the 2014 Clinical Congress:

- A Panel Session: Enrolling Patients in Cancer Clinical Trials: The Nuts and Bolts
- A Town Hall: Oncologic Surgery and Cancer Care for Underserved Populations
- Three Meet-the-Expert Luncheons:
  - Efficient Disease Management: The Geisinger Model for Cancer Care
  - Is My Patient Frail? Assessment and Clinical Implications for Cancer Surgery
  - A Framework for Conducting Quality Improvement Projects in a Cancer Surgical Practice

The ACS CRP sponsored five surgical investigator meetings to promote Alliance clinical trials and membership among surgeons. The ACS CRP has completed the manuscript for *Operative Standards for Cancer Surgery*. Production began in September with a targeted publication date of February 2015.

The ACS CRP received funding for three studies from the Patient-Centered Outcomes Research Institute (PCORI):

- Improving the Effectiveness of Routine Surveillance following Lung Cancer Resection
- Post-Treatment Surveillance in Breast Cancer: Bringing CER to the Alliance
- Patient-Centered, Risk-Stratified Surveillance After Curative Resection of Colorectal Cancer

Another two proposals submitted to PCORI are under consideration: Comparison of Patient-Centered Outcomes According to Ductal Carcinoma in Situ Management Strategies, and Optimizing the Effectiveness of Routine Post-Treatment Surveillance in Prostate Cancer Survivors.

More than 1,200 patients have enrolled in Phase II of the ACS CRP’s ProvenCare lung cancer collaborative. The collaborative has been expanded to include radiation and medical oncology (Phase III), set to launch in early 2015.

Content development for the *American Joint Committee on Cancer’s (AJCC’s)* eighth edition of the *Cancer Staging Manual* begins in October. The infrastructure to support more than 500 volunteers, 18 expert panels, five cores, and the editorial board is now in place.

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

CoC marketing-related efforts are being enhanced and include:

- Using data from the American Hospital Association to develop lists of accredited and non-accredited programs to increase market penetration
- Implementing a comprehensive advertising campaign to promote CoC and NAPBC accreditation
- Participating in the combined ACS Quality Program marketing initiative discussed previously
Member Services
The Division of Members Services continues to implement initiatives in support of its three main focus areas: retention and recruitment of members, member engagement, and governance and internal structures to support individual members.

Presently, the College has 78,361 members: 65,042 Fellows (58,437 U.S., 1,380 Canadian, 5,225 International); 2,743 Associate Fellows; 8,550 Residents; 1,769 Medical Student; and 257 Affiliate Members. Approximately 12 percent of these members are female. This year’s Initiates class—one of the largest ever—totaled 1,640, with 1,184 U.S., 26 Canadian, and 430 International surgeons.

To boost membership, we have launched a Young Surgeons Marketing Campaign, called Realize the Potential of Your Profession, and a Show Your Pride campaign to reinforce use of the FACS insignia. Specialty-specific recruitment strategies also are under way, along with efforts to increase international outreach.

With respect to member engagement, the ACS is evaluating the committee nominations and engagement process, conducting a member and non-member survey, deploying a Leadership Guide, and expanding opportunities for members to become involved in College committees.

The Board of Governors (B/G) continues its work under the reorganization that took place in 2013. Each Governor serves on a Workgroup, which falls under one of the five divisional Pillars: Member Services; Education; Advocacy and Health Policy; Quality, Research and Optimal Patient Care; and Communications. The Workgroups have been very active with a variety of projects that were highlighted in the September Bulletin.

Furthermore, the B/G has completely redesigned its annual survey to better meet the needs of the College, the Governors, and their constituents. The 2014 survey results were presented to the Board of Regents in October.

The Advisory Councils are completing a reorganization similar to the B/G’s. At their spring meetings, the Advisory Councils provided feedback on Optimal Resources for Children’s Surgical Care in the United States and the Statement on Peak Performance in Surgery through Recognition and Mitigation of the Impact on Fatigue. The Advisory Council for Rural Surgery sponsored a successful symposium at ACS headquarters in May, and all Advisory Councils contributed suggestions regarding reasons their colleagues should join the ACS.

The United Arab Emirates and Bolivia formed ACS chapters in the first half of 2014, and a Guam Chapter was approved at the Regents’ October meeting. Jordan and Nigeria also plan to form chapters and have applied to have Governors appointed.

Domestic chapter revitalization continues. For example, the Alaska, Georgia, and Utah chapters are creating strong meetings and increasing membership among young surgeons, and the western states are planning a super-regional meeting for 2016.

A panel presentation and networking reception will be offered at the Clinical Congress for all chapter officers and administrators, sponsored by both the Governors Chapter Activities Workgroup and the International Workgroup. International Chapter Presidents also will have opportunities to meet by region.

More than 425 ACS leaders, chapter officers, and young surgeons participated in the 2014 Leadership & Advocacy Summit. In addition to providing information on best practices for running a chapter, mentoring, and other general topics of interest, the Leadership Summit focused on the importance of emotional intelligence (EI) and its relevance to surgical leadership. Next year’s event is scheduled for April 18–21 in Washington, DC.

The Resident and Associate Society (RAS-ACS) continues to offer opportunities for trainees and early-career surgeons to engage in ACS activities, aided by the launch of an online Community. At this year’s Clinical Congress, the RAS-ACS hosted several sessions, including Surgical Jeopardy and Spectacular Cases. At the RAS Symposium, essay contest winners and other speakers shared their perspectives on Five-Year General Surgery Residency: Reform or Revolution? The ACS Communities launched in July. As of mid-September, the platform had grown to 27 communities covering a variety of member surgeon interests. More communities will be available soon.
Surgical Jeopardy Tool Kit is being piloted at several chapter meetings, and the RAS continues to expand its representation on ACS committees.

The Young Fellows Association (YFA), which has been expanding its representation on College committees and Advisory Councils, presented its annual meeting and Initiates program at Clinical Congress. The YFA Mentorship Program continues to grow, with 22 mentor/mentee pairs participating this year. In addition, the YFA has formed a joint task force with RAS to develop membership recruitment and retention strategies and increase involvement in advocacy efforts. The YFA also launched an online Community.

The role of the International Relations Committee (IRC) has been expanded to better serve as the primary home for international activities and outreach within the College. A new subcommittee structure has been put in place, which is now fully operational. The IRC has prepared metrics on International members and a proposed dues structure.

The Women in Surgery Committee is working with the Program Committee to offer a Women’s Health Day curriculum at the 2015 Clinical Congress and has implemented a Mentorship Program that matched 37 pairs. In addition to launching a new Community, this committee has started a series of podcasts exploring opportunities for leadership within the College.

In 2014, the Central Judiciary Committee (CJC) reviewed 13 new cases. Those cases involved questionable expert witness testimony, physician impairment, felony conviction, negligence, alteration or failure to maintain medical records, and unprofessional conduct. This year, the CJC recommended that six Fellows be charged with Bylaws violations.

Over the course of this last year, the Scholarships Committee presented 33 domestic awards (mostly research-oriented) and 32 international awards (mostly travel/observation). The total amount awarded was $1,527,500.

The Society of Surgical Chairs, which the College manages, has increased its membership to 175 dues-paying members in the U.S. and Canada. It continues to hold its annual meeting during Clinical Congress and has added a mentorship program and tri-annual newsletter as member benefits.

A new Archivist, Adam Carey, has been hired to develop a strategic plan to make the Archives more accessible to Fellows. He is creating a Web-based Master Finding Aid that lists all ACS archival holdings. Specific archival records are being digitized and will be made instantly accessible to Fellows in the near future. Finally, the ACS Surgical History Group continues to generate enthusiasm regarding College history and has proposed several outreach opportunities for next year’s Clinical Congress.

**Integrated Communications**

The Division of Integrated Communication is responsible for producing the ACS website and online Communities, member publications, marketing initiatives, and social media.

On August 5, the ACS launched its new public website, fascs.org. The site was completely redeveloped based on member input and through significant effort on the part of staff throughout the College. The site is organized as a member would naturally search for information—around the College’s core pillars: Member Services, Quality Programs, Education, and Advocacy. The site’s responsive design allows users to access all components easily on a desktop, tablet, or smartphone. Furthermore, all College-related business is easily handled through password-protected areas of the new website.

The ACS Web Oversight Group met for the first time in August. The group comprises staff from major ACS program groups and is charged with ensuring that ACS website content remains up-to-date and relevant. ACS Communities launched in July. As of mid-September, the platform had grown to 27 communities covering a variety of member surgeon interests. More communities will be available soon.

The total number of JACS submissions has almost doubled since 2013. Accepted but not yet typeset manuscripts are posted on the JACS website and are fully citable within two weeks of acceptance. The impact factor has remained stable over the past three years.
at approximately 4.5, currently ranking JACS ninth out of 202 surgery journals. To further develop JACS’ online presence, a Social Media Editor was hired, and to increase the quality of published CME content, have hired a CME Editor. A new “responsive design” for desktop, smartphone, and tablet formats, developed by the Information Technology (IT) area at ACS, will enable greater access to featured CME activities online.

Strategic planning for moving more content and driving readers to the Bulletin microsite will begin after Clinical Congress. As a first step in this process, the division plans to survey the membership to determine their preferred format for reading the Bulletin.

The ACS Inspiring Quality tour visited six more regions/states in 2014: Northern California, January 14; North Carolina, February 19; Ohio, March 28; South Carolina, April 1; Iowa, June 27; and Utah, October 3.

The ACS enjoyed prominent news coverage in 2014. Major media outlets and ACS-related stories they covered are as follows:

• CBS San Francisco, “Health leaders discuss lessons learned from Asiana crash response”

• Los Angeles Times, “Report criticizes LA County spending on emergency medical services”

• Boston Globe, “How to reform the Medicare physician payment system”

• USA Today, “Marathon bombing prompts police to carry tourniquets”

• Yahoo! Health, “No surgery required for children’s appendicitis”

• U.S. News & World Report, “10 changes in surgery in 25 years”

• Boston Globe, “Honoring a once scorned voice for medical openness”

• FierceHealthcare, “Tennessee hospital quality program cuts complications 20%, saves 533 lives”

• Wall Street Journal, “Programs aim to standardize surgical care for children”

One of the College’s marketing initiatives centered on bundling ACS Quality Programs together to build awareness of all related ACS programs and the College’s role as a leader in this arena. In addition, the marketing area was instrumental in developing the Show Your Pride campaign.

The College has made progress in expanding its social media presence, as the table on this page demonstrates.

### ACS SOCIAL MEDIA PRESENCE

<table>
<thead>
<tr>
<th>Social media site</th>
<th>2010 October</th>
<th>2011 October</th>
<th>2012 August</th>
<th>2013 December</th>
<th>2014 September</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facebook</td>
<td>0 “Likes”</td>
<td>250 “Likes”</td>
<td>1,717 “Likes”</td>
<td>5,958 “Likes”</td>
<td>7,863 “Likes”</td>
</tr>
<tr>
<td>Twitter</td>
<td>907 followers</td>
<td>2,972 followers</td>
<td>6,063 followers</td>
<td>12,695 followers</td>
<td>16,366 followers</td>
</tr>
<tr>
<td>YouTube</td>
<td>11 videos 1,150 views 7 subscribers</td>
<td>40 videos 45,809 views 90 subscribers</td>
<td>76 videos 94,956 views 217 subscribers</td>
<td>194 videos 219,194 views 616 subscribers</td>
<td>242 videos 277,260 views 811 subscribers</td>
</tr>
<tr>
<td>LinkedIn</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>2,690 followers</td>
<td>4,154 followers</td>
</tr>
<tr>
<td>Google+</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>214 have in circles</td>
<td>312 have in circles</td>
</tr>
</tbody>
</table>

*ACS Foundation*

The centerpiece of the Foundation’s activities in the last year has been the 1913 Legacy Campaign, which launched in conjunction with the ACS Centennial. At press time, Fellows, friends, and corporations had donated more than $2.4 million through the 1913
Legacy Campaign. Nearly half of the ACS Fellows who donated gave $5,000 in honor of the Centennial. The ACS Regents and Officers, Governors, Past-Presidents, Chapters, and committee members have participated as donors and, in some cases, as peer-to-peer volunteers seeking campaign gifts. Through the campaign, the Foundation has secured financial support to advance the College’s priorities, increased unrestricted gifts, boosted the number of planned gifts, and enhanced member engagement.

The 1913 Legacy Campaign benefits the surgeon, the profession, and the societal good. In collaboration with ACS divisions, the Foundation informs donors about the programs to which they direct gifts, including new initiatives, such as the Rural Surgery Fund and the Codman Quality and Safety Fund.

Nine donors became members of the Mayne Heritage Society in FY 2014, and the 1913 Legacy Campaign has encouraged at least six bequest commitments of $25,000 or more since June 2013.

The 1913 Legacy Campaign established a National Steering Committee of 30 to 35 Fellows to engage their peers in philanthropy. Their contributions of time and effort have allowed for broader implementation of a peer-to-peer campaign promotion. In addition, the Foundation has developed and implemented a strategy to encourage “home-grown” philanthropic champions in each ACS chapter. These Fellows convey key messages and serve as points of contact during their chapter meetings.

The annual gift appeal program has experienced an overall increase of 60 percent in donor response. This fund provides yearly income to nonrevenue programs.

To better communicate the impact of donations, the Foundation partnered with the Bulletin to articulate how ACS Resident Research and Faculty Research Scholars develop innovative methods of providing quality care to surgical patients and point to ACS funding as a start to their research. Additionally, former International Guest Scholars were interviewed and described how they have used the knowledge and skills gained through their ACS-funded travel awards to improve patient care in their countries.

Service areas

The Convention and Meetings area has continued to generate revenue through exhibit sales at the Clinical Congress and other internal and external client meetings. Association Management Service (AMS) celebrates its 10th anniversary this year. In FY 2014, AMS added two clients, the Society of University Otolaryngologists—Head and Neck Surgeons and the Association of Academic Department Otolaryngologists—Head and Neck Surgeons, for a total of 18. In addition, the John B. Murphy Memorial Auditorium continues to attract events and recently hosted a NASCAR media event and 20th Century Fox TV filming. Social media has played an important role in attracting new clients.

The Performance Improvement (PI) team is tracking 265 projects; 90 are under way, and 106 have been completed. In addition, over the course of this year, the team began 10 new projects; two have been completed, and six are in process.

PI has trained 96 staff members in the Change Acceleration Process (CAP) and designated seven Master Change Agents (MCAs), who participate in training, revising PI curricula, and facilitating projects. CAP/PI sharing sessions are being offered, as are CAP tool refreshers for Change Agents. PI staff have created an ACS Branded Curriculum for CAPS and other resources, which will be rolled out to the next wave of scheduled PI volunteer training courses.

We are designing a curriculum to train all staff in leadership skills. It includes a two-hour innovation orientation and longer engagements, including exercises to encourage innovation. Almost all staff have completed the DiSC and EI training courses.

An Employee Engagement survey was conducted, and each division was provided with their scores in relation to the overall ACS results. Each division has identified at least one focus area to improve staff engagement.

In addition, PI is assisting Member Services in streamlining the member application process, researching the e-publication models available, and assisting Human Resources (HR) in a review of the employee recognition program.
HR hired 69 new employees and promoted or transferred 15 employees in 2013. As of mid-September, the ACS had filled 55 positions in 2014.

The performance review format has been updated to incorporate ACS values and employee self-appraisal.

Monthly UConnect sessions are offered to all supervisors, and values training is offered to new hires. Meanwhile, Executive staff engaged in four two-day sessions focused on development in the following areas: Values, Individual Development Plans, EI, Building High-Performing Teams with DiSC Assessment, Coaching, Conflict Resolution, and Fostering Innovation. ULead II provided one day of training for each staff member, the focus of which was EI and DiSC. More than 300 staff members attended.

Information technology (IT) played an active role in the launch of the new ACS website and Communities. IT also assisted in the creation of a unified billing process for the College, rollout of the MBSAQIP accreditation system, My CME upgrades, data registry vendor evaluation, and upgrading the CoC accreditation system for new standards. Other IT projects include:

• Rollout of new video conferencing and collaboration software
• Development of AEI accreditation management system
• Integration of meeting planning system with meeting app

Closing comments
A few other highlights from this past year include the introduction of an operational oversight system. This system has allowed us to improve internal communication and overall awareness of the accomplishments of the staff across the College.

In addition, at Clinical Congress, the College finalized an agreement to form a strategic partnership with the DoD and the military health care system. This alliance will add an exciting new dimension to the work of both the College and the military.

It also should be noted that several ACS employees have enjoyed recognition by external peer groups for their work on behalf of the College, including:

• Clifford Y. Ko, MD, MS, MSHS, FACS, Director of the ACS Division of Research and Optimal Patient Care, was appointed to the National Quality Forum’s Surgery Standing Committee.
• Michelle McGovern, Director of HR, was elected vice-chairman of the board at HRMAC.
• Dr. Sachdeva was elected vice-president of the Society for Academic Continuing Medical Education.
• Patricia L. Turner, MD, FACS, Director, ACS Division of Member Services, was elected to the American Medical Association Foundation.
• Gay Vincent, CPA, Chief Financial Officer, has been nominated for chief financial officer of the year by the Chicago Chapter of Financial Executives International.

Finally, we were all saddened to learn that Thomas R. Russell, MD, FACS, former Executive Director of the ACS, passed away this summer. At this year’s Clinical Congress, we presented the ACS Lifetime Achievement Award posthumously to Dr. Russell and hosted a “Celebration of Life” service in his memory.

The College continues to grow in size and influence because of the dedicated staff and volunteers of this organization. I want to thank each of you for your hard work and commitment to the surgical profession and patient.
Georgia coalition develops bariatric surgery pilot project

by Kathryn Drake Browning

Chapters of the American College of Surgeons (ACS) play a significant role in grassroots advocacy at the state level. With political gridlock in Washington, DC, it often falls to the states to address health care issues. In addition, the practice of medicine and surgery is regulated by state governments through professional licensure, establishment of standards for health care facilities, and so on.

Successful grassroots advocacy involves many strategic elements, perhaps most notably drawing together a strong, functional coalition of like-minded organizations to work for passage of legislation. We were able to achieve this goal in Georgia over the long term concerning the issue of coverage for bariatric surgery, and we hope the following story will inspire and motivate other ACS chapters in their own grassroots advocacy initiatives.

Roots of the problem
In 2011, due to state budget cuts, the Georgia Department of Community Health (DCH) abruptly discontinued coverage of bariatric surgery for members of the State Health Benefit Plan.* From that point on, Georgia surgeons were hard at work advocating for their patients by seeking reestablishment of this important treatment option for morbid obesity. Members of the Georgia Society of the ACS (GSACS) and the Georgia Chapter of the American Society of Metabolic and Bariatric Surgeons entered into a coalition with patients, the Obesity Action Coalition (OAC), the Georgia Hospital Association (GHA), and medical device makers. These stakeholders worked together to restore the bariatric surgery benefit.

In 2012, the coalition focused its efforts on restoring funding in the state budget, thereby having the bariatric surgery benefit reinstated. The coalition was successful, and the Georgia legislature allocated $1.75 million in the state budget to restore the benefit for fiscal year 2013. Unfortunately, Gov. Nathan Deal (R) vetoed the language designating the appropriation for restoration of bariatric surgery coverage.

Snatching victory from the jaws of defeat
Based on advice from the legislation’s champions in the capital, the coalition changed its strategy in 2013. The new goal was to achieve legislative relief by way of a pilot project to study the return on investment of the bariatric surgery benefit in the State Health Benefit Plan.* From that point on, Georgia surgeons were hard at work advocating for their patients by seeking reestablishment of this important treatment option for morbid obesity. Members of the Georgia Society of the ACS (GSACS) and the Georgia Chapter of the American Society of Metabolic and Bariatric Surgeons entered into a coalition with patients, the Obesity Action Coalition (OAC), the Georgia Hospital Association (GHA), and medical device makers. These stakeholders worked together to restore the bariatric surgery benefit.

In 2012, the coalition focused its efforts on restoring funding in the state budget, thereby having the bariatric surgery benefit reinstated. The coalition was successful, and the Georgia legislature allocated $1.75 million in the state budget to restore the benefit for fiscal year 2013. Unfortunately, Gov. Nathan Deal (R) vetoed the language designating the appropriation for restoration of bariatric surgery coverage.

Plan. H.B. 511 was introduced and called for implementing a pilot program within the State Health Benefit Plan for coverage of 75 bariatric operations per year for two years, plus requisite follow-up care. During the 2013 legislative session, the Georgia House of Representative passed H.B. 511 with an overwhelming majority. However, the legislation was never called up for a vote in the Georgia Senate—not because of opposition to bariatric surgery, but because of fears that the legislation would be amended to include other, more contentious provisions.

Between the end of the 2013 Georgia legislative session and the beginning of the 2014 session, the coalition again approached the DCH and asked that the benefit be restored outright. That request was denied, so when legislators gathered at Georgia’s capitol in January of 2014, the coalition was there to greet them. Finally, after considerable advocacy efforts on the part of the coalition, H.B. 511 received final approval and was signed by Governor Deal in the spring of 2014. The pilot project is scheduled to begin in January 2015.

While this effort will not be considered successful until the benefit is restored completely, the passage of H.B. 511 is worth celebrating. This achievement could not have been accomplished by any one member of the coalition.

Building success
For a coalition to be successful, communication is paramount. In Georgia, our coalition established a clearly defined goal and a strong commitment from all the stakeholders to stay focused on achievement of the goal. The strengths and weaknesses of each member of the coalition were considered in developing a strategy that prominently featured the core assets of the group. One of our greatest strengths was agreeing early on that it did not matter which organization took the lead or got the credit.

The OAC identified patients and advocates who made telephone calls to legislators, wrote testimonials, and submitted op-ed pieces to media outlets. Patients and surgeons testified before legislative committees, putting human faces to the value of bariatric surgery beyond the return on investment data. The GHA and surgeon advocates partnered to provide information, education, and testimony on the safety of the surgery and the outcomes. The medical industry members of the coalition provided a wealth of data on the success of pilot projects in other states and the return on investment for bariatric surgery. When faced with an obstacle, the coalition evaluated the situation and made a unified decision. The strength and ultimate success of the coalition was, and continues to be, its collective commitment to the goal.

As is true of many efforts at the state level, this initiative will take some time to complete; state legislatures rarely take immediate action to address a problem, even with a solution that seems obvious. Political factors usually come into play, slowing down—or, in some rare cases, speeding up—the process and requiring regular re-evaluation of advocacy strategies. The Georgia coalition remains unified and will continue to work toward the successful completion of the bariatric surgery pilot project and, ultimately, the restoration of bariatric surgery coverage for Georgia’s state employees.

KEY ADVOCACY TAKEAWAYS
• Communication is a priority when building a strong coalition
• Heed the advice offered by legislative champions (such as senators or representatives sponsoring the legislation) when the advocacy strategy requires revising
• Engage all coalition members by emphasizing members’ strong points and areas of expertise and use these assets to the fullest
• Prepare targeted testimony for greatest effect
• Understand that the advocacy effort is an ongoing process that will likely span multiple sessions of the legislature

State legislatures proved to be successful in debating, passing, and implementing a significant amount of legislation in 2014, even though some states had shorter, budget-focused sessions, while the legislative bodies in other states—Montana, Nevada, North Dakota, and Texas—did not convene. Lawmakers at the state level conquered a host of issues related to health care, ranging from youth concussion prevention to expanding Medicaid. The American College of Surgeons’ (ACS) State Affairs staff, with the assistance of an online tracking system, reviewed more than 2,000 bills and actively monitored 500 of those proposed pieces of legislation. Bills addressing various aspects of medical liability reform, scope of practice, trauma systems and funding, injury prevention, cancer, bariatric surgery, and the implementation of the Affordable Care Act were among those closely monitored.

This article provides an overview of the most noteworthy bills that moved through the state legislative process in 2014, describes how surgeons had an impact on policymaking in their states, and offers suggestions on how to engage in legislative advocacy in 2015.

**Medical liability reform**
States continued to address various facets of medical liability reform in 2014, including such issues as whether statements of apology or compassion may be used as evidence in a liability lawsuit, caps on noneconomic damages, and other reforms.

**Wisconsin** Gov. Scott Walker (R), signed A.B. 120, legislation that allows physicians and other health care professionals to apologize to patients without worrying whether the statements could be used against them in court. The law is more comprehensive than many other state laws passed on this issue, protecting statements expressing fault, liability, and responsibility, along with those of benevolence, compassion, or condolence. **Alaska** Gov. Sean Parnell (R) signed H.B. 250, a bill that would make expressions of apology or compassion inadmissible as evidence in medical liability cases, in July. This legislation, however, would not protect an expression of apology or sympathy if made with an admission of liability or negligence. **Kansas** Gov. Sam Brownback (R) in April signed S.B. 311, which increases the cap on noneconomic damages in liability claims to $350,000 from $250,000 over the next eight years. This bill was sponsored by the Kansas Medical Society and supported by the Kansas Chapter of the ACS.

Legislation reinstating caps on noneconomic damages failed in the **Missouri** Senate before the session ended May 16. H.B. 1173 and S.B. 589 would have removed medical liability from the common law and created a statutory cause of action for medical liability cases. This provision would have granted the legislature the ability to cap noneconomic damages without violating the right to a jury trial. In 2012, the state’s Supreme Court based its decision to strike down Missouri’s caps on this common law/statutory law differ-
ence, in which common law causes of action violate the state constitution, but statutorily created laws do not.

The Kentucky Senate passed S.B. 119—legislation that would prevent meritless liability lawsuits filed against health care providers by instituting an independent review panel to evaluate liability claims. This panel would consist of three independent members charged with evaluating each claim. While the bill passed the full Senate, it died at the end of session in the House.

Legislation in New York, A. 1056, would have revised the statute of limitations for medical, dental, and podiatric liability actions. The two-and-one-half-year statute of limitations would begin on the date the patient discovers the injury. A second bill, S. 7130, also created a date-of-discovery statute of limitations but would prohibit a liability action from being filed more than 10 years after the date of the alleged act. Neither bill advanced beyond its chamber of introduction.

In California, Proposition 46, a ballot initiative that would have increased the state’s cap on noneconomic damages to $1.1 million from $250,000, as well as required physician drug testing and the use of the state’s prescription drug monitoring program, was defeated in the November election. More than 600 physician and health care groups, hospitals, political organizations, politicians, educational groups, business organizations, labor unions, and specialty medical societies signed on to oppose this effort. The College participated in the campaign by providing co-branded posters for California surgeons to hang in their offices, and the three California chapters worked on local media initiatives with op-eds and letters to the editor. All who worked to defeat this ballot initiative are to be congratulated for a job well done. For more information, contact Justin Rosen, State Affairs Associate, at jrosen@facs.org or 202-672-1528.

Scope of practice

The Connecticut legislature passed and Gov. Dan Malloy (D) signed S.B. 36, legislation that expands the scope of practice for advance practice registered nurses (APRN) and allows for independent practice after three years of collaboration with a physician. The Connecticut Chapter of the ACS and the Connecticut State Medical Society opposed this bill.

In Utah, legislation requiring all licensed health care professionals to disclose their names and types of license to a patient was signed into law by Gov. Gary Herbert (R) in March.

Legislators in New York considered two bills that would help ensure that patients are properly informed of their health care professional’s credentials; neither bill advanced. Truth-in-advertising bills were also introduced, but did not advance, in California, Georgia, Massachusetts, Nebraska, New Jersey, Pennsylvania, and Washington.

In Louisiana, Gov. Bobby Jindal (R) signed H.B. 1065, which expands optometric scope of practice to include procedures performed with scalpels and lasers as well as injections. More specifically, the new law allows optometrists to inject anesthesia into the eyelid for surgical procedures; perform scalpel eyelid operations on lesions, cysts, chalazia, and pterygia; use selective laser trabeculoplasty (SLT) and argon laser trabeculoplasty (ALT) for glaucoma; perform yttrium aluminum garnet (YAG) posterior capsulotomy; and insert needles for paracentesis procedures.

The College worked closely with the ACS Louisiana Chapter, as well as other specialty societies, to oppose this legislation. These efforts included sending a letter to Governor Jindal asking him to veto the legislation, as well as sending action alerts to Louisiana Fellows, who, as a result, sent close to 150 messages to the governor.

A bill in California, S.B. 492, which was originally meant to expand optometry’s scope of practice to include scalpel and laser surgery and injections, failed at the end of session. The bill, introduced by Sen. Edward Hernandez (D-24), an optometrist who chairs the Senate Health Committee, passed the Senate, but was amended significantly in the Assembly. As a result, the bill was pulled from consideration. The original version of the bill would have permitted optometrists to perform scalpel eyelid operations on lesions, cysts, and chalazia; perform SLT, ALT, and YAG procedures; and inject potent medications. Surgeons sent more than 130 messages opposing this bill to their representatives, helping to defeat it.

New Jersey enacted trauma legislation that calls for appointing the state’s first Trauma Medical Director and establishing a state trauma system advisory committee.
Trauma and injury prevention
Legislation was introduced in the Pennsylvania Senate that would allow health care professionals to register in advance of or during a declared disaster or emergency to provide volunteer services in the state, but, as of press time, it had not advanced. This legislation, also known as the Uniform Emergency Volunteer Health Practitioners Act (UEVHPA), would ensure that in future disasters, health care professionals can be quickly deployed to medical facilities and disaster relief organizations while following clear and well-understood rules that provide an effective framework for ensuring that disaster victims have access to timely, high-quality care.

The New York Chapter of the ACS sponsored S. 2171—a bill requiring agencies that conduct autopsies following traumatic death (such as medical examiners, coroners, and so on) to share their findings with referring hospitals in order to facilitate a quality improvement process. New York surgeons Daniel J. Bonville, DO, FACS; William Doscher, MD, FACS; and Mark Gestring, MD, FACS, were primary advocates for this bill and helped usher S. 2171 from the initial committee process to Gov. Andrew Cuomo’s (D) desk for his signature.

New Jersey enacted trauma legislation that calls for appointing the state’s first Trauma Medical Director and establishing a state trauma system advisory committee. This committee will comprise physicians, nurses, and other trauma, burn, and rehabilitation professionals. The ACS Committee on Trauma (COT) has recommended standards for the Trauma Medical Director position, which will include analyzing trauma care data, designing a formal system with specific standards for prehospital triage and care, and evaluating the system on an ongoing basis.

Legislation enacted in Idaho allows the state’s Department of Health and Welfare to develop and administer a time-sensitive emergency system (TSES). The TSES will provide protocols for treating and responding to time-sensitive emergencies, such as traumatic injury, heart attacks, and strokes—conditions that rank among the top five causes of death in Idaho.

The Michigan legislature addressed funding for the development of a statewide trauma system during its session. Since 2011, up to $3.5 million of any excess revenue from the Crime Victims Fund has been allocated to the development of Michigan’s trauma system. This money was scheduled to begin to diminish this year, with only 50 percent of the original amount allowed to be used for the trauma system moving forward, unless additional action was taken. Legislation was adopted late this year to continue this funding for another four years. However, because these funds have never materialized, funding was requested through the regular appropriations process as well, with $1.3 million allocated to trauma system development in the budget bill signed into law in June.

Indiana enacted legislation requiring football coaches to take concussion awareness training classes and mandating a 24-hour sit-out period for student athletes who may have sustained concussions or other head injuries. Every two years under this law, football coaches will be required to take and pass accredited courses on player safety, including concussion awareness, equipment fitting, heat emergency preparedness, and proper technique. This legislation would also provide civil immunity for football coaches in certain circumstances.

Virginia Gov. Terry McAuliffe (D) signed legislation requiring any non-school-sponsored athletic program using school grounds to establish policies and procedures regarding the identification and handling of suspected concussions in student athletes.

Legislation enacted in New Hampshire establishes a definition of head injury and requires school districts to distribute a concussion and head injury information sheet to student athletes. Illinois enacted legislation requiring an online certification program to be developed on concussion awareness and reduction of repetitive sub-concussive hits and concussions. This online certification will be mandatory for high school coaching personnel, including the head coach, assistant coaches, and athletic directors.

A new law in Rhode Island requires teachers and school nurses to complete a training course and an
annual refresher course on concussions and traumatic brain injuries.

In California, legislation was enacted that limits full-contact football practices and requires a student athlete who has suffered a concussion or head injury to complete a graduated return-to-play protocol of at least seven days.

Legislation to stiffen penalties for drivers who cause serious injury or death while talking or texting was enacted in Maryland. Under the revised statute, individuals who are found guilty of violating the law face possible imprisonment for up to one year, a fine of up to $5,000, or both. The law does not apply to emergency use of a handheld telephone, including calls to 911, a hospital, an ambulance provider, a fire department, a law enforcement agency, or a first-aid squad.

The Massachusetts legislature and Gov. Deval Patrick (D) approved a 2014–2015 budget that included funding for a state trauma registry and 1.5 staff positions. The Massachusetts Chapter of the ACS and members of the COT have advocated strongly for these funds.

**Bariatric surgery**

Louisiana Rep. James Armes (D) introduced H.B. 1049, which would require state employee group benefit plans to cover bariatric surgery for the treatment of morbid obesity. H.B. 1049 defined morbid obesity as a body mass index (BMI) of at least 40 or a BMI of at least 35 when accompanied by a comorbidity or another medical condition, such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes. Gastric bypass operations and other methods recognized by the National Institutes of Health would be covered as well. The bill stalled in the House, although hundreds of letters of support were sent through the state action center to lawmakers encouraging them to pass this legislation.

The ACS is also advocating for state health insurance exchanges to cover bariatric surgery as an essential health benefit. In September, the ACS sent letters to health officials encouraging the inclusion of bariatric surgery as an essential medical benefit in the following state health care exchanges: Arkansas, Colorado, Connecticut, the District of Columbia, Idaho, Kentucky, Minnesota, Nevada, Oregon, Utah, and Washington. Officials who received the letter in each state include the governor, director of the state exchange, insurance commissioner, chairs/executive directors of the Democratic and Republican parties, the Speaker of the House, and the President of the Senate.

**Cancer**

In Wisconsin, Governor Walker signed a bill requiring state-regulated health plans to provide the same coverage for chemotherapy, regardless of whether it is administered in pill form or intravenously. The bill also establishes a cap of $100 for a 30-day supply of oral chemotherapy medication. Other states enacting oral chemotherapy parity legislation in 2014 include Arizona, Georgia, Kentucky, Maine, Missouri, and Ohio, bringing the total number of states with these laws to 34.

This year, nearly a dozen state legislatures passed bills to regulate the use of tanning beds. Those states include Alabama, Delaware, Hawaii, Indiana, Louisiana, Minnesota, Missouri, Nebraska, Pennsylvania, and Washington. The bills range from Alabama’s first-time establishment of regulations on the use of tanning beds to Hawaii’s and Washington’s ban on children and adolescents under age 18 using tanning devices without a prescription from a physician.

Other states debated similar bills, including Iowa, Kansas, Massachusetts, Michigan, New Hampshire, and Virginia, but no action was taken during their legislative sessions.

**Miscellaneous issues**

The New York Chapter of the ACS endorsed legislation addressing the restrictions that some health insurance companies have been placing on patients’ out-of-network options, which ultimately limits their coverage. The legislation requires insurance companies to provide adequate coverage for out-of-network care and to disclose the percentage of likely costs that the policy

Using the Surgery State Legislative Action center, surgeons sent more than 1,000 messages to their state legislators asking them to take action on issues of importance to surgery and surgical patients.
will cover. Many surgeons contacted their state legislators through the action center to get this legislation passed and signed into law.

A bill in Idaho was enacted to allow expanded eligibility for J-1 visas to include general surgery by adding it to the definition of primary care. This legislation was brought forward with the goal of increasing the primary-care physician workforce in designated shortage areas of rural and frontier Idaho. In the statement of purpose, the bill sponsor noted that “the specialty of general surgery is commonly regarded now as a component of a constellation of specialties often referred to as ‘primary care medicine,’ along with family medicine, pediatrics, obstetrics, gynecology, internal medicine, and psychiatry.”

**Medicaid expansion**

The Affordable Care Act was enacted more than four years ago, but many states are still attempting to implement its many components. Medicaid expansion is one element of the law that requires state intervention. Originally mandatory for all states, Medicaid expansion is now optional due to the 2012 U.S. Supreme Court ruling. Under the ruling, states are allowed to choose whether to expand Medicaid to all individuals earning up to 138 percent of the federal poverty limit. At the start of 2014, 25 states and the District of Columbia had expanded their Medicaid programs. Of these, Arkansas, Iowa, and Michigan received Section 1115 waivers to test innovative approaches.

In 2014, two more states—New Hampshire and Pennsylvania—expanded Medicaid coverage using these 1115 waivers. As described in a previous Bulletin article, a 1115 waiver allows the Secretary of the U.S. Department of Health and Human Services (HHS) to waive state compliance with certain federal requirements. The New Hampshire legislature voted to institute a two-and-one-half-year pilot project under which private health insurers provide insurance to low-income adults in the state. The federal government is providing 100 percent of the funding for the project, which will have to be reauthorized when federal funding begins to decline in 2017. In Pennsylvania, the program begins January 1, 2015, and will require beneficiaries to pay premiums of up to 2 percent of their incomes and charge an $8 copayment when beneficiaries use the emergency department for nonemergency situations.

A few other states are still debating whether to expand their Medicaid programs. Indiana has applied for a 1115 waiver to expand its current Healthy Indiana Plan. Indiana’s application asks for the ability to require beneficiaries to contribute to a personal responsibility account, which is modeled after a health savings account. The application also contains a provision to create a job training and work referral program as a condition of eligibility. At press time, the Centers for Medicare & Medicaid Services was still reviewing the application.

In Virginia, Governor McAuliffe worked to expand Medicaid after he made it a central platform of his campaign. However, after a bitter battle with the legislature, which included the unexpected resignation of a state senator, the effort failed. Utah Governor Herbert has negotiated a deal with HHS to expand Medicaid, but so far the state legislature has opposed the effort if it involves federal funding. Wyoming is also discussing its options with the federal government, and the legislature will likely take another look during its session in 2015.

**Getting involved in state advocacy**

Fellows continued to play a critical role in advocating for their profession in state legislatures. Using the Surgery State Legislative Action center, surgeons sent more than 1,000 messages to their state legislators asking them to take action on issues of importance to surgery and surgical patients.

As noted earlier, surgeons in New York led the effort to require agencies that conduct autopsies following traumatic death to share their findings with referring hospitals to facilitate a quality improvement process. Likewise, a strong response in California to the ACS action alert requesting that surgeons express their opposition to S.B. 492 helped ensure the bill did not advance out of the House. These are just two
examples of how surgeons made a difference by getting involved in state advocacy.

Many more opportunities for surgeons to get involved will arise in 2015. One specific opportunity would be to assist in achieving passage of the UEVHPA in all 50 states. Efforts are under way to get the UEVHPA introduced and passed in Alabama, Florida, Georgia, Mississippi, North Carolina, and South Carolina during the 2015 session. Surgeons in these states are encouraged to get involved.

Other opportunities include responding to the action alerts the College sends, attending your state chapter’s lobby day, and joining the SurgeonsVoice State Councilor program as a State Advocacy Representative (StAR). Action alerts are sent to Fellows and posted to SurgeonsVoice, Facebook, and Twitter, so be sure to follow the ACS on these platforms to stay up-to-date on what is going on in legislatures around the country.

State chapters that are scheduled to host a lobby day in 2015 include Alabama, Brooklyn/Long Island, California (North, South, and San Diego), Connecticut, Florida, Georgia, Indiana, Kansas, Louisiana, Massachusetts, Michigan, North Carolina, Ohio, Tennessee, South Texas, and Virginia. Fellows in these states should consider participating in the event.

The College’s StAR program, now a decade old, is in the process of merging with the State Councilor program. State Councilors fill a key role for SurgeonsVoice, as they serve as the boots-on-the-ground grassroots advocacy network for the entire program. The goal of this merger is to better promote grassroots involvement at all levels. More information on this and other state legislative activities is available on the SurgeonsVoice website, www.surgeonsvoice.org.

For some surgeons, the prospect of engaging in advocacy can be intimidating. To help encourage surgeons’ involvement, the College has published Surgeons As Advocates: A Guide to Successful State Advocacy to educate both surgeons and state chapters on the nuts and bolts of state advocacy. The guide is available at www.facs.org/advocacy/state.

If you have any questions on these programs or would like to get involved in any of these efforts, contact Tara Leystra Ackerman, MPH, State Affairs Associate, at 202-672-1522 or tleystra@facs.org.

Acknowledgment

Justin Rosen, ACS State Affairs Associate, and Jon Sutton, ACS State Affairs Manager, contributed to this article.

REFERENCES

Hugh Agnew Gamble, MD, FACS: A legacy to the College

by Michael C. Trotter, MD, FACS

The Mississippi Delta is defined as the 7,200 square-mile region stretching from Memphis, TN, to Vicksburg, MS, and lying in the alluvial floodplain between the Mississippi and the Yazoo Rivers. It is a storied, legendary place with an enduring influence on art, music, literature, cuisine, and culture, largely due to its socioeconomic history. It is perhaps an unlikely place for surgical success and medical innovation. However, Hugh Agnew Gamble, MD, FACS, who lived and worked in the Delta, became a nationally known surgeon who crossed racial boundaries in the Jim Crow South to provide all patients with high-quality surgical care. Dr. Gamble embodied professionalism and left a significant legacy to the American College of Surgeons (ACS).

Dr. Gamble’s family history laid the groundwork for his career. His father, William Gaston Gamble, MD, was born in 1834 in Wilcox County, AL. William Gamble graduated from the University of Alabama, Tuscaloosa, in 1855 and entered the University of Louisiana Medical Department, now Tulane University Medical School,
New Orleans, graduating in 1860. During the Civil War, he served as an infantry private before he was confirmed as an assistant surgeon in the Confederate States Army in 1863. He served at hospitals in Auburn, AL; Catoosa County and Macon, GA; and Iuka, MS. Following the war, the senior Dr. Gamble practiced medicine in Saltillo, MS, before settling in Guntown in the northeast corner of the state in 1892, where he remained until his death in 1920. He married Iva Agnew in 1872 and they had seven children—two of whom, Hugh and Paul, became physicians.2,3

Education and early career

Hugh Agnew Gamble was born in 1876, near the end of the Reconstruction era, in Saltillo. He was educated locally in the public schools and then graduated from Mississippi Agricultural and Mechanical College, now Mississippi State University, Starkville, in 1898. He served in the First Mississippi Volunteer Infantry during the Spanish-American War. In 1899, he entered Vanderbilt University School of Medicine, Nashville, TN, completed the two-year course, and served a two-year internship at Natchez Charity Hospital, MS. Dr. Gamble then entered Tulane University School of Medicine and graduated in 1904.6 He did another two-year internship at Charity Hospital in New Orleans, where he trained under the renowned surgeon Rudolph Matas, MD, FACS, an ACS founder and Past-President. Dr. Matas is legendarily known as the “father of modern vascular surgery.”4 Interestingly, Dr. Matas' landmark pioneering operation in 1888, repair of a traumatic brachial artery aneurysm, was born from humanism. Dr. Matas opted for an untried procedure to avoid amputation for his patient, an African-American laborer, reasoning that he would need both arms to make a living and avoid becoming dependent on others. The operation was a success.4 This act of humanism would strongly influence Dr. Matas' disciples, Dr. Gamble among them.

In 1907, Dr. Gamble settled in Greenville, MS, a river-port town in the northwest part of the state, and would remain there for the rest of his life. In his early years of practice, he delivered babies and made house calls on horseback and, after a time, he cultivated a remarkable surgical career.5

By the standards of the day, he was exceptionally well trained. He was an original Fellow of the College and later served as an ACS Governor. He was among the founders group of the American Board of Surgery, signifying his dedication to the high standards of quality care, professionalism, and ethics.6 He was a member of the Southern Surgical Association, Southern Medical Association, American Association of Railway Surgeons, American Association for the Study of Goiter, and the Southeastern Surgical Congress.6 He served as President of the Mississippi State Medical Association in 1929. He published 41 clinical articles in medical and scientific journals between 1910 and 1953, all while living and practicing in Greenville. Among these were articles on what we today know as abdominal surgery, vascular surgery, thoracic surgery, orthopaedic surgery, neurosurgery, trauma surgery, surgical oncology, endocrine surgery, anesthesia, and hospital and nursing care. His gen-
eral surgical practice of the day could be described as “limited to skin and contents.”

In 1915, Dr. Gamble founded what would become a multispecialty clinic, the Gamble Brothers Clinic. Dr. Gamble provided surgical and gynecological care, and his brother Paul handled urologic cases. The specialties of eye/ear/nose and throat (EENT before it diverged into ophthalmology and otolaryngology), dermatology, radiology, internal medicine, pediatrics, obstetrics, and pathology had been added by 1930. The clinic also employed anesthetists, a technician, and a physician who served as an assistant.5,7,8

When two members left the clinic and set up a local practice in 1935, the clinic enforced its non-compete clause, but it was not upheld in the local county chancery court. The clinic appealed to the Mississippi Supreme Court and prevailed. The two physicians left town, and the case is still cited as case law in Mississippi.8 The practice’s primary hospital facility, located adjacent to the clinic, was the white-only King’s Daughters Hospital. The clinic medical staff served as the faculty for the hospital’s nursing school.

Dr. Gamble maintained a longstanding interest in abdominal wound infection following contaminated surgery. He was an early advocate of open treatment of these wounds and, between 1925 and 1943, published six articles on his progressive experience and methodology with remarkably successful results in the pre-antibiotic era.9,10 Dr. Gamble successfully repaired arterial aneurysms (traumatic and syphilitic) before the advent of heparin.11 The breadth and depth of his surgical expertise is demonstrated by his report on repair of tracheo-esophageal fistula.12

An important friendship

Dr. Gamble’s many friendships included one with William J. Mayo, MD, FACS, which was likely fostered through their common professional societies. Dr. Mayo took semi-annual working vacations on the Mississippi River aboard the family yacht, the 124-foot North Star. The yacht was built for the Mayo brothers in 1922 at a cost of $105,000 and could accommodate 26 people.13 In the fall, they often sailed southbound to the Gulf of Mexico with necessary stops along the way. The Greenville stop was convenient to restock supplies and provisions and visit with Dr. Gamble and his colleagues. After the Great Mississippi Flood of 1927, the fall trip was made between October and November, and Dr. Mayo reported on the condition of the lower Mississippi River. Dr. Mayo visited the surgical infirmary of Drs. Hugh and Paul Gamble and reported on the relief work being done there.14 In 1929, the Greenville stop included a tour of the King’s Daughters Hospital with Dr. Hugh Gamble. Dr. Mayo complimented the hospital and medical staff as complete, modern, and advanced, with a national reputation.15

Dr. Mayo and his fellow travelers spent Saturday, November 14, 1931, in Greenville, “doing the town in a leisurely way” before “the men called on Dr. Gamble and visited clinics and hospitals.”16 The visits were reciprocated at the Mayo Clinic when Dr. Hugh Gamble visited his family’s Wisconsin lake cabin.5 Their correspondence between 1934 and 1938 reflected their ongoing friendship, mutual respect, and collegiality. Dr. Gamble sent a letter of introduction for a friend who was the physician in charge of a hospital at Tunda Station in the former Belgian Congo, and Dr. Mayo, welcoming him for a visit.
Dr. Mayo noted his moratorium on the Mississippi River trips due to the economic impact of the Great Depression on those around him. Nonetheless, the pair remained in contact during this period. They exchanged article reprints with comments, and Dr. Mayo encouraged Dr. Gamble to write and speak more often. They exchanged Christmas greetings, and Dr. Mayo expressed his appreciation for Dr. Gamble’s gift of “perfect” Mississippi pecans.17

Innovation

It is clear that Dr. Gamble loved his profession, and he continually explored ways to improve upon outcomes and results. In the early 1930s, he designed and constructed a patient carriage to maintain the Trendelenburg position after spinal anesthesia to optimize the effect and safety of the anesthetic.18 He also designed and had built a recumbent stationary bicycle-type exerciser, termed a “bedcycle,” for the prevention of the often fatal postoperative pulmonary emboli, and he advocated for early (day of surgery) postoperative mobilization.5,19,20

In the 1930s and 1940s, Dr. Gamble made a series of 16mm films, both color and black-and-white, of various operations. There were 12 complete films and 48 short films. The making of these surgical films likely reflected the influence of his mentor Dr. Matas, who first recognized the educational value of the cinematograph and reported his experience with this new teaching methodology in 1912.21 In 2004, the films, camera, and projector were donated to the College by Dr. Gamble’s grandson, Hugh A. Gamble II, MD, FACS. In December 2012, the films were digitized at the University of Chicago, IL. Thanks to the efforts of the College, two of the films are now online and available for viewing, with more planned to be accessible in the future.22 These films are expected to add to the rich and growing legacy of the College and the body of information being archived by the College in conjunction with the newly formed ACS History Group headed by LaMar S. McGinnis, Jr., MD, FACS.

Dr. Gamble also had a lifelong interest in agriculture and farming.2 It has been said that many physicians were involved in farming at the time Dr. Gamble was professionally active simply to make a living, as medical practice would often not generate sufficient income. Whether farming income supplemented medicine or medical income supplemented farming would likely require examination of the business ledgers, but it is hardly surprising that Dr. Gamble was involved in one of the pivotal developments in agricultural history—the mechanical cotton picker. Starting in 1922, Dr. Gamble financed the development of a mechanical cotton picker with local Greenville mechanics H. N. Berry and his son Charles. The Berry-Gamble Mechanical Cotton Picker picked the first large shipment of mechanically picked cotton to be shipped out of the area. The machine proved as effective in Arizona as it had in the Mississippi Delta. This endeavor continued over the next 30 years and produced more than 30 patents. Dr. Gamble had invested approximately $200,000 before International Harvester and John Deere & Co. were able to mass-produce simpler machines, although he did not receive any income for his efforts. The machine is currently on display in the Mississippi Agricultural & Forestry Museum in Jackson.2,23
Hospital care

Dr. Gamble was deeply involved in the development of hospital care in the Delta. In his professional life, he witnessed the evolution from private sanitariums to segregated hospitals to hospitals built in accordance with the Hospital Survey and Construction Act of 1946, also called the Hill-Burton Act. This federal law provided government funding to hospitals provided certain criteria were met. These criteria included non-discrimination based on race but allowed separate but equal facilities. In 1953, the 200-bed Washington County General Hospital opened in Greenville with separate but equal facilities (100 beds + 100 beds).24 Dr. Gamble was instrumental in pursuing and accomplishing this via the Hill-Burton Act and was the first chief of staff of the hospital.6 The Delta Democrat Times, in a section devoted to welcoming the new hospital, proudly noted, “Qualified Negro doctors of the county, as well as white doctors will care for patients in the Negro wing of the hospital.”25 This was clearly intended to be a reference to quality of care, as African-American physicians did not provide care for white patients.

Dr. Gamble was instrumental in developing the Colored King’s Daughters Hospital in Greenville.26 As the only existing hospital in the city prior to 1953, King’s Daughters Hospital did not admit African-American patients. The Colored King’s Daughters Hospital was primarily a 65-bed charity surgical hospital that often exceeded its capacity.7 African-American physicians did not practice there, likely because of the charity care. The surgical care rendered appears to have been

REFERENCES

comprehensive and included such successful operations as pneumonectomy and repair of cardiac wounds. Dr. Gamble personally provided funding to the hospital and recruited the services of colleagues to provide care for these patients.\textsuperscript{7,26} He was able to conduct some degree of clinical research there, and all patients, rich or poor, received the same quality of care from him.

Dr. Gamble married Innes Starling in 1911 and had one son, Lyne Starling Gamble. Lyne Gamble finished medical school at Vanderbilt and embarked on an internship there, intending to carry on the family tradition of surgery. He had survived rheumatic fever as a child but sustained another episode as an intern. The elder Gamble and his friend Barney Brooks, MD, FACS, chairman of surgery at Vanderbilt University, Nashville, TN, conferred about the rigors of surgical training and its perceived impact on Lyne’s health. Subsequently, Lyne completed EENT training at Tulane and practiced ophthalmology in Greenville until his death in 1984 at age 72.\textsuperscript{27}

\textbf{“His full measure”}

Dr. Gamble served his community as well as his patients. He was a Greenville City Councilman for 13 years and was an elder of the First Presbyterian Church of Greenville. He died of renal cancer in 1954 at age 77.

Dr. Gamble was much more than a rural community surgeon. He was instrumental in providing high-quality surgical care in the Mississippi Delta despite the obstacles of racial segregation and socioeconomic status in the Jim Crow South. As a practicing general surgeon he achieved professional success and national prominence in an unlikely rural setting, and he embodied the ideals of the ACS. He was memorialized by Eugene R. Nobles, MD, with the statement: “As a laborer in the field of medicine he gave his full measure.”\textsuperscript{28}

\textbf{REFERENCES (CONTINUED)}


25. Medical staff of new hospital will be: All qualified doctors. \textit{Delta Democrat Times}. Greenville, MS. March 5, 1953.


28. Nobles ER. Memorial Address Before the American Cancer Society, Mississippi Division, Greenville, MS. February 1, 1955.
Surgeons and other health care professionals have been working to reduce and prevent health care-associated infections (HAIs), including surgical site infections (SSIs); however, individual efforts alone can only go so far. The hospitals where these surgeons and physicians work must address the problem with a strategic, system-wide program. An updated HAI compendium provides practical recommendations to assist hospitals in implementing and prioritizing their efforts regarding this issue with a multidisciplinary approach.

*A Compendium of Strategies to Prevent Healthcare-Associated Infections in Acute Care Hospitals* is a free guide from The Joint Commission and several other partners, including the Society for Healthcare Epidemiology of America (SHEA), which has been updated to accelerate the adoption of important evidence-based practices known to be effective at addressing HAIs and SSIs.

**The role of surgeons**

According to the updated compendium, a vital element of preventing HAIs is for surgeons and health care professionals to be accountable, as accountability provides the necessary translational link between science and implementation. Without clear accountability, scientifically determined implementation strategies will be used in an inconsistent or fragmented way, decreasing their effectiveness in preventing HAIs.*

Surgeons and health care professionals can improve their accountability for SSI prevention efforts by:

- Complying with appropriate antimicrobial prescribing practices before and after surgery
- Following protocols for hair removal, preoperative skin disinfection, and control of blood glucose levels in cardiac patients
- Using a checklist based on the World Health Organization’s specifications to ensure compliance with best practices to improve surgical patient safety
- Complying with hand hygiene practices, both individually and by observing and correcting the hand

---


Infections in Acute Care Hospitals
hygiene practices among other members of the operating room team

• Implementing postoperative surveillance by reviewing microbiology reports, patient medical records, surgeon and patient surveys, and by screening for readmissions or returns to the operating room

• Educating patients about SSIs and their role in the prevention of this type of infection through SHEA’s related patient guide, which can be found at http://www.shea-online.org/Assets/files/patient%20guides/NNL_SSI.pdf

Surgeons should also be provided with regular continuing education opportunities directed at minimizing SSIs. Routine auditing and confidential feedback on SSI rates and adherence to process measures should be provided to individual surgeons as well as to the surgical division, department chiefs, and hospital leadership.

**Recommended implementation strategies**

The updated compendium includes a new implementation section with examples of strategies that may be used to reduce and prevent SSIs. These strategies reference SSI resources from The Joint Commission, including the Joint Commission Center for Transforming Healthcare’s Surgical Site Infections project† and The Joint Commission’s Implementation Guide for NPSG.07.05.01 on Surgical Site Infections: The SSI Change Project.‡

The recommended implementation strategies may be applied in specific locations or patient populations, or they may be carried out hospital-wide, depending on the outcome data, risk assessment, and/or local requirements. The strategies are organized into four stages based on key concepts: engagement, education, execution, and evaluation, the details of which follow:

• **Engagement phase:** Clear and effective communication as to the reasons why SSI implementation strategies are important for patient care are disseminated

• **Education phase:** Education pertaining to practices to prevent SSIs is essential for senior leadership, physicians, nurses, patients, and their families

• **Execution phase:** Deployment of quality improvement methodology, information technologies, and recommendations on the use of preoperative/postoperative order sets

• **Evaluation phase:** The focus in this phase is on the use of measurement and evaluation tools to determine the effectiveness of implementation strategies in the prevention of SSIs. Performance improvement tools, observations of evidence-based practices, and longitudinal evaluations of SSI rates and compliance rates are completed

Together, surgeons can work with their hospitals to implement a HAI program that engages and educates surgeons, while also incorporating recommended strategies to best reduce and prevent SSIs.

To access the updated compendium, visit www.shea-online.org/PriorityTopics/CompendiumofStrategiestoPreventHAI.aspx. For more information on SSIs, visit The Joint Commission’s HAI portal at www.jointcommission.org/hai.aspx.


The last few National Trauma Data Bank® (NTDB®) columns have centered on potential traumatic injuries associated with alcohol consumption. One of the side effects of alcohol ingestion is the inhibition of antidiuretic hormone, a nine-amino acid peptide secreted from the posterior pituitary, which results in increased urine flow by reducing water reabsorption in the renal medullary and cortical collecting ducts. This increase in urine flow can begin within 20 minutes of consumption. An increase in urine volume will ultimately result in a distended bladder, which is more prone to rupture when subjected to compressive forces than one that is collapsed and empty.

**Causes of bladder injury**

Nearly 80 percent to 85 percent of bladder injuries are caused by blunt abdominal trauma. Blunt injuries to the bladder arise as a result of two distinct mechanisms. The first is a direct blow to the abdomen in a patient with a distended bladder. Normally, the bladder resides within the pelvis and is fairly well protected by the surrounding bony structure. As it becomes distended, the bladder rises into the abdomen, thereby reducing its pelvic protection. A direct blow increases intravesical pressures, resulting in rupture of the dome of the bladder (the weakest point) and intraperitoneal urine extravasation. Children anatomically have an intra-abdominal bladder; therefore, the majority of pediatric bladder injuries are intraperitoneal in nature.*

The second distinct mechanism of blunt bladder injury is a pelvic fracture, which accounts for more than 80 percent of bladder injuries. If the injury is an extraperitoneal bladder rupture, the association with pelvic fracture increases to more than 95 percent. A pelvic fracture may cause injury by sheer force or by direct laceration from bone fragments. Approximately 65 percent of pelvic fracture-associated bladder lacerations occur as a result of a contrecoup burst injury opposite to the pelvic fracture site, as opposed to a direct bone laceration.

**Bladder injuries in the U.S.**

To examine the occurrence of injuries that include blunt bladder rupture in the NTDB research dataset for 2013, admissions medical records were searched using the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnoses codes. Specifically searched were records containing a blunt mechanism of injury and a diagnosis code 867.0, injury to bladder and urethra, without mention of open wound into cavity.

A total of 3,003 records containing a blunt mechanism of injury and a diagnosis of injury to bladder and urethra were found, of which 2,257 records contained a discharge status, including 1,096 patients discharged to home, 578 to acute care/rehab, and 356 sent to skilled nursing facilities; 227 died. These patients were 70 percent male, on average 41.6 years of age, had an average hospital length of stay of 13.4 days, an intensive care unit length of stay of 8.9 days, an average injury severity score of 24.3, and were on the ventilator for an average of 8.4 days. The most common mechanism of injury was motor vehicle (59 percent) followed by fall (15 percent), pedestrian (12 percent), other transport (6.7 percent); struck by/against, pedal cyclist, and machinery make up the final 7 percent. (See Figures 1 and 2 on page 52.)

With the holidays upon us, there will be the usual holiday

parties. This may lead to a toast or two. Before getting into that taxi or vehicle with your designated driver, stop by the restroom, keep your bladder within the pelvis, and make sure you go before you go.

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

Acknowledgment
Statistical support for this article has been provided by Chrystal Caden-Price, Data Analyst, and Alice Rollins, NTDB Coordinator.
J. David Richardson, MD, FACS, professor of surgery and vice-chairman, department of surgery, University of Louisville School of Medicine, KY, was elected President-Elect of the American College of Surgeons (ACS) at the Annual Business Meeting of the Members, October 29, in San Francisco, CA. The First and Second Vice-Presidents-Elect also were elected at the meeting.

**Multifaceted surgeon and educator**

An eminent general, thoracic, and trauma surgeon and surgical educator, Dr. Richardson is a 1970 graduate of the University of Kentucky School of Medicine, Lexington. He completed a surgery internship and worked as a junior assistant resident at the University of Kentucky before moving to the School of Medicine at the University of Texas Health Science Center at San Antonio to complete a general surgery and a thoracic surgery residency.

After completing his surgical training in 1976, he returned to Kentucky to teach and practice at the University of Louisville School of Medicine. He rose through the academic ranks at the institution, starting as an assistant professor of surgery and becoming associate professor of surgery in 1979. He has served in his current positions as professor of surgery and vice-chair of the department of surgery since 1983 and 1985, respectively. He has served as chief of surgery service and director of emergency surgical services at the University of Louisville Hospital since 2005.

Dr. Richardson became an ACS Fellow in 1980. Since then, he has served the ACS in various leadership capacities, most recently as Chair of the Board of Regents (2011–2012). In that role, he also chaired the Regents’ Finance and Executive Committees.

Dr. Richardson was a member of the ACS Board of Regents from 2003 to 2010, when he became Vice-Chair. He also has played a leadership role on several other ACS committees. He was the ACS Governor from Kentucky (1989–1995) and served on the Governors Committee on Surgical Infections (1992–1995). He was Chair of the Research and Optimal Patient Care Committee (2004–2011) and Vice-Chair of the Health Policy and Advocacy Group (2010–2011). He has been an active member of the ACS Committee on Trauma (COT), having served as Chair of the Emergency Services-Prehospital Subcommittee (1992–1999) and as a member of the COT’s Executive Committee (1992), Membership Committee (1993), and Verification/Consultation Committee (1993).

In addition, Dr. Richardson has served on the ACS Advisory Council for General Surgery (1997–2002), the Advisory Council for Vascular Surgery as a Regent (2003–2006), and the Advisory Council for Rural Surgery as an Ex Officio member (2011–2012). He also was a member of the ACS Committee on Video-Based Education (1991–1997).

Currently, Dr. Richardson is Chair of the ACS Transition to Practice Program in General Surgery Steering Committee.

At the state level, he has served as Chair (1985–1987) and Vice-Chair (1981–1985) of the Kentucky COT, and he has been Secretary-Treasurer (1983–1986) and President (1987) of the Kentucky Chapter of the ACS. He served on the Kentucky Committee on Applicants (1997–2002) as well.

In addition to his leadership roles within the ACS, Dr. Richardson has served at the highest levels in the following organizations: former director (1987) and chairman (1998–1999), American Board of Surgery; director (1994), American Board of Emergency Medicine; president (1999), American Association for Surgery of Trauma; president (1999), Southeastern Surgical Congress; president (2003), Southern Surgical Association;

A prolific author, Dr. Richardson has published more than 345 articles in peer-reviewed publications, 50 book chapters, and has 10 publications in press. He currently is the editor of The American Surgeon, serves on the Editorial Board of the Journal of the American College of Surgeons, is an editorial consultant for The Journal of Trauma Injury, Infection & Critical Care, and is on the editorial board of the International Scholarly Research Network.

Vice-Presidents-Elect
The Vice-Presidents-Elect also were elected at the Annual Business Meeting. The First Vice-President-Elect is Ronald V. Maier, MD, FACS, Jane and Donald D. Trunkey Endowed Chair in Trauma Surgery, and professor and vice-chairman of surgery, University of Washington (UW) Medicine, Seattle. Dr. Maier also is surgeon-in-chief at Harborview Medical Center and director of the Northwest Regional Trauma Center.

A Fellow of the College since 1984, Dr. Maier has played an active role on several key ACS committees, particularly the COT. He chaired the COT’s Ad Hoc Committee on Prevention (1992–2002) after serving as a member of the subcommittee for three years (1989–1992). He also served on the COT Performance Improvement Committee (1994–2004), Trauma System Committee (1994–2004), Committee on Emerging Surgical Technology and Education member (2001) and senior member (2001–2003), Regional Committee Organization (1990–2000), and Publications Committee (1988–2004).

He was State Chair for the COT (1987–1990) and Chair of Region 10 for the COT (1990–1996). He has been an active member of the Program Committee, serving as Consultant (2007–present), Vice-Chair (2004–2005), and member (2004–2007). He served on the Committee for the Forum on Fundamental Surgical Problems (1991–1994) as well. Dr. Maier has held numerous leadership positions in other surgical organizations, exemplified by having served as president of the Society of University Surgeons, Surgical Infection Society, Shock Society, American Association for the Surgery of Trauma, and the Halsted Society, in addition to being Chair of the Board of Directors of the American Board of Surgery.

Dr. Maier’s research interests include cell biology of inflammation, dysregulation of the immune response after severe injury, wound healing, gene expression response to injury, modulation of inflammatory mediators, acute respiratory distress syndrome, biomaterials for healing, injury prevention, trauma care outcomes, and trauma systems analyses. Dr. Maier’s research efforts have been recognized through prestigious awards from the Shock Society, the American Heart Association, and the American Surgical Society. He received the ACS Sheen Award for Contributions to Medicine and Medical Research in 2013.

The Second Vice-President-Elect is Walter J. Pories, MD, FACS, founding chair, department of
Dr. Pories’ major clinical interests have been in pediatric and bariatric surgery.

surgery; professor of surgery, biochemistry, and kinesiology; and director, bariatric surgery research group, East Carolina University, Greenville, NC.

A Fellow of the College since 1964, Dr. Pories is a former ACS Governor (1986–1992) and was on the Governors’ Committee on Surgical Practice (1989–1993). He has played an active role on the International Relations Committee as Vice-Chair (1984–1986) and as a member/senior member (1980–1990). He served as Secretary of the Ohio Chapter of the ACS (1974–1977) while on the faculty at Case Western Reserve, Cleveland, and as President of the North Carolina Chapter (1985–1986).

Dr. Pories’ major clinical interests have been in pediatric and bariatric surgery. His research interests include the discovery that zinc is an essential element and required for wound healing, the development of animal feeds, and the addition of trace elements to parenteral and alimentary formulations. He was the first surgeon to describe wound suction and the cisterna chyli/vena cava anastomosis. He also was the first surgeon to describe the full and sustained remission of type 2 diabetes following gastric bypass surgery.

He has served as the president of several surgical societies and as editor or associate editor of a number of journals. He is the recipient of numerous honors, including the Goldwater Award in Nutrition, the McGovern Award, and the Max O. Joyner Award.

Submit 2015 ACS Surgical Volunteerism and Humanitarian Award nominations, January 1–February 28

The American College of Surgeons (ACS), in association with Pfizer, Inc., will accept nominations for the 2015 Surgical Volunteerism and Humanitarian Awards from January 1 to February 28. These awards, which celebrate humanitarian outreach, hold high esteem among ACS members. The stories shared by these surgical volunteers and humanitarians have inspired generations of practitioners. Qualified nominees may apply for the following awards:

- In recognition of the contributions of an ACS Fellow’s exemplary surgical volunteer work domestically
- In recognition of the contributions of an ACS Fellow’s exemplary surgical volunteer work internationally
- Exemplary volunteerism in the setting of military service
- For a resident member of the ACS who has made exemplary contributions in the course of surgical training
- For a Fellow whose surgical career has been characterized by humanitarian service

More details on how to access the application site and the nomination process will be published in the January issue of the Bulletin, in the ACS weekly e-newsletter, NewsScope, and on the ACS website, www.facs.org. Direct questions to Connie Bura at cbura@facs.org.
The Board of Governors of the American College of Surgeons (ACS) has reelected six members of the Board of Regents to additional three-year terms. The reelected Regents are as follows:

- **James K. Elsey, MD, FACS**, a general and vascular surgeon and visiting professor of surgery, Emory University School of Medicine, Atlanta, GA

- **Gerald M. Fried, MD, FACS, FRCSC, FCAHS**, Edward W. Archibald Professor and chairman, department of surgery, McGill University, and surgeon-in-chief, McGill University Health Centre Hospitals, Montreal, QC

- **B.J. Hancock, MD, FACS, FRCSC**, associate professor, departments of surgery and pediatrics and child health, University of Manitoba, and pediatric surgeon and pediatric intensivist, Children’s Hospital of Winnipeg, MB

- **Lenworth M. Jacobs, Jr., MD, MPH, FACS**, professor of surgery and chairman, department of traumatology and emergency medicine, University of Connecticut, and director, trauma institute, Hartford Hospital, CT

- **Mark A. Malangoni, MD, FACS**, associate executive director, American Board of Surgery, and adjunct professor of surgery, University of Pennsylvania Perelman School of Medicine, Philadelphia

- **Valerie W. Rusch, MD, FACS**, vice-chair for clinical research, department of surgery, and Miner Family Chair in Intrathoracic Cancers, Memorial Sloan Kettering Cancer Center, and professor of surgery, Cornell University Medical College, New York, NY

In addition, the Board of Governors elected **Fabrizio Michelassi, MD, FACS**, the Lewis Atterbury Stimson Professor of Surgery and chairman of surgery, Weill Cornell Medical College, and surgeon-in-chief, New York-Presbyterian/Weill Cornell Medical Center, to serve as Chair of its Executive Committee; **Karen J. Brasel, MD, FACS**, professor of surgery and general surgery program director, Oregon Health & Science University, Portland, to serve as Vice-Chair; and **James C. Denny III, MD, FACS**, executive vice-president and chief executive officer, American Academy of Otolaryngology–Head and Neck Surgery (AAO-HNS), and AAO-HNS Foundation, Alexandria, VA, to serve as Secretary.

Newly elected to the Executive Committee of the Board of Governors are **Kevin Behrns, MD, FACS**, the Edward R. Woodward Professor and chair, department of surgery, University of Florida, Gainesville; **Diana Farmer, MD, FACS**, chair and Pearl Stamps Stewart Professor, department of surgery, University of California, Davis, Children’s Hospital; and **Steven C. Stain, MD, FACS**, the Henry and Sally Schaffer Chair and professor, department of surgery, Albany Medical Center, NY.
ACS presents Lifetime Achievement Award posthumously to Dr. Russell

by Carlos A. Pellegrini, MD, FACS, FRCSI(Hon)

Editor’s note: Carlos A. Pellegrini, MD, FACS, FRCSI, Immediate Past-President of the American College of Surgeons (ACS), presented the ACS Lifetime Achievement Award to Thomas R. Russell, MD, FACS, former Executive Director of the College, during the Convocation, October 26, at Clinical Congress 2014 in San Francisco, CA. The award was presented posthumously, and Dr. Russell’s wife Nona and his daughters, Jackie and Katie, accepted it on his behalf. Following is the text of Dr. Pellegrini’s remarks. They have been edited to conform to Bulletin style.

It is my great honor to present the Lifetime Achievement Award of the American College of Surgeons. This award is presented to an extraordinary individual for a lifetime of contributions to the art of medicine and surgery, and service to the ACS. Not surprisingly, this is only the third time that our College has conferred this award in its 100-year history. In choosing Dr. Thomas Russell, the College is not only recognizing his contributions and service to the organization’s mission, but also is recognizing a dedicated leader, a compassionate humanitarian, and a man who touched many lives in ways that left us all better people for having known him.

A committed physician
Dr. Russell spent his youth in California, and had the unique experience as a teenager of working as a wrangler at a dude ranch, a job that would have a profound influence in his life. After earning his bachelor of arts degree at the University of California, Berkeley, and his medical degree from Creighton University Medical School, Omaha, NE, Tom returned to the Bay Area for his surgical residency training at the University of California, San Francisco. His training was interrupted by service in the Vietnam War from 1968 to 1970, during which he served as a Lieutenant Commander and flight surgeon in the U.S. Navy. In 1975, he joined a practice in San Francisco and began what would become 25 years as a practicing general and colon and rectal surgeon.
Tom became a Fellow of the ACS in 1979. He was Secretary and later President of the Northern California Chapter of the College. He was elected to the Board of Governors in 1990 and served in that role until 1993, when he was elected to the Board of Regents. His roles in the ACS as a Regent are too numerous to name, but included chairing the Nominating Committee and serving on the Member Services Liaison Committee and the Advisory Council for Colon and Rectal Surgery.

Insightful leadership

In 1999, the Board of Regents, facing unprecedented challenges, asked Tom to take the difficult job of Executive Director of the College. Our College was in need of thoughtful and compassionate leadership, and Tom was the right person for the job. He had a reputation as a bright, kind, high-energy individual who was willing to weigh all sides of an issue.

Soon after assuming the position of Executive Director, he initiated a strategic planning process, which revealed his innovative and insightful leadership. The College structure was reorganized. Education programs were expanded to offer new and innovative courses. He directed the establishment of the ACS Foundation in 2005 to better support the ACS’ scholarship programs.

A mission statement was developed to guide the work of staff and volunteers alike: “The American College of Surgeons is dedicated to improving the care of the surgical patient and to safeguarding standards of care in an optimal and ethical practice environment.” These articulately presented ideals continue to guide us.

Dr. Russell encouraged the College to take a proactive stance in the politically charged atmosphere of the early 2000s to protect patients’ access to quality care. Under his leadership, our presence in Washington, DC, grew, and a new building was erected near Capitol Hill to house our Division of Advocacy and Health Policy.

One of Dr. Russell’s most significant accomplishments as ACS Executive Director was bringing the Veterans Affairs National Surgical Quality Improvement Program into the private sector under the College’s aegis as ACS NSQIP®, which launched in 2004. Nearly 600 hospitals have since become participants in ACS NSQIP and have used the program’s risk-adjusted, evidence-based outcomes data to significantly reduce complications, limit errors, and save countless lives and millions of dollars.

Kind, fair, and honorable

I count it among one of the great blessings of my life that I am able to call Tom a friend. He was insightful, generous, personable, compassionate, and above all, kind, fair, and honorable. His spirit lives on in the lives of his partner and wife, Nona, and his daughters, Katie and Jackie, the three “stars” of his life. His gentle humor and enduring optimism always brought out the best in people. His imprint will permanently remain on the College and the countless lives he touched while living every day by his motto, “Take the stairs, be nice to the janitor, and the patient comes first.”
A panel of regional health care experts met October 3 at the Utah State Capitol, Salt Lake City, at the American College of Surgeons (ACS) Surgical Health Care Quality Forum Mountain Region. The panelists discussed best practices for improving patient care and highlighted quality programs that improve patient outcomes and reduce costs.

Amalia Cochran, MD, FACS, FCCM, associate professor of surgery, University of Utah School of Medicine, Salt Lake City, and President of the ACS Utah Chapter, hosted the event. Brent C. James, MD, MStat, chief quality officer and executive director, Institute for Health Care Delivery Research, Intermountain Healthcare, delivered the keynote address. Panelists included:

- Timothy B. Anderson, JD, Jones Waldo, Holbrook & McDonough PC Health Care Law Practice Group; member, University of Utah Hospitals and Clinics Board of Trustees, Salt Lake City
- Samuel R. G. Finlayson, MD, MPH, FACS, professor and Claudius Y. Gates, MD, and Catherine B. Gates Presidential Endowed Chair, department of surgery, University of Utah School of Medicine, Salt Lake City
- Sara Hartsaw, MD, FACS, general surgeon and owner, High Plains Surgical Associates, PC, Gillette, WY; chair, Board of Trustees, Campbell County Memorial Hospital; lieutenant commander, U.S. Naval Reserve
- David B. Hoyt, MD, FACS, Executive Director, ACS
- Vivian S. Lee, MD, PhD, MBA, senior vice-president, health sciences, University of Utah; dean, University of Utah School of Medicine; chief executive officer (CEO), University of Utah Health Care
- E. Marc Mariani, MD, orthopaedic surgeon—adult reconstruction, St. Mark’s Hospital, MountainStar Healthcare, Salt Lake City
- Mark J. Ott, MD, FACS, medical director, surgical services, Intermountain Healthcare, Murray, UT; adjunct associate professor of surgery, University of Utah School of Medicine
- Charles Sorenson, MD, FACS, president and CEO, Intermountain Healthcare, Salt Lake City

The full forum video archive and event photos are posted on the ACS website at https://www.facs.org/quality-programs/about/inspiring-quality/tour/mountain. For more information, e-mail InspiringQualityTour@facs.org.
The American College of Surgeons (ACS) is loaning one of its treasures to a major exhibition at the Art Institute of Chicago, IL—Ireland: Crossroads of Art and Design, 1690–1840. The College’s ancient Irish deer antlers from Ballybetagh will be on display at the exhibit, which will open on St. Patrick’s Day 2015, and run through June 7. According to ACS Archivist Adam Carey, the massive skull and antlers of an extinct Irish elk displayed in the reception area of the College’s Chicago headquarters office was a diplomatic gift to the College from the Royal College of Surgeons in 1921.

Mr. Carey gives credit for the Art Institute’s pursuit of the antlers to Dan D. Steinke, ACS Office Services Manager, who oversaw the construction of the current display case, with staff from the Field Museum of Natural History, Chicago, providing assistance on proper mounting. “It was that connection that prompted the Art Institute to contact us for the loan,” Mr. Carey said.

The antlers are steeped in history. The College received the antlers at the height of Ireland’s “Troubles” in the 1920s. The Troubles refer to the decades of violence between elements of Northern Ireland’s Irish nationalist community, who are mostly Catholics, and its unionist community, mainly self-identified as British and/or Protestant. Ancient elk or deer antlers served as prominent symbols in Irish country homes. Preserved in Ireland’s bogs for thousands of years, antlers displayed in an entrance hall signified a family’s roots and claims to Irish land.

In a letter to the College, Douglas Druick, president and Eloise W. Martin Director of the Art Institute, expressed gratitude to the ACS for loaning this vital artifact to the exhibit. Mr. Druick explained that the agricultural depression in the British Isles in the 1880s resulted in the delivery of many extraordinary objects from Ireland to the U.S. and Canada. These relics are now scattered from Honolulu, HI, to Portland, ME, San Antonio, TX, and Ottawa, Canada. “Through this exhibition and the accompanying catalogue published by the Art Institute of Chicago in association with Yale University Press, these often little-known objects will be shown together for the first time,” Mr. Druick explained. Chicago will be the only venue for the exhibit.

The exhibition will present 300 objects drawn from public and private collections across North America. Arranged thematically throughout six galleries, the exhibit’s paintings, sculpture, and architecture, as well as book bindings, ceramics, glass, furniture, metalwork, and textiles, will celebrate the Irish as artists, collectors, and patrons.
Italy Chapter holds 28th annual meeting in Rome

The Italy Chapter of the American College of Surgeons (ACS) held its 28th annual meeting, October 12–15, at the Palazzo dei Congressi in Rome. The meeting was held in conjunction with the 116th Congress of the Italian Society of Surgery and other associated surgical societies. The educational program comprised a series of lectures, symposia, and scientific sessions dedicated to surgery of the esophagus and pancreas, patient safety, the prevention and treatment of complications in minimally invasive surgery, new approaches to the treatment of cancer of the lower rectum, and the educational standard for training in trauma care. Carlos A. Pellegrini, MD, FACS, FRCSI(Hon), then-President of the ACS, gave two presentations at the Congress, one on the use of anti-reflux surgery to treat gastroesophageal reflux disease, and the other on the surgeon as a leader in quality of care.

Dr. Pellegrini chaired most of the educational sessions at the meeting and presented the Young Surgeons Best Presentation Award to Gennaro Nappo, MD, Campus Bio-Medico University, Rome, for “Laparoscopic Versus Open Surgery in the Left Side Pancreatic Adenocarcinoma: a Retrospective Analysis in a High-Volume Center of Pancreatic
Surgery.” Dr. Pellegrini also recognized Ali Zarrinpar, MD, PhD, a transplant surgeon at the University of California, Los Angeles, who was selected to participate in the Resident and Associate Society of the ACS’ International Exchange Program this year. This program has been in place in Italy since 2012, and to date, three Italian residents and two resident surgeons from the U.S. have had the chance to visit institutions in each other’s countries.

Another session at the 116th Congress meeting focused on the proliferation of the Advanced Trauma Life Support (ATLS®) program in Italy. On October 29, a celebration in Turin marked the 20th anniversary of the ATLS course in Italy, which included a reunion meeting and a gala dinner. Planning is now under way for the next ACS Italy Chapter meeting, scheduled to be held October 21–24, 2015, in Milan, which will take place in conjunction with the 117th Congress of the Italian Society of Surgery.

Illinois Chapter and Illinois Surgical Society hold combined annual meeting

The Illinois Chapter of the American College of Surgeons held its annual meeting in conjunction with the Illinois Surgical Society, September 18–21, at the Carle Hospital conference center, University of Illinois, Champaign-Urbana. Gavish N. Patel, MD, FACS, President, Illinois Chapter, and Norman C. Estes, MD, FACS, president of the Illinois Surgical Society, made opening remarks and program introductions. Program Committee Director for the Illinois Chapter, Sherfield Dawson, MD, FACS, and Chapter Executive Director, Luann White, arranged for a diverse array of educational presentations and social events at the multi-day event, which more than 70 healthcare professionals attended.

Educational sessions at the meeting included a Founder’s Resident Paper Competition and an update on College activities offered by John Preskitt, MD, FACS, ACS First Vice-President. Social events at the meeting included a Welcome Reception on Thursday evening at the Atrium Mills Breast Cancer Center, which included a tour of the Carle Hospital Heart and Vascular Institute; a Friday night cocktail and dinner party at the University of Illinois Alice Campbell Alumni Center; and a Saturday evening gala. The featured speaker at the gala was John Hedstrom, JD, Deputy Director, ACS Division of Advocacy and Health Policy, Washington, DC, who addressed the Changing Health Care Payment and Delivery System—A Proactive Approach. Donna Tieberg, Chapter Services Manager, also attended the meeting.

Massachusetts Chapter honors state legislators for State Trauma Registry advocacy

On September 30, the Massachusetts Chapter of the ACS honored two state legislators at the Massachusetts General Hospital, Boston, for their advocacy efforts and leadership in helping to secure funding.
Right: State legislators honored at Massachusetts Chapter meeting. From left to right, Robert DeLeo, Massachusetts Speaker of the House; Peter Masiakos, MD, FACS, Chair of the Massachusetts Chapter’s Legislative Advocacy Committee; Senator Moore; Representative Manuel deMacedo; Terry Buchmiller, MD, FACS, Massachusetts Chapter President; and Peter L. Slavin, MD, president, Massachusetts General Hospital, Boston.

Left: Katie Russell, MD, PGY-6 surgery resident, University of Utah, winner of the College’s 2014 Chassin Award for Professionalism; Earl (Joe) Downey, MD, FACS, pediatric surgeon, Intermountain Healthcare; Jim Fowler, MD, FACS, plastic surgeon, private practice in SLC, UT; and Tawnya Bowles, MD, FACS, surgical oncologist, Intermountain Healthcare and the University of Utah.

to allow for 1.5 full-time staff positions for the Massachusetts State Trauma Registry program.

Senate President pro tempore Richard T. Moore (D) and Rep. Viriato Manuel deMacedo (R), were tireless advocates for incorporating trauma registry funding into the 2014–2015 state budget. The Massachusetts Chapter and members of the ACS Committee on Trauma have been strong advocates for trauma funding and in the past have allocated time during their 2013 Legislative Advocacy Day to appeal to legislators for appropriation for trauma programs. For more information regarding the Massachusetts Trauma Registry or advocacy in general, contact ACS State Affairs staff at state_affairs@facs.org.

Utah Chapter holds annual meeting and Surgical Health Care Quality Forum Mountain Region

The Utah Chapter of the ACS hosted its annual meeting October 3 at the Little America Hotel, Salt Lake City. The guest speaker for the meeting was Sara Hartsaw, MD, FACS, a general surgeon and member of the ACS Health Care Advisory Council, who presented on the topic of advocacy for surgeons and the use of the SurgeonsVoice program. The early afternoon portion of the meeting covered a variety of topics under the general theme of What’s New for You? Mark Savarise, MD, FACS, Utah Chapter Secretary, provided an update on billing and coding; Ray Price, MD, FACS, ACS Governor, Utah, discussed sustainable global surgery efforts (a topic that refers to the inequity of access to surgical care around the world); and Nate Gladwell, RN, MHA, director of telemedicine, University of Utah Health Care, educated the audience on the use of telemedicine in surgical care.

Spencer Galt, MD, FACS, and Ric Rasmussen, MD, FACS, closed the afternoon session of the meeting with a discussion on the use of advanced practice clinicians in surgical practices. The final event of the day was the annual Michael Collins Resident and Student Poster Competition. The first-place poster winner was Meg Bowen, MD, postgraduate year (PGY) 4 surgery resident; second place went to Patrick Loftus, a third-year medical student; and third place went to Aaron Healey, MD, PGY-5 surgery resident. All three poster winners hail from the University of Utah. The chapter meeting followed the Surgical Health Care Quality Forum Mountain Region.

Fellows in Guam form new chapter

At its October meeting in San Francisco, CA, the ACS Board of Regents unanimously approved the establishment of the Guam Chapter, making it the 106th chapter of the College. With the addition of Guam, the College now has 67 domestic chapters, with two other proposed chapters currently in the formative stage. The newly elected officers of the Guam Chapter are as follows: Jerone T. Landstrom, MD, FACS, President; Michael W. Cruz, MD, FACS, Vice-President; Sunggeun Samuel Im, MD, FACS,
Dr. McKellar (far left), with participants at the Hawaii Chapter of the ACS Resident Research Competition. From left: Joy Sarkar, MD, PGY-4 surgical resident, Tripler Army Medical Center, winner of first place; Megan Kuba, MD, PGY-3 orthopaedic surgery resident, University of Hawaii, sixth place; John Dupaix, MD, PGY-2 orthopaedic surgery resident, University of Hawaii, fifth place; Christopher Loo, MD, PhD, PGY-2 surgical resident, University of Hawaii, first place; and Paul Wetstein, MD, PGY-3 surgery resident, Tripler Army Medical Center Program, third place.

Layton F. Rikkers, MD, FACS, special guest speaker at New Mexico annual meeting

ACS New Mexico Chapter members and board members with Layton F. Rikkers, MD, FACS (third from right, back row), professor emeritus, University of Wisconsin-Madison; Past ACS Vice-President; and guest speaker at the New Mexico Chapter annual meeting held on September 12–13.

Participants at the New Mexico annual meeting included board members (from left, sitting) Glenroy Heywood, MD, FACS, Chapter CoC Liaison; Melania Yeats, MD, FACS, Chapter Vice-President; Katherine T. Morris, MD, FACS, New Mexico Chapter Councilor; and James Goff, Jr., MD, FACS, Chapter President-Elect.

From left, standing: Anthony Vigil, MD, FACS, ACS Governor; Charles Guimaraes, MD, FACS, Rehoboth McKinley Christian Care Services; Albert Kwan, MD, FACS, Chapter Secretary/Treasurer; Dr. Rikkers; John Russell, MD, FACS, chair and professor of surgery, department of surgery, University of New Mexico School of Medicine; and Murugan Athigaman, MD, FACS, Chapter President.

Secretary/Treasurer; Noel L. Concepcion, MD, FACS, Councilor; and Ricardo Eusebio, MD, FACS, ACS Governor.

Hawaii Chapter meeting includes updates on cancer initiatives

The ACS Hawaii Chapter held its 2014 annual meeting at the state-of-the-art Queen’s Conference Center on the campus of the Queen’s Medical Center, Honolulu, August 23. Keynote speakers were ACS Commission on Cancer (CoC) Chair Daniel P. McKellar, MD, FACS, who presented an overview of the CoC programs and initiatives aimed at improving the quality of cancer care. Other keynote speakers included Charles J. Rosser, MD, PhD, FACS, program director, clinical and translational research program, University of Hawaii Cancer Center (a National Cancer Institute-designated cancer center); and Eric Z. Matayoshi, MD, FACS, Hawaii Chapter Governor. Dr. Rosser presented an update on clinical and translational research at the University of Hawaii Cancer Center, and Dr. Matayoshi provided an update on the development of accountable care organizations. Michael Hayashi, MD, FACS, and Richard Smith, MD, FACS, provided State Trauma Committee and State CoC briefings, respectively. Danny M. Takanishi, Jr., MD, FACS, Hawaii Chapter President, presided over the Resident Research Competition and chapter business meeting. ♦
Editor’s note: Media around the world, including social media, frequently report on American College of Surgeons (ACS) activities. Following are brief excerpts from news stories published from July through September 2014 that mention key ACS programs and initiatives, including research findings that appear in the Journal of the American College of Surgeons. To access the news items in their entirety, visit the online ACS Newsroom at https://www.facs.org/media/acs-in-the-news.

Connecticut cops expand training to stop bleeding
SFGate, September 1, 2014
“The new wave of police training was spurred by recommendations made in Hartford by a group of law enforcement, medical, and military experts including [Alexander Eastman, MD, FACS] who were brought together by the American College of Surgeons. The idea was to find ways to increase the number of survivors in mass shootings.”

Programs aim to standardize surgical care for children
Wall Street Journal, September 1, 2014
“Studies show there are fewer complications, better survival, and shorter hospital stays when newborns and children undergo surgery in hospitals with expert resources for pediatric patients. Because of their anatomy and growth stage, children have unique needs, including specialized pediatric anesthesiologists, radiologists, and emergency physicians. Yet close to half of pediatric surgeries take place in adult-focused general hospitals, which often lack dedicated pediatric staff and resources. That means children often don’t receive optimal care and could face more postoperative risks, according to David Hoyt [MD, FACS], executive director of the American College of Surgeons.”

Gloucester sculptor crafts tribute to surgeon
Gloucester Times, August 14, 2014
“The late Dr. Ernest Codman, an icon in American surgery, finally received a headstone at Mt. Auburn Cemetery in Cambridge, nearly 74 years after his death. The artist who created the relief sculpture on the memorial headstone was Gloucester’s Daniel Altshuler. Altshuler attended the recent unveiling at a dedication ceremony attended by leaders from the American College of Surgeons and other medical organizations at the cemetery, which is a National Historic Landmark.”

Tennessee hospital quality program cuts complications 20%, saves 533 lives
FierceHealthcare, July 29, 2014
“Hospitals participating in the Tennessee Surgical Quality Collaborative (TSQC) saved more than 500 lives and cut costs by more than $75 million. The collaborative, established in 2008, announced it gathered clinical 30-day outcomes from 10 participating hospitals to analyze trends and identify best practices. The hospitals gathered data on more than 55,000 surgical procedures and 17 different surgical complication categories between 2009 and 2012, according to research presented at the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP) National Conference.”

Surgical robot fails to show advantages in treating bladder cancer
Wall Street Journal, July 23, 2014
“It’s estimated that 15% to 22% of bladder removal procedures, known as radical cystectomies, are done robotically, according to data collected by the American College of Surgeons and the American Cancer Society. Bladder cancer is expected to cause 15,600 deaths this year, according to the National Cancer Institute.”
Spend Your Time Learning, Not Searching

Selected Readings in General Surgery (SRGS®) is the premier literature review for general surgeons.

• Explore an expert summary of the latest published research.
• Study a variety of topics, including specialty areas like pediatrics, breast, and vascular diseases.
• Earn a substantial number of self-assessment credits for MOC Part II.*
• Expand your knowledge when it’s convenient for you. Read SRGS on any platform at home, in the office, or while traveling.

* The American College of Surgeons (ACS) is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians. The ACS designates this enduring material for a maximum of 80 AMA PRA Category 1 Credits™ annually. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Subscribe today!
www.facs.org/publications/srgs
or call 800-631-0033
ACKERMANN, LEYSTRA, TARA, Liability reform, scope of practice, trauma topped state legislative agendas in 2014, 99, 12:37
–and ROSEN, JUSTIN, Implementation of the ACA: Turning federal law into state-level reality, 99, 5:23
–and ROSEN, JUSTIN, State lobby days build bridges, 99, 10:18
–and ROSEN, JUSTIN, Surgeons as state advocates, 99, 9:33
AGRAWAL, NEHA, What surgeons should know about...Physician Payments Sunshine Act data scheduled for release, 99, 9:48
–and SAGE, JILL, and OLLAPALLY, VINITA, What surgeons should know about...The FY 2015 Inpatient Prospective Payment System final rule, 99, 11:45
ANGELOS, PETER, and HALL, BRUCE L., and RAV-AL, MEHUL V., and SAKRAN, JOSEPH V., and MEDBERY, RACHEL LAURA, Distinguishing QI projects from human subjects research: Ethical and practical considerations, 99, 7:21
ARMSTRONG, JOHN H., and SUTTON, JON H., The debate continues: ACS at the AMA House of Delegates, 99, 3:47
–and SUTTON, JON H., Surgeons influence AMA policy, 99, 9:73
AZOURY, SAID C., Second-place essay—reform: Revisiting the visions of Halsted, Churchill, and Dudley to fix surgical training a century later, 99, 11:26

BAHNSON, ROBERT, From residency to retirement: Remembering Hank, 99, 5:43
BAILEY, H. RANDOLPH, and MEARA, JOHN G., and GUTNIK, LILY, and SMITH, HEATHER, and GOLDSZER, JAMES F., Merging Medicare Parts A and B: Potential effects on beneficiaries, surgeons, and other stakeholders, 99, 2:19
BAILEY, LISA, and BOUGHEY, JUDY C., ACS Clinical Research Program: Neoadjuvant cancer therapy: Benefitting patients and improving cancer care, 99, 6:51
–and MABRY, CHARLES, and OLLAPALLY, VINITA, and SAVARISE, MARK, and SENKOWSKI, CHRIS-
TOPHER, Coding and practice management corner: Reporting patient safety indicator-15, 99, 5:39
  –and NICOLETTI, BETSY, and SAVARISE, MARK, What surgeons should know about...Billing for services performed by nonphysician practitioners, 99, 5:36
  –and SAVARISE, MARK, and WHITACRE, ERIC, Coding and practice management corner: Frequently asked questions about coding for breast surgery, 99, 9:52
BARRETT, ALLISON, and BHOLAT, OMAR, and DEGLIUMONI, JOHN, and WALLACK, MARC, and KHITHANI, AMIT, Lessons in collaboration: New York surgeons look back at Superstorm Sandy, 99, 10:10
BAUER, THOMAS L., SR., and BOUGHEY, JUDY C., ACS Clinical Research Program: Community-based physicians and hospitals need to participate in clinical trials, 99, 4:46
BAXTER, NANCY, 2013 Traveling Fellow reports on trip to Australia and New Zealand, 99, 1:78
BAZZARELLI, AMY, and ECONOMOPOULOS, KONSTANTINOS P., and SUN, RAPHAEL, and GARVEY, ERIN, and HOGAN, JESSICA, Coaching and mentoring modern surgeons, 99, 8:30
BECHAMPS, GERALD J., and KURTZMAN, SCOTT, Adverse behaviors and their effect on credentialing and licensure, 99, 10:32
BEKTESHI, FLAMUR, and RIVERA, RENATO, and LATIFI, RIFAT, and MORA, FRANCISCO, Preoperative telemedicine evaluation of surgical mission patients: Should we use it routinely? 99, 1:7
BERRY, ROBERT, From the Archives: ACS returns books to the Illinois College Medical Library: A look at their history, 99, 4:48
BHOLAT, OMAR, and DEGLIUMONI, JOHN, and WALLACK, MARC, and KHITHANI, AMIT, and BARRETT, ALLISON, Lessons in collaboration: New York surgeons look back at Superstorm Sandy, 99, 10:10
BILIMORIA, KARL, and KO, CLIFFORD Y., Scholars in Residence Program benefits surgical residents and the ACS, 99, 3:55
BINGENER, JULIANE, and SLOAN, JEFF, and BOUGHEY, JUDY C., ACS Clinical Research Program: QOL concerns in surgical patients: Assessment and intervention, 99, 10:44
BOSCO, JOSEPH, and SHAH, PARESH C., and IORIO, RICHARD, and SLOVER, JAMES D., and TORRANCE, ALECIA, Optimizing the OR for bundled payments: A case study, 99, 11:29
BOUGHEY, JUDY C., and BAILEY, LISA, ACS Clinical Research Program: Neoadjuvant cancer therapy: Benefitting patients and improving cancer care, 99, 6:51
  –and BAUER, THOMAS L., ACS Clinical Research Program: Community-based physicians and hospitals need to participate in clinical trials, 99, 4:46
  –and BINGENER, JULIANE, and SLOAN, JEFF, ACS Clinical Research Program: QOL concerns in surgical patients: Assessment and intervention, 99, 10:44
  –and SHEN, PERRY, ACS Clinical Research Program: Colorectal cancer metastatic to the liver: Making the unresectable resectable, 99, 11:49
BRITT, L. D., Citation for Prof. O. James Garden, BSc, MB, BCh, CBE, MD, FRCSGlas, FRCPEd, FRSE, 99, 11:64
Author index


BROWNING, KATHRYN DRAKE, Georgia coalition develops bariatric surgery pilot project, 99, 12:35

BROWNSON, ELISHA G., Annual RAS-ACS essay contest: Accepting accountability and moving forward, 99, 1:11

BRUNT, L. MICHAEL, FLS: Celebrating a decade of innovation in surgical education, 99, 11:10

BUSUTTIL, RONALD W., Citation for Prof. Chung-Mau Lo, MB, BS, FACS, 99, 11:66

CAROPRESO, PHIL, Dispatches from rural surgeons: ACS rural listserv: An “underdog” success story, 99, 7:48

CHAGPAR, ANEES B., Claude H. Organ, Jr., MD, FACS, Traveling Fellow reports on experience in India, 99, 10:76

CHAMBERS, CHRISTOPHER M., and WOLK, SETH, and MANSOUR, M. ASH, and CUFF, ROBERT, and SLAIKEU, JASON, and WONG, PETER, and MIX, ADAM, Vascular practice develops night float call system to improve attending well-being without decreasing productivity, 99, 5:30


–and NELSON, HEIDI, and GREENBERG, CAPRICE, ACS Clinical Research Program: Patient-centered outcomes research: Is this really something new? 99, 1:51

CLARKE, JOHN R., Is your office helping you prevent wrong site surgery? 99, 4:28

CLOYD, JORDAN M., and WREN, SHERRY M., Surgical training abroad: It’s not about the cases, 99, 9:42

COFFRON, MATTHEW, and HANKS, JOHN B., and MEARA, JOHN G., and TRACCI, MARGARET CLARKE, and RAYKAR, NAKUL, and MANDIGO, MORGAN, and NAGENGAST, ERIC, Medicaid expansion likely to affect the delivery of surgical care, 99, 3:10

COPELAND, EDWARD M. III, From residency to retirement: Surgeons as employees: Is the lining always golden? 99, 1:48

CUFF, ROBERT, and SLAIKEU, JASON, and WONG, PETER, and MIX, ADAM, and CHAMBERS, CHRISTOPHER M., and WOLK, SETH, and MANSOUR, M. ASH, Vascular practice develops night float call system to improve attending well-being without decreasing productivity, 99, 5:30

D

DARZI, ARA W., and KEOWN, OLIVER P., and AL-THANI, HASSAN ALI, and AL-DAFA, MARYAH B., and PELLEGRINI, CARLOS A., World Innovation Summit for Health provides a global perspective on surgery, 99, 6:13

DEGLIUOMINI, JOHN, and WALLACK, MARC, and KHITHANI, AMIT, and BARRETT, ALLISON, and BHOLAT, OMAR, Lessons in collaboration: New York surgeons look back at Superstorm Sandy, 99, 10:10

DONOVAN, CORY, Pregnant with hematemesis, 99, 1S:7


Dwyer, KAITLYN, and MOYE, CHANTAY P., 2014 Advocacy program: Attendees learn about traditions that influence legislative outcomes, 99, 6:65

E

ECONOMOPOULOS, KONSTANTINOS P., and SUN, RAPHAEL, and GARVEY, ERIN, and HOGAN, JESSICA, and BAZZARELLI, AMY, Coaching and mentoring modern surgeons, 99, 8:30

ELLISON, E. CHRISTOPHER, Citation for Prof. Alberto Raul Ferreres, MD, PhD, MPH, FACS, 99, 11:63

–and STEINBERG, STEVEN M., and ZINNER, MICHAEL J., Health policy program produces surgeon advocates and leaders, 99, 3:22

F

FANTUS, RICHARD J., NTDB® data points: BYOB helmet, 99, 8:61
–NTDB® data points: Don’t chance it: Use your seatbelt, 99, 9:63
–NTDB® data points: The DTs: Delirium tremens, 99, 11:56
–NTDB® data points: Flotation devices—Mae West style, 99, 6:56
–NTDB® data points: Residential institutions, 99, 5:51
–NTDB® data points: Top 10 list, 99, 4:53
–NTDB® data points: Unanticipated withdrawal, 99, 10:48
–NTDB® data points: Zero tolerance, 99, 3:43
–and FANTUS, RICHARD JACOB, NTDB® data points: Go before you go: Bladder injuries, 99, 12:51
–and NANCE, MICHAEL L., NTDB® data points: To protect your children, keep your pool safe, 99, 7:58
–and FANTUS, RICHARD JACOB, and FANTUS, RICHARD JOSEPH, NTDB® data points: Go before you go: Bladder injuries, 99, 12:51
–and FARMA, JEFFREY M., 2014 Traveling Fellow to Germany reports on experiences, 99, 11:81
–and FAYANJU, OLUVADAMILOLA, Under your nose, 99, 15:8
–and GARVEY, ERIN, and HOGAN, JESSICA, and BAZZARELLI, AMY, and ECONOMOPOULOS, KONSTANTINOS P., and SUN, RAFAEL, Coaching and mentoring modern surgeons, 99, 8:30
–and GLICKSON, JEANNIE, And the beat goes on: Surgeons take a break from the OR to play in rock bands, 99, 6:24
–and GOKAK, SANA, What surgeons should know about...Avoiding the 2015 Medicare EHR Incentive Program penalty, 99, 6:48
GOLDSZER, JAMES F., and BAILEY, RANDOLPH H., and MEARA, JOHN G., and GUTNIK, LILY, and SMITH, HEATHER, Merging Medicare Parts A and B: Potential effects on beneficiaries, surgeons, and other stakeholders, 99, 2:19

GRABOWSKI, DAVID C., and McDONALD, KRISTIN, and KAUPS, KRISTA L., and MEARA, JOHN G., and MURTHY, SHILPA S., and WEISSMAN, JOEL S., Dual eligible beneficiaries: Roles for surgeons under health care reform, 99, 4:10

GRANT, SCOTT B., and McNALLY, MEGAN E., and MOUAWAD, NICOLAS J., and SPANIOLAS, KONSTANTINOS, and IYER, PRIYA H., The e-volution of the 21st century surgeon, 99, 8:42

GREENBERG, CAPRICE, and CHANG, GEORGE J., and NELSON, HEIDI, ACS Clinical Research Program: Patient-centered outcomes research: Is this really something new?, 99, 1:51

GREENE, FREDERICK, and JOHNSTONE, DAVID, and STRAND, NANCY, ACS commemorates 50-year anniversary of Surgeon General’s report on smoking and health, 99, 8:69

HALL, BRUCE L., and RAVAL, MEHUL V., and SAKRAN, JOSEPH V., and MEDBERY, RACHEL, and LAURA, and ANGELOS, PETER, Distinguishing QI projects from human subjects research: Ethical and practical considerations, 99, 7:21

HANKS, JOHN B., and MEARA, JOHN G., and TRACCI, MARGARET CLARKE, and RAYKAR, NAKUL, and MANDIGO, MORGAN, and NAGENGAST, ERIC, and COFFRON, MATTHEW, Medicaid expansion likely to affect the delivery of surgical care, 99, 3:10

HEDSTROM, JOHN, The SGR repeal: How bad politics ruined sound policy, 99, 6:9

HOYT, DAVID B., Executive Director’s annual report, 99, 12:19

HOGAN, JESSICA, and BAZZARELLI, AMY, and ECONOMOPoulos, KONSTANTINoS, P., and SUN, RAPHAEL, and GARVEY, ERIN, Coaching and mentoring modern surgeons, 99, 8:30


HOWLE, JULIE, Inaugural Murray F. Brennan, MD, FACS, International Guest Scholar provides report, 99, 7:70

HOGAN, JESSICA, and BAZZARELLI, AMY, and ECONOMOPoulos, KONSTANTINoS, P., and SUN, RAPHAEL, and GARVEY, ERIN, Coaching and mentoring modern surgeons, 99, 8:30


HOFMANN, REBECCA L., and KING, RAY S., and AHAD, AHMAD W., and LELAND, HYUMA A., The “bionic” era: Exploring the use of advanced technology in surgery, 99, 8:36

HOYT, DAVID B., Executive Director’s annual report, 99, 12:19

HOGAN, JESSICA, and BAZZARELLI, AMY, and ECONOMOPoulos, KONSTANTINoS, P., and SUN, RAPHAEL, and GARVEY, ERIN, Coaching and mentoring modern surgeons, 99, 8:30


HOWLE, JULIE, Inaugural Murray F. Brennan, MD, FACS, International Guest Scholar provides report, 99, 7:70

HOYT, DAVID B., Executive Director’s annual report, 99, 12:19

HALL, BRUCE L., and RAVAL, MEHUL V., and SAKRAN, JOSEPH V., and MEDBERY, RACHEL, and LAURA, and ANGELOS, PETER, Distinguishing QI projects from human subjects research: Ethical and practical considerations, 99, 7:21

HANKS, JOHN B., and MEARA, JOHN G., and TRACCI, MARGARET CLARKE, and RAYKAR, NAKUL, and MANDIGO, MORGAN, and NAGENGAST, ERIC, and COFFRON, MATTHEW, Medicaid expansion likely to affect the delivery of surgical care, 99, 3:10

HEDSTROM, JOHN, The SGR repeal: How bad politics ruined sound policy, 99, 6:9

–What surgeons should know about...Repealing the SGR, 99, 2:39


HINSDALE, JAMES G., and KAUPS, KRISTA L., and MAA, JOHN, and GARRY, JOHN E., and UPADHYAYA, POOJA, Northern California Chapter engages in ongoing legislative activities, 99, 3:51

HOFFMAN, REBECCA L., and KING, RAY S., and AHAD, AHMAD W., and LELAND, HYUMA A., The “bionic” era: Exploring the use of advanced technology in surgery, 99, 8:36

HOGAN, JESSICA, and BAZZARELLI, AMY, and ECONOMOPoulos, KONSTANTINoS, P., and SUN, RAPHAEL, and GARVEY, ERIN, Coaching and mentoring modern surgeons, 99, 8:30


HOWLE, JULIE, Inaugural Murray F. Brennan, MD, FACS, International Guest Scholar provides report, 99, 7:70

HOYT, DAVID B., Executive Director’s annual report, 99, 12:19

–Looking forward, 99, 1:7 (advances and challenges in surgery); 2:8 (sustainable growth rate); 3:8 (Military Advanced Training Center); 4:8 (Transition to Practice Program); 5:8 (trends in surgical procedures); 6:7 (funding ACS programs); 7:7 (Medical Directors in Washington office); 8:9 (Leadership Development Program); 9:8 (Codman memorial); 10:8 (Dr. Russell); 11:8 (Education and
Training campaign); 126 (accomplishments in 2013–2014)

HUGHES, TYLER G., ACS-Surgeons Voice plays critical role, 99, 10:42

–and PELLEGRINI, CARLOS A., and PULS, MARK W., and LEDESMA, CARLOS L., Dispatches from rural surgeons: Rural surgery is a global issue: The perspective of an Argentine surgeon, 99, 4:38


IORIO, RICHARD, and SLOVER, JAMES D., and TORRANCE, ALECIA, and BOSCO, JOSEPH, and SHAH, PARESH C., Optimizing the OR for bundled payments: A case study, 99, 11:29

ITANI, KAMAL M.F., 2013 Clinical Trials Methodology Course provides opportunity for learning and networking, 99, 2:54


–and GRANT, SCOTT B., and SPANIOLAS, KONSTANTINOS, and MOUAWAD, NICOLAS J., From residency to retirement: RAS-ACS International Exchange Scholarship Program provides unique opportunity for global collaboration, 99, 4:42

–and LEICHTLE, STEFAN W., and SANGJI, NAVEEN, and WARD, WILLIAM H., What does the ACA mean for residents and their future practice? 99, 8:17


JARMAN, BENJAMIN T., and GEORGIEFF, ERYNN M., and KALLIES, KARA J., and MATHIASON, MICHELLE A., Gundersen Health System studies effect of modifier 22 on reimbursement for complex operations, 99, 3:31


JOHNSTONE, DAVID, and STRAND, NANCY, and GREENE, FREDERICK, ACS commemorates 50-year anniversary of Surgeon General’s report on smoking and health, 99, 8:69


JONES, DOUGLAS W., Avoid getting kicked, 99, 1S:10

KALLIES, KARA J., and MATHIASON, MICHELLE A., and JARMAN, BENJAMIN T., and GEORGIEFF, ERYNN M., Gundersen Health System studies effect of modifier 22 on reimbursement for complex operations, 99, 3:31

KAOUTZANIS, CHRISTODoulos, and MOUAWAD, NICOLAS J., and LEICHTLE, STEFAN W., The five-year general surgery residency: Reform or revolution? 99, 8:49

KAPLAN, ALAN L., Treating the difficult patient can be a long journey, 99, 6:11

KAUPS, KRISTA L., and GARRETT, KEVIN, The aging surgeon: When is it time to leave active practice? 99, 4:32

–and MAA, JOHN, and GARRY, JOHN E., and UPADHYAYA, POOJA, and HINSDALE, JAMES G., Northern California Chapter engages in ongoing legislative activities, 99, 3:51

–and MEARA, JOHN G., and MURTHY, SHILPA S., and WEISSMAN, JOEL S., and GRABOWSKI, DAVID C., and McDONALD, KRISTIN, Dual eligible beneficiaries: Roles for surgeons under health care reform, 99, 4:10

KENNING, ERIN M., and ZHENG, FEIBI, and KULAYLAT, AFIF N., and McKINLEY, SOPHIA K., Surgical education and training at the crossroads between medical school and residency, 99, 8:24

KEOWN, OLIVER P., and AL-THANI, HASSAN ALI, and AL-DAFA, MARYAH B., and PELLEGRINI, CARLOS A., and DARZI, ARA W., World Innova-
tion Summit for Health provides a global perspective on surgery, 99, 6:13


KHITHANI, AMIT, and BARRETT, ALLISON, and BHOLAT, OMAR, and DEGLIUOMINI, JOHN, and WALLACK, MARC, Lessons in collaboration: New York surgeons look back at Superstorm Sandy, 99, 10:10

KIM, TAD, Annual RAS-ACS essay contest: Responding to, reflecting on, and moving forward from a surgical complication, 99, 1:12


KO, CLIFFORD Y., and BILIMORIA, KARL, Scholars in Residence Program benefits surgical residents and the ACS, 99, 3:55


KULAYLAT, AFIF N., and McKinley, Sophia K., and KENNING, ERIN M., and ZHENG, FEIBI, Surgical education and training at the crossroads between medical school and residency, 99, 8:24

KURTZMAN, SCOTT, and BECHAMPS, GERALD J., Adverse behaviors and their effect on credentialing and licensure, 99, 10:32

LATIFI, RIFAT, and MORA, FRANCISCO, and BEKTESHI, FLAMUR, and RIVERA, RENATO, Preoper-erative telemedicine evaluation of surgical mission patients: Should we use it routinely? 99, 1:7

LEDESMA, CARLOS L., and HUGHES, TYLER G., and PELLEGRINI, CARLOS A., and PULS, MARK W., Dispatches from rural surgeons: Rural surgery is a global issue: The perspective of an Argentine surgeon, 99, 4:38

LEE, WALTER T., First YFA Essay Contest winner: The promise of a profession lies within us, 99, 10:30

LEICHTLE, STEFAN W., and KAOUTZANIS, CHRISTODoulos, and MOUAWAD, NICOLAS J., The five-year general surgery residency: Reform or revolution? 99, 8:49

–and SANGJI, NAVEEN, and WARD, WILLIAM H., and IYER, PRIYA, What does the ACA mean for residents and their future practice? 99, 8:17

LELAND, HYUMA A., and HOFFMAN, REBECCA L., and KING, RAY S., and AHAD, AHMAD W., The “bionic” era: Exploring the use of advanced technology in surgery, 99, 8:36

LOSBY, JIM, and GARNESKI, SALLY, and SCHWARTZ, JERRY, A new era begins for ACS online properties, 99, 9:12

MAA, JOHN, and GARRY, JOHN E., and UPADHYAYA, POOJA, and HINSDALE, JAMES G., and KAUPS, KRISTA L., Northern California Chapter engages in ongoing legislative activities, 99, 3:51

–and SLAPPY, A.L. JACKSON, and SWEENEY, JOHN, and O’SHEA, JOHN, Will acute care surgery and surgeons help to avert an emergency care crisis? 99, 2:34

–and SUTTON, JON H., Preserving MICRA and patient access to surgical care in California, 99, 10:60

MABRY, CHARLES D., and GOKAK, SANA Z., The benefits of PQRS participation and what the College is doing on your behalf, 99, 9:28

–and OLLAPALLY, VINITA, and SAVEARISE, MARK, and SENKOWSKI, CHRISTOPHER, and BARNEY, LINDA, Coding and practice management corner: Reporting patient safety indicator-15, 99, 5:39

MANDIGO, MORGAN, and NAGENGAST, ERIC, and COFFRON, MATTHEW, and HANKS, JOHN B., and MEARA, JOHN G., and TRACCI, MARGARET
Author index

CLARKE, and RAYKAR, NAKUL, Medicaid expansion likely to affect the delivery of surgical care, 99, 3:10
MANSOUR, M. ASH, and CUFF, ROBERT, and SLAIKEU, JASON, and WONG, PETER, and MIX, ADAM, and CHAMBERS, CHRISTOPHER M., and WOLK, SETH, Vascular practice develops night float call system to improve attending well-being without decreasing productivity, 99, 5:30
MATHIASON, MICHELLE A., and JARMAN, BENJAMIN T., and GEORGIEFF, ERYNN M., and KALLIES, KARA J., Gundersen Health System studies effect of modifier 22 on reimbursement for complex operations, 99, 3:31
MATTHEWS, MIKA, Familial ties in treating the difficult patient, 99, 1S:6
McANENY, DAVID, Massachusetts Chapter develops new grassroots advocacy program, 99, 11:37
McDONALD, KRISTIN, and KAUPS, KRISTA L., and MEARA, JOHN G., and MURTHY, SHILPA S., and WEISSMAN, JOEL S., and GRABOWSKI, DAVID C., Dual eligible beneficiaries: Roles for surgeons under health care reform, 99, 4:10
–and SANGJI, NAVEEN F., Trauma and emergency care under the Affordable Care Act, 99, 4:20
–and WEIRETER, LEONARD J. Jr., and SANGJI, NAVEEN F., and SUTTON, JON, Liability reforms needed to provide timely care to disaster victims, 99, 5:10
McKINLEY, SOPHIA K., and KENNING, ERIN M., and ZHENG, FEIBI, and KULAYLAT, AFIF N., Surgical education and training at the crossroads between medical school and residency, 99, 8:24
McNALLY, MEGAN E., and MOUAWAD, NICOLAS J., and SPANIOLAS, KONSTANTINOS, and IYER, PRIYA H., and GRANT, SCOTT B., The evolution of the 21st century surgeon, 99, 8:42
MEARA, JOHN G., and GUTNIK, LILY, and SMITH, HEATHER, and GOLDSZER, JAMES F., and BALEY, RANDOLPH H., Merging Medicare Parts A and B: Potential effects on beneficiaries, surgeons, and other stakeholders, 99, 2:19
–and MURTHY, SHILPA S., and WEISSMAN, JOEL S., and GRABOWSKI, DAVID C., and McDonalD, KRISTIN, and KAUPS, KRISTA L., Dual eligible beneficiaries: Roles for surgeons under health care reform, 99, 4:10
–and TRACCI, MARGARET CLARKE, and RAYKAR, NAKUL, and MANDIGO, MORGAN, and NAGEN-GAST, ERIC, and COFFRON, MATTHEW, and HANKS, JOHN B., Medicaid expansion likely to affect the delivery of surgical care, 99, 3:10
MEDBERRY, RACHEL LAURA, and ANGELOS, PETER, and HALL, BRUCE L., and RAVAL, MEHUL V., and SAKRAN, JOSEPH V., Distinguishing QI projects from human subjects research: Ethical and practical considerations, 99, 7:21
MERRELL, RONALD, Citation for Prof. Edgar Rodas, MD, FACS, 99, 11:67
MIX, ADAM, and CHAMBERS, CHRISTOPHER M., and WOLK, SETH, and MANSOUR, M. ASH, and CUFF, ROBERT, and SLAIKEU, JASON, and WONG, PETER, Vascular practice develops night float call system to improve attending well-being without decreasing productivity, 99, 5:30
MOHEBALI, JAHAN, First-place essay—改革: Reform of current surgical residency and fellowship training is the best solution, 99, 11:23
MOORE, HUNTER, Finding my friend’s heart in the difficult patient, 99, 1S:12
MORA, FRANCISCO, and BEKTESHI, FLAMUR, and RIVERA, RENATO, and LATIFI, RIFAT, Preoperative telemedicine evaluation of surgical mission patients: Should we use it routinely? 99, 1:7
MORSE, SARA, SurgeonsVoice: Your patients, your profession, your voice, 99, 7:28
MOYE, CHANTAY, Building a global perspective at International Surgical Leaders forum, 99, 1:58—and DWYER, KAITLYN, 2014 Advocacy program: Attendees learn about traditions that influence legislative outcomes, 99, 6:65
MSHELFWALA, PHILIP, 2013 International Surgical Education Scholar reports on experience in North America, 99, 7:75
MURTHY, SHILPA S., and WEISSMAN, JOEL S., and GRABOWSKI, DAVID C., and MCDONALD, KRISTIN, and KAUPS, KRISTA L., and MEARA, JOHN G., Dual eligible beneficiaries: Roles for surgeons under health care reform, 99, 4:10
NAGENGAST, ERIC, and COFFRON, MATTHEW, and HANKS, JOHN B., and MEARA, JOHN G., and TRACCI, MARGARET CLARKE, and RAYKAR, NAKUL, and MANDIGO, MORGAN, Medicaid expansion likely to affect the delivery of surgical care, 99, 3:10
NAHRWOLD, DAVID L., From the Archives: Franklin H. Martin, MD, FACS: Gynecologic surgeon, 99, 7:55—and From the Archives: The gift that keeps on giving, 99, 11:52
NICOLETTI, BETSY, and SAVARISE, MARK, and BARNEY, LINDA, What surgeons should know about...Billing for services performed by nonphysician practitioners, 99, 5:36
NUMANN, PATRICIA J., In memoriam: C. Barber Mueller, MD, FACS, FRCSC, recognized for contributions to the ACS and academic surgery, 99, 8:67
O’SHEA, JOHN, and MAA, JOHN, and SLAPPY, A. L., JACKSON, and SWEENEY, JOHN, Will acute care surgery and surgeons help to avert an emergency care crisis? 99, 2:34
P

PADBERG, FRANK T. Jr., In memoriam: Frank T. Padberg, Sr., MD, FACS: ACS department director, DSA recipient, and trailblazer in neurosurgery, 99, 6:73

PELLEGRINI, CARLOS, ACS presents Lifetime Achievement Award posthumously to Dr. Russell, 99, 12:57

–and DARZI, ARA W., and KEOWN, OLIVER P., and AL-THANI, HASSAN ALI, and AL-DAFA, MARYAH B., World Innovation Summit for Health provides a global perspective on surgery, 99, 6:13

–and PULS, MARK W., and LEDESMA, CARLOS L., and HUGHES, TYLER G., Dispatches from rural surgeons: Rural surgery is a global issue: The perspective of an Argentine surgeon, 99, 4:38

–and SCHNEIDMAN, DIANE S., In memoriam: Thomas R. Russell, MD, FACS, remembered for his enduring contributions to the ACS, 99, 10:52

PEREGRIN, TONY, 2014 Leadership program: Emotional intelligence, mentoring are keys to effective performance, 99, 6:58

–International Guest Scholarships: An investment in surgical training around the globe, 99, 5:16

–Surgeons see future applications for Google Glass, 99, 7:9

POON, JENSEN, First Carlos Pellegrini Traveling Fellow reports on experience, 99, 7:64

PULS, MARK W., and LEDESMA, CARLOS L., and HUGHES, TYLER G., and PELLEGRINI, CARLOS A., Dispatches from rural surgeons: Rural surgery is a global issue: The perspective of an Argentine surgeon, 99, 4:38

R

RAVAL, MEHUL V., and SAKRAN, JOSEPH V., and MEDBERY, RACHEL LAURA, and ANGELOS, PETER, and HALL, BRUCE L., Distinguishing QI projects from human subjects research: Ethical and practical considerations, 99, 7:21


RAYKAR, NAKUL, and MANDIGO, MORGAN, and NAGENGAST, ERIC, and COFFRON, MATTHEW, and HANKS, JOHN B., and MEARA, JOHN G., and TRACCI, MARGARET CLARKE, Medicaid expansion likely to affect the delivery of surgical care, 99, 3:10

RIoux, John, Chapter leadership succession planning helps to build stronger chapters, 99, 4:65

RIVERA, RENAT0, and LATIFI, RIFAT, and MORA, FRANCISCO, and BEKTESHI, FLAMUR, Preoperative telemedicine evaluation of surgical mission patients: Should we use it routinely? 99, 1:7

ROBICSEK, FRANCIS, Founding surgeon reflects on 25 years of UNICAR, the Guatemalan Heart Institute, 99, 9:38


ROSE, DEVIN, Fellows honored for volunteerism, 99, 9:67

–and SANDERS, BETTY, Past recipients of the ACS/Pfizer Surgical Volunteerism and Humanitarian Awards: Where are they now? 99, 10:24

ROSEN, JUSTIN, and ACKERMAN, TARA LEYSTRA, Implementation of the ACA: Turning federal law into state-level reality, 99, 5:23

–and ACKERMAN, TARA LEYSTRA, State lobby days build bridges, 99, 10:18

–and ACKERMAN, TARA LEYSTRA, Surgeons as state advocates, 99, 9:33

S

SAGE, JILL, What surgeons should know about...The Measure Applications Partnership, 99, 4:36
—What surgeons should know about...The Patient-Centered Outcomes Research Institute, 99, 10:35
—and OLLAPALLY, VINITA, and AGRAWAL, NEHA, What surgeons should know about...The FY 2015 Inpatient Prospective Payment System final rule, 99, 11:45
—and SENKOWSKI, CHRISTOPHER, and BARNEY, LINDA, and MABRY, CHARLES, and OLLAPALLY, VINITA, Coding and practice management corner: Reporting patient safety indicator-15, 99, 5:39
—and WHITACRE, ERIC, and BARNEY, LINDA, Coding and practice management corner: Frequently asked questions about coding for breast surgery, 99, 9:52
SCHWARTZ, GARY, Doctor heal thyself...because we won’t, 99, 1S:13
SCHWARTZ, JERRY, and LOSBY, JIM, and GARNESKI, SALLY, A new era begins for ACS online properties, 99, 9:12
SELIM, NIAZY M., Teaching the teacher: An ethical model for international surgical missions, 99, 6:17
SENKOWSKI, CHRISTOPHER, and BARNEY, LINDA, and MABRY, CHARLES, and OLLAPALLY, VINITA, and SAVARISE, MARK, Coding and practice management corner: Reporting patient safety indicator-15, 99, 5:39
SERRANO, PABLO, Annual RAS-ACS essay contest: Talk it out, and slow it down, 99, 1:13
SHAH, PARESH C., and IORIO, RICHARD, and SLOVER, JAMES D., and TORRANCE, ALECIA, and BOSCO, JOSEPH, Optimizing the OR for bundled payments: A case study, 99, 11:29
SHEN, PERRY, and BOUGHEY, JUDY C., ACS Clinical Research Program: Colorectal cancer metastatic to the liver: Making the unresectable resectable, 99, 11:49
SHENVI, EDNA C., First-place essay—revolution: Surgical training: Time for a revolution, 99, 11:17
SHUHAIBER, JEFFREY, From residency to retirement: The quest for safe surgical care: Are we missing the obvious? 99, 2:42
SIGMAN, MICHAEL, Punched in the face, 99, 1S:14
SLAIKEU, JASON, and WONG, PETER, and MIX, ADAM, and CHAMBERS, CHRISTOPHER M., and WOLK, SETH, and MANSOUR, M. ASH, and CUFF, ROBERT, Vascular practice develops night float call system to improve attending well-being without decreasing productivity, 99, 5:30
SLAPPY, A.L. JACKSON, and SWEENEY, JOHN, and
O’SHEA, JOHN, and MAA, JOHN, Will acute care surgery and surgicalists help to avert an emergency care crisis? 99, 2:34

SLOAN, JEFF, and BOUGHEY, JUDY C., and BINGENER, JULIANE, ACS Clinical Research Program: Patient quality of life: Vitally important, 99, 5:46

SLOAN, JEFF, and BOUGHEY, JUDY C., and BINGENER, JULIANE, ACS Clinical Research Program: QOL concerns in surgical patients: Assessment and intervention, 99, 10:44

SLOVER, JAMES D., and TORRANCE, ALECIA, and BOSCO, JOSEPH, and SHAH, PARESH C., and IORIO, RICHARD, Optimizing the OR for bundled payments: A case study, 99, 11:29

SMITH, HEATHER, and GOLDSZER, JAMES F., and BAILEY, RANDOLPH H., and MEARA, JOHN G., and GUTNIK, LILY, Merging Medicare Parts A and B: Potential effects on beneficiaries, surgeons, and other stakeholders, 99, 2:19

SOANS, ROHIT, Treating the difficult patient may require stepping out of your comfort zone, 99, 1S:15

SPANIOLAS, KONSTANTINOS, and IYER, PRIYA H., and GRANT, SCOTT B., and McNALLY, MEGAN E., and MOUAWAD, NICOLAS J., The e-volution of the 21st century surgeon, 99, 8:42

–and MOUAWAD, NICOLAS J., and IYER, PRIYA, and GRANT, SCOTT B., From residency to retirement: RAS-ACS International Exchange Scholarship Program provides unique opportunity for global collaboration, 99, 4:42

STEINBERG, STEVEN M., and ZINNER, MICHAEL J., and ELLISON, E. CHRISTOPHER, Health policy program produces surgeon advocates and leaders, 99, 3:22

STRAND, NANCY, and GREENE, FREDERICK, and JOHNSTONE, DAVID, ACS commemorates 50-year anniversary of Surgeon General’s report on smoking and health, 99, 8:69

STRASBERG, STEVEN M., Citation for Prof. Pierre-Alain Clavien, MD, PhD, FACS, FRCSEng, FRCSEd, 99, 11:62

SUN, RAPHAEL, and GARVEY, ERIN, and HOGAN, JESSICA, and BAZZARELLI, AMY, and ECONOMOPOULOS, KONSTANTINOS P., Coaching and mentoring modern surgeons, 99, 8:30

SUTTON, JON H., Reading the tea leaves for state legislatures in 2014, 99, 1:24

–and ARMSTRONG, JOHN H., The debate continues: ACS at the AMA House of Delegates, 99, 3:47

–and ARMSTRONG, JOHN H., Surgeons influence AMA policy, 99, 9:73

–and MAA, JOHN, Preserving MICRA and patient access to surgical care in California, 99, 10:60

–and MCDONALD, KRISTIN, and WEIRETER, LEONARD J. Jr., and SANGJI, NAMEEN F., Liability reforms needed to provide timely care to disaster victims, 99, 5:10


SWEENEY, JOHN, and O’SHEA, JOHN, and MAA, JOHN, and SLAPPY, A.L. JACKSON, Will acute care surgery and surgicalists help to avert an emergency care crisis? 99, 2:34


SWENDIMAN, ROBERT A., Dispatches from rural surgeons: Students need exposure to the joys of rural surgery, 99, 1:46

TIEBERG, DONNA, Chapter news, 99, 2:60, 4:61, 6:82, 8:76, 10:69, 12:61

TIMMERMAN, GARY L., Board of Governors pillars improve productivity, communication: An update, 99, 9:78


–Report on ACSPA/ACS activities: June 2014, 99, 10:64

TORRANCE, ALECIA, and BOSCO, JOSEPH, and SHAH, PARESH C., and IORIO, RICHARD, and SLOVER, JAMES D., Optimizing the OR for bundled payments: A case study, 99, 11:29

TRACCI, MARGARET CLARKE, and RAYKAR, NAKUL, and MANDIGO, MORGAN, and NAGENGAST, ERIC, and COFFRON, MATTHEW, and HANKS, JOHN B., and MEARA, JOHN G., Medicare expansion likely to affect the delivery of surgical care, 99, 3:10

TROTTER, MICHAEL C., Hugh Agnew Gamble, MD, FACS: A legacy to the College, 99, 12:43
UPADHYAYA, POOJA, and HINSDALE, JAMES G., and KAUPS, KRISTA L., and MAA, JOHN, and GARRY, JOHN E., Northern California Chapter engages in ongoing legislative activities, 99, 3:51

WALLACK, MARC, and KHITHANI, AMIT, and BARRETT, ALLISON, and BHOLAT, OMAR, and DEGLI-UOMINI, JOHN, Lessons in collaboration: New York surgeons look back at Superstorm Sandy, 99, 10:10
WARD, WILLIAM H., and IYER, PRIYA, and LEICHTLE, STEFAN W., and SANGJI, NAVEEN, What does the ACA mean for residents and their future practice? 99, 8:17
WARSHAW, ANDREW L., Presidential Address: Achieving our personal best—Back to the future of the American College of Surgeons, 99, 12:9
WEIRETER, LEONARD J., Jr., and SANGJI, NAVEEN F., and SUTTON, JON, and McDONALD, KRISTIN, Liability reforms needed to provide timely care to disaster victims, 99, 5:10
WEISSMAN, JOEL S., and GRABOWSKI, DAVID C., and McDONALD, KRISTIN, and KAUPS, KRISTA L., and MEARA, JOHN G., and MURTHY, SHILPA S., Dual eligible beneficiaries: Roles for surgeons under health care reform, 99, 4:10
WHITACRE, ERIC, and BARNEY, LINDA, and SAVARISE, MARK, Coding and practice management corner: Frequently asked questions about coding for breast surgery, 99, 9:52
WINFIELD, ROBERT D., Annual RAS-ACS essay contest: How surgeons deal with complications: Introductory remarks, 99, 1:10—Making the transition from mentee to mentor, 99, 8:13
WOLK, SETH, and MANSOUR, M. ASH, and CUFF, ROBERT, and SLAIKEU, JASON, and WONG, PETER, and MIX, ADAM, and CHAMBERS, CHRISTOPHER M., Vascular practice develops night float call system to improve attending well-being without decreasing productivity, 99, 5:30
WONG, PETER, and MIX, ADAM, and CHAMBERS, CHRISTOPHER M., and WOLK, SETH, and MANSOUR, M. ASH, and CUFF, ROBERT, and SLAIKEU, JASON, Vascular practice develops night float call system to improve attending well-being without decreasing productivity, 99, 5:30
WREN, SHERRY M., and CLOYD, JORDAN M., Surgical training abroad: It’s not about the cases, 99, 9:42
WRIGHT, COREY, RAS-ACS Symposium essays: Residents debate whether to reform or revolutionize surgical training, 99, 11:16
WRIGHT, G. PAUL, Annual RAS-ACS essay contest: Consequences, 99, 1:15
YI, WILLIAM, Annual RAS-ACS essay contest: Complications are shared experiences, 99, 1:16
ZHENG, FEIBI, and KULAYLAT, AFIF N., and McKINLEY, SOPHIA K., and KENNING, ERIN M., Surgical education and training at the crossroads between medical school and residency, 99, 8:24
ZOU, WEI, ACS/ANZ Traveling Scholar reports on trip to Singapore and Australia, 99, 8:84
ZINNER, MICHAEL J., and ELLISON, E. CHRISTOPHER, and STEINBERG, STEVEN M., Health policy program produces surgeon advocates and leaders, 99, 3:22
Subject index

A

ACCESS TO CARE (see: WORKFORCE ISSUES and HEALTH CARE REFORM)
ACCREDITATION (see: THE JOINT COMMISSION)
ADVOCACY AND HEALTH POLICY (see also: AMERICAN COLLEGE OF SURGEONS: Advocacy and Health Policy and LEGISLATIVE AND GOVERNMENT ISSUES)
Health policy program produces surgeon advocates and leaders (Steinberg, Zinner, Ellison), 99, 3:22
AFFORDABLE CARE ACT (see: LEGISLATIVE AND GOVERNMENT ISSUES: FEDERAL)
AMERICAN COLLEGE OF SURGEONS
Activities (see also: AMERICAN COLLEGE OF SURGEONS: Inspiring Quality campaign)
–2013 Clinical Trials Methodology Course provides opportunity for learning and networking (Itani), 99, 2:54
–ACS and other specialty surgical organizations release Physicians as Assistants at Surgery report, 99, 1:64
–ACS commemorates 50-year anniversary of Surgeon General’s report on smoking and health (Greene, Johnstone, Strand), 99, 8:69
–ACS Committee on Diversity Issues seeks new members, 99, 6:85
–ACS supports December Health Affairs theme issue on emergency care, 99, 2:53
–ACS Women in Surgery Committee issues call for mentees: July 31 deadline, 99, 7:62
–ACS Women in Surgery Committee seeks new members, 99, 6:85
–Headstone honoring Ernest A. Codman, MD, FACS, placed at Mount Auburn Cemetery, 99, 9:72
–Register now for ACS Comprehensive General Surgery Review Course, 99, 6:78
–Report on ACSPA/ACS activities: October 2013 (Napolitano), 99, 1:68
–Report on ACSPA/ACS activities: June 2014 (Timmerman), 99, 10:64
–Surgeons, anesthesiologists develop resource standards for optimal pediatric care, 99, 4:57
Advocacy and Health Policy (see also: ADVOCACY AND HEALTH POLICY
–2014 Advocacy program: Attendees learn about traditions that influence legislative outcomes (Moye, Dwyer), 99, 6:65
–ACS SurgeonsVoice plays critical role (Hughes), 99, 10:42
–Health Policy Scholars announced, 99, 6:87
–Massachusetts Chapter develops new grassroots advocacy program (McAneny), 99, 11:37
–State lobby days build bridges (Ackerman, Rosen), 99, 10:18
–Surgeons as state advocates (Ackerman, Rosen), 99, 9:33
–SurgeonsVoice: Your patients, your profession, your voice (Morse), 99, 7:28
Alliance/ACS Clinical Research Program
Subject index

- ACS Clinical Research Program: Colorectal cancer metastatic to the liver: Making the unresectable resectable (Shen, Boughey), 99, 11:49
- ACS Clinical Research Program: Community-based physicians and hospitals need to participate in clinical trials (Bauer, Boughey), 99, 4:46
- ACS Clinical Research Program: Less invasive option for small hepatocellular carcinoma: Thermal ablation as first-line therapy? (Rocha, Boughey, Nelson), 99, 2:46
- ACS Clinical Research Program: NCDB and ACS-CRP: Working together to develop risk-stratified strategies for surveillance (Chang, Greenberg, Kozower, Boughey, Francescatti, McKellar, Winchester), 99, 8:57
- ACS Clinical Research Program: Neoadjuvant cancer therapy: Benefitting patients and improving cancer care (Bailey, Boughey), 99, 6:51
- ACS Clinical Research Program: Patient-centered outcomes research: Is this really something new? (Greenberg, Chang, Nelson), 99, 1:51
- ACS Clinical Research Program: Patient quality of life: Vitally important (Bingener, Sloan, Boughey), 99, 5:46
- ACS Clinical Research Program: QOL concerns in surgical patients: Assessment and intervention (Bingener, Sloan, Boughey), 99, 10:44
- ACS Clinical Research Program: SLN surgery for clinically node-positive breast cancer patients treated with neoadjuvant therapy (Mittendorf, Boughey, Hunt), 99, 7:52
- ACS Clinical Research Program: Treating metastatic prostate cancer now and in the future (Meng, Boughey), 99, 9:55

American College of Surgeons Foundation (see also: AMERICAN COLLEGE OF SURGEONS: Scholarships and Fellowships)
- 1913 Legacy Campaign announces $1.75 million raised toward goal, 99, 5:54
- American College of Surgeons Foundation Annual Report, 2013, 99, 6:30
- Past recipients of the ACS/Pfizer Surgical Volunteerism and Humanitarian Awards: Where are they now? (Rose, Sanders), 99, 10:24

American College of Surgeons National Surgical Quality Improvement Program
- 2014 International ACS NSQIP Scholarship applications due February 14, 99, 1:76
- 2014 National Conference: ACS NSQIP celebrates 10th anniversary of improving patient outcomes (Glickson), 99, 11:68
- The ACS NSQIP Geriatric Surgery Pilot Project: Improving care for older surgical patients (Robinson, Rosenthal), 99, 10:21

American College of Surgeons Professional Association (ACSPA)
- Report on ACSPA/ACS activities: October 2013 (Napolitano), 99, 1:68
- Report on ACSPA/ACS activities: February 2014 (Timmerman), 99, 5:60
- Report on ACSPA/ACS activities: June 2014 (Timmerman), 99, 10:64

Annual meeting (see: AMERICAN COLLEGE OF SURGEONS: Clinical Congress)
- ACS Archives: Historic films now available online, 99, 5:59
- ACS loans ancient Irish deer antlers to Art Institute of Chicago exhibit, 99, 12:60
- From the Archives: ACS returns books to the Illinois College Medical Library: A look at their history (Berry), 99, 4:48
- From the Archives: “Everything Old Is New Again” (McGinnis), 99, 9:58
- From the Archives: Franklin H. Martin, MD, FACS: Gynecologic surgeon (Nahrwold), 99, 7:55
- From the Archives: The gift that keeps on giving (Nahrwold), 99, 11:52

Awards
- 2014 Volunteerism and Humanitarian Award nominations due February 28, 99, 2:58
- ACS presents Lifetime Achievement Award posthumously to Dr. Russell (Pellegrini), 99, 12:57
- College accepting nominations for 2015 Jacobson Promising Investigator Award, 99, 11:77
- Fellows honored for volunteerism (Rose), 99, 9:67
- J. Wayne Meredith, MD, FACS, chosen as 2014 Distinguished Service Award recipient, 99, 10:50
- Nominations for 2014 volunteerism and humanitarian awards due February 28, 99, 1:63
- Nominations for Jacobson Promising Investigator Award accepted through February 28, 99, 1:57
- Robin T. Cotton, MD, FACS, FRCS, receives 2014 ACS
Subject index

Jacobson Innovation Award, 99, 8:64
− Past recipients of the ACS/Pfizer Surgical Volunteerism and Humanitarian Awards: Where are they now? (Rose, Sanders), 99, 10:24
− Submit 2015 ACS Surgical Volunteerism and Humanitarian Award nominations, January 1–February 28, 99, 12:55

Bulletin of the American College of Surgeons
− Correction, 99, 9:75
− Letters to the Editor, 99, 3:45, 9:65

Chapters
− Chapter leadership succession planning helps to build stronger chapters (Rioux), 99, 4:65
− Chapter news (Tieberg), 99, 2:60, 4:61, 6:82, 8:76, 10:69, 12:61
− Georgia coalition develops bariatric surgery pilot project (Browning), 99, 12:35
− Massachusetts Chapter develops new grassroots advocacy program (McAney), 99, 11:37
− Northern California Chapter engages in ongoing legislative activities (Kaups, Maa, Garry, Upadhyaya, Hindsdale), 99, 3:51

Clinical Congress
− Clinical Congress 2014 Preliminary Program, 99, 7:31
− Highlights of the 2013 Clinical Congress, 99, 1:27
− MOC review course offered at Clinical Congress, 99, 10:61
− New CME information for 2014 Clinical Congress attendees, 99, 10:62
− Official notice: Annual Business Meeting of Members, American College of Surgeons, 99, 9:71

Commission on Cancer
− Outstanding Achievement Award granted to 74 CoC facilities, 99, 7:60

Disciplinary actions
− Disciplinary actions taken, 99, 2:59, 5:68

Executive Director
− Executive Director’s annual report (Hoyt), 99, 12:19
− Looking forward (Hoyt), 99, 1:7 (advances and challenges in surgery); 2:8 (sustainable growth rate); 3:8 (Military Advanced Training Center); 4:8 (Transition to Practice Program); 5:8 (trends in surgical procedures); 6:7 (funding ACS programs); 7:7 (Medical Directors in Washington office); 8:9 (Leadership Development Program); 9:8 (Codman memorial); 10:8 (Dr. Russell); 11:8 (Education and Training campaign); 12:6 (accomplishments in 2013–2014)

Fellows and Members (see also: AMERICAN COLLEGE OF SURGEONS: Awards)
− Apply for ACS Fellowship and take the next big step in your career, 99, 9:83
− Dr. Hall appointed co-chair of NQF Admissions and Readmissions Committee, 99, 6:79
− Dr. Ko appointed to NQF Surgery Standing Committee, 99, 7:61
− Dr. Mattox receives AMA award for citizenship and community service, 99, 1:65
− Dr. Sachdeva delivers Ira A. Ferguson, MD, Lecture at Emory, 99, 6:79
− Dr. Sachdeva elected vice-president of the Society for Academic Continuing Medical Education, 99, 7:61
− Drs. Warshaw and Shah accorded RCSEd Honorary Fellowships, 99, 6:75
− From residency to retirement: Remembering Hank (Bahnson), 99, 5:43
− Melina Kibbe, MD, FACS, appears on 60 Minutes segment, 99, 4:59
− Members in the news, 99, 1:66, 8:75, 11:74

Governors, Board of
− ACS Officers, Regents, and Board of Governors’ Executive Committee, 99, 1:38
− Board of Governors pillars improve productivity, communication: An update (Timmerman), 99, 9:78
− Call for nominations for ACS Board of Governors, 99, 1:67, 2:57
− Regents reelected and new Board of Governors Executive Committee installed, 99, 12:56

Honorary Fellowships
− Citation for Prof. Pierre-Alain Clavien, MD, PhD, FACS, FRCSEng, FRCSEd (Strasberg), 99, 11:62
− Citation for Prof. Alberto Raul Ferreres, MD, PhD, MPH, FACS (Ellison), 99, 11:63
− Citation for Prof. O. James Garden, BSc, MB, BCh, CBE, MD, FRCSGlas, FRCPEd, FRSE (Britt), 99, 11:64
− Citation for Prof. Toni Lerut, MD, PhD, MHP, FACS (Finley), 99, 11:65
− Citation for Prof. Chung-Mau Lo, MB, BS, FACS (Busuttil), 99, 11:66
− Citation for Prof. Edgar Rodas, MD, FACS (Merrell), 99, 11:67
− Six outstanding surgeons conferred Honorary Fellowship in the ACS, 99, 11:60
Subject index

In memoriam
- In memoriam: C. Barber Mueller, MD, FACS, FRCSC, recognized for contributions to the ACS and academic surgery (Numann), 99, 8:67
- In memoriam: Frank T. Padberg, Sr., MD, FACS: ACS department director, DSA recipient, and trailblazer in neurosurgery (Padberg, Jr.), 99, 6:73
- In memoriam: Thomas R. Russell, MD, FACS, remembered for his enduring contributions to the ACS (Pellegri, Schneidman), 99, 10:52

Informatics
- A new era begins for ACS online properties (Schwartz, Losby, Garneski), 99, 9:12

Inspiring Quality campaign
- ACS, Arizona health care leaders share successes, discuss challenges at IQ Forum, 99, 1:61
- ACS hosts Inspiring Quality Forum in Utah, 99, 12:59
- ACS Inspiring Quality Forum in South Carolina focuses on surgical checklists, 99, 6:77
- ACS, Iowa health care leaders at IQ Forum focus on rural surgery, 99, 9:76
- ACS, Ohio health care leaders identify tools for improving health care quality, patient outcomes, 99, 5:53
- Health care leaders focus on emergency and trauma care at Northern California IQ forum, 99, 3:49
- North Carolina IQ Forum participants identify challenges, opportunities in health care, 99, 4:68

Meetings
- 2014 Advocacy program: Attendees learn about traditions that influence legislative outcomes (Moye, Dwyer), 99, 6:65
- 2014 Leadership program: Emotional intelligence, mentoring are keys to effective performance (Perugini), 99, 6:58
- ACS to cosponsor seminar at SESC Scientific Meeting, 99, 2:55
- Building a global perspective at International Surgical Leaders forum (Moye), 99, 1:58
- COT to host 33rd Point/Counterpoint Surgery Conference June 1–4, 99, 2:53
- Register now for 2014 Rural Surgery Symposium, May 9–10, in Chicago, 99, 4:59

Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP)
- HealthLeaders Media: Accreditation improves bariatric outcomes, 99, 4:56

National Cancer Data Base (NCDB)
- Study shows secondary thyroid tumors more deadly in young people, 99, 5:57

Officers and staff
- ACS Officers, Regents, and Board of Governors’ Executive Committee, 99, 1:38
- Andrew L. Warshaw, MD, FACS, FRCSEd(Hon), installed as 95th President of the ACS, 99, 11:58
- Call for nominations for ACS Officers-Elect, 99, 1:67, 2:57
- Drs. Frank Opelka and Patrick Bailey join ACS leadership team, 99, 6:72
- J. David Richardson, MD, FACS, next President-Elect of the ACS, 99, 12:53

Operation Giving Back (see also: VOLUNTEERISM)
- College seeks Medical Director for Operation Giving Back, 99, 5:56

Presidential Address
- Presidential Address: Achieving our personal best—Back to the future of the American College of Surgeons (Warshaw), 99, 12:9

Regents, Board of
- ACS Officers, Regents, and Board of Governors’ Executive Committee, 99, 1:38
- Regents reelected and new Board of Governors Executive Committee installed, 99, 12:56

Research and Optimal Patient Care (see AMERICAN COLLEGE OF SURGEONS: American College of Surgeons National Quality Improvement Program and QUALITY)
- Resident and Associate Society of the American College of Surgeons (RAS-ACS) (see also: EDUCATION AND TRAINING and YOUNG SURGEONS)
- 2012 annual RAS-ACS essay contest: Treating the difficult patient, 99, 1S:5
- ACS Resident and Associate Society: Surgical care and training at the crossroads, 99, 8:12
- Accepting accountability and moving forward (Brownson), 99, 1:11
- Annual RAS-ACS essay contest: Dealing with surgical complications, 99, 1:9
- Avoid getting kicked (Jones), 99, 1S:10
- Coaching and mentoring modern surgeons (Economopoulos, Sun, Garvey, Hogan, Bazzarelli), 99, 8:30
- The “bionic” era: Exploring the use of advanced technology in surgery (Leland, Hoffman, King, Ahad) 99, 8:36
- Complications are shared experiences (Yi), 99, 1:16
- Consequences (Wright), 99, 1:15
- Doctor heal thyself...because we won’t (Schwartz), 99, 1S:13
- The evolution of the 21st century surgeon (Iyer, Grant, McNally, Mouawad, Spaniolas), 99, 8:42
- Familial ties in treating the difficult patient (Matthews), 99, 1S:6
- Finding my friend’s heart in the difficult patient (Moore), 99, 1S:12
- The five-year general surgery residency: Reform or revolution? (Leichtle, Kaoutzanis, Mouawad), 99, 8:49
- From residency to retirement: RAS-ACS International Exchange Scholarship Program provides unique opportunity for global collaboration (Mouawad, Iyer, Grant, Spaniolas), 99, 4:42
- How surgeons deal with complications: Introductory remarks (Winfield), 99, 1:10
- Making the transition from mentee to mentor (Winfield), 99, 8:13
- Mea maxima culpa—Dealing with surgical complications (Swain), 99, 1:14
- Patience with the difficult patient (Garcia), 99, 1S:9
- Pregnant with hematemesis (Donovan), 99, 1S:7
- Punched in the face (Sigman), 99, 1S:14
- RAS-ACS Symposium essays: Residents debate whether to reform or revolutionize surgical training (Wright), 99, 11:16
- RAS-ACS Symposium: First-place essay—reform: Reformation of current surgical residency and fellowship training is the best solution (Mohebali), 99, 11:23
- RAS-ACS Symposium: First-place essay—revolution: Surgical training: Time for a Revolution (Shenvi), 99, 11:17
- RAS-ACS Symposium: Second-place essay—reform: Revisiting the visions of Halsted, Churchill, and Dudley to fix surgical training a century later (Azoury), 99, 11:26
- RAS-ACS Symposium: Second-place essay—revolution: Five-year general surgery residency: Reform or revolution? (DuCoin), 99, 11:20
- Responding to, reflecting on, and moving forward from a surgical complication (Kim), 99, 1:12
- Surgical education and training at the crossroads between medical school and residency (Kulaylat, McKinley, Kenning, Zheng), 99, 8:24
- Talk it out, and slow it down (Serrano), 99, 1:13
- Treating the difficult patient can be a long journey (Kaplan), 99, 1S:11
- Treating the difficult patient may require stepping out of your comfort zone (Soans), 99, 1S:8
- What does the ACA mean for residents and their future practice? (Leichtle, Sangji, Ward, Iyer), 99, 8:17

Scholarships/fellowships
- 2013 International Surgical Education Scholar reports on experience in North America (Mshelbwala), 99, 7:75
- 2013 Traveling Fellow reports on trip to Australia and New Zealand (Baxter), 99, 1:78
- 2014 ACS Japan, Germany Traveling Fellows selected, 99, 2:71
- 2014 Australia-New Zealand, Japan, and German Exchange Travelers announced, 99, 8:82
- 2014 Claude H. Organ, Jr., MD, FACS, Traveling Fellow announced, 99, 10:74
- 2014 Health Policy Scholars announced, 99, 6:87
- 2014 International ACS NSQIP Scholarship applications due February 14, 99, 1:76
- 2014 international scholars and awardees selected, 99, 2:70
- 2014 Oweida Scholar announced, 99, 7:67
- 2014 Traveling Fellow to Germany reports on experiences (Farman), 99, 11:81
- ACS accepting applications for Oweida Scholarship, 99, 11:78
- ACS/ANZ Traveling Scholar reports on trip to Singapore and Australia (Zhou), 99, 8:84
- ACS Faculty Research Fellowships awarded to five surgeons, 99, 5:70
- ACS offering International Scholarships for surgical education, 99, 3:57
- Applications being accepted for the ACS Traveling Fellowship to Japan for 2015, 99, 4:71
- Applications for 2015 ACS Traveling Fellowship to Germany now being accepted, 99, 3:59
| Applications for ACS/Triological Society Award due in May, 99, 3:58 |
| Applications for Resident Research Scholarships due September 2, 99, 8:83 |
| Applications now being accepted for 2015 Faculty Research Fellowships honoring ACS leaders, 99, 9:88 |
| Apply by February 2 for 2015 health policy management scholarships, 99, 11:80 |
| Apply by July 1 for 2015 ACS Community Surgeon Travel Awards, 99, 6:89 |
| Apply now for 2016 ANZ, Germany, Japan traveling fellowships, 99, 10:73 |
| Claude H. Organ, Jr., MD, FACS, Traveling Fellow reports on experience in India (Chagpar), 99, 10:7 |
| Clowes Award offered to promising surgical investigator, 99, 7:69 |
| First Carlos Pellegrini Traveling Fellow reports on experience (Poon), 99, 7:64 |
| From residency to retirement: RAS-ACS International Exchange Scholarship Program provides unique opportunity for global collaboration (Mouawad, Iyer, Grant, Spaniolas), 99, 4:42 |
| Inaugural Murray F. Brennan, MD, FACS, International Guest Scholar provides report, (Howle), 99, 7:70 |
| International Guest Scholarships: An investment in surgical training around the globe (Peregrin), 99, 5:16 |
| July 1 deadline to apply for 2015 International Guest Scholarships, 99, 6:90 |
| New award available for hand surgery research, 99, 11:79 |
| Regents award six Resident Research Scholarships for 2014, 99, 5:71 |
| Report of the 2014 ACS Traveling Fellow to Japan (Mullen), 99, 9:90 |
| Resident Research Scholarship change, 99, 8:87 |
| Scholars in Residence Program benefits surgical residents and the ACS (Bilimoria, Ko), 99, 3:55 |

**Statements**

- Statement on advance directives by patients: “Do Not Resuscitate” in the operating room, 99, 1:42
- Statement on bicycle safety and the promotion of bicycle helmet use, 99, 9:45
- Statement on the effects of tobacco use on surgical complications and the utility of smoking cessation counseling, 99, 8:55
- Statement on intimate partner violence, 99, 9:46
- Statement on older adult falls and falls prevention, 99, 9:47
- Statement on peak performance and management of fatigue, 99, 8:53

**Trauma (see also: TRAUMA)**

- 2014 Residents Trauma Papers Competition winners announced, 99, 6:80
- ACS-supported trauma legislation discussed at press conference, 99, 10:58
- ACS Trauma Program reaches milestone: 400 center verifications, 99, 3:54
- COT to host 33rd Point/Counterpoint Surgery Conference June 1–4, 99, 2:53
- NTDB® data points: 2013 Pediatric Report: Pediatric consumers (Fantus, Nance), 99, 2:49
- NTDB® data points: Annual Report 2013: Where did they go? (Fantus, Nance) 99, 1:55
- NTDB® data points: BYOB helmet (Fantus), 99, 8:61
- NTDB® data points: The DTs: Delirium tremens (Fantus), 99, 11:56
- NTDB® data points: Don’t chance it: Use your seatbelt (Fantus), 99, 9:63
- NTDB® data points: Flotation devices—Mae West style (Fantus), 99, 6:56
- NTDB® data points: Go before you go: Bladder injuries (Fantus, Fantus), 99, 12:51
- NTDB® data points: Residential institutions (Fantus), 99, 5:51
- NTDB® data points: To protect your children, keep your pool safe (Fantus, Nance), 99, 7:58
- NTDB® data points: Top 10 list (Fantus), 99, 4:53
- NTDB® data points: Unanticipated withdrawal (Fantus), 99, 10:48
- NTDB® data points: Zero tolerance (Fantus), 99, 3:43
- Ronald M. Stewart, MD, FACS, to head Committee on Trauma, 99, 1:57

**Young Fellows Association**

- First YFA Essay Contest winner: The promise of a profession lies within us (Lee), 99, 10:30
- The YFA Essay Contest: Introduction (Farrokhi), 99, 10:29
- YFA essay submissions, “Promise of a profession,” due May 1, 99, 3:54
Subject index

A

AMERICAN MEDICAL ASSOCIATION
The debate continues: ACS at the AMA House of Delegates (Armstrong, Sutton), 99, 3:47
Dr. Mattox receives AMA award for citizenship and community service, 99, 1:65
Surgeons influence AMA policy (Armstrong, Sutton), 99, 9:73

B

BARIATRIC SURGERY (see also: AMERICAN COLLEGE OF SURGEONS: Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program [MBSAQIP])
Georgia coalition develops bariatric surgery pilot project (Browning), 99, 12:35
HealthLeaders Media: Accreditation improves bariatric outcomes, 99, 4:56

C

CANCER (see also: AMERICAN COLLEGE OF SURGEONS: Commission on Cancer and AMERICAN COLLEGE OF SURGEONS: Alliance/ACS Clinical Research Program)
Study shows secondary thyroid tumors more deadly in young people, 99, 5:57

CLINICAL TRIALS (see also: AMERICAN COLLEGE OF SURGEONS: Alliance/ACS Clinical Research Program)
2013 Clinical Trials Methodology Course provides opportunity for learning and networking (Itani), 99, 2:54

CURRENT PROCEDURAL TERMINOLOGY (CPT) (see: PRACTICE MANAGEMENT and REIMBURSEMENT)

D

DISASTER MANAGEMENT
Lessons in collaboration: New York surgeons look back at Superstorm Sandy (Khitani, Barrett, Bholat, DeGliuomini, Wallack), 99, 10:10
Liability reforms needed to provide timely care to disaster victims (Sangji, Sutton, McDonald, Weireter, Jr.), 99, 5:10

E

EDITORIAL
Looking forward (Hoyt), 99, 1:7 (advances and challenges in surgery); 2:8 (sustainable growth rate); 3:8 (Military Advanced Training Center); 4:8 (Transition to Practice Program); 5:8 (trends in surgical procedures); 6:7 (funding ACS programs); 7:7 (Medical Directors in Washington office); 8:9 (Leadership Development Program); 9:8 (Codman memorial); 10:8 (Dr. Russell); 11:8 (Education and Training campaign); 12:6 (accomplishments in 2013–2014)

EDUCATION AND TRAINING
The ACS Accredited Education Institutes Fellowship Program: Training leaders in simulation-based education (Sweet, Goldman, Johnson), 99, 7:17
ACS Resident and Associate Society: Surgical care and training at the crossroads, 99, 8:12
The “bionic” era: Exploring the use of advanced technology in surgery (Lelan, Hoffman, King, Ahad), 99, 8:36
Coaching and mentoring modern surgeons (Economopoulos, Sun, Garvey, Hogan, Bazzarelli,), 99, 8:30
The e-volution of the 21st century surgeon (Iyer, Grant, McNally, Mouawad, Spaniolas), 99, 8:42
FLS: Celebrating a decade of innovation in surgical education (Brunt), 99, 11:10
First YFA Essay Contest winner: The promise of a profession lies within us (Lee), 99, 10:30
The five year general surgery residency: Reform or revolution? (Leichtle, Kaoutzianis, Mouawad), 99, 8:49
Making the transition from mentee to mentor (Winfeld), 99, 8:13
RAS-ACS Symposium essays: Residents debate whether to reform or revolutionize surgical training (Wright), 99, 11:16
RAS-ACS Symposium: First-place essay—reform: Reform of current surgical residency and fellowship training is the best solution (Mohebali), 99, 11:23
RAS-ACS Symposium: First-place essay—revolution: Surgical training: Time for a Revolution (Shenvi), 99, 11:17
RAS-ACS Symposium: Second-place essay—reform: Revisiting the visions of Halsted, Churchill, and Dudley to fix surgical training a century later (Azoury), 99, 11:26

RAS-ACS Symposium: Second-place essay—revolution: Five-year general surgery residency: Reform or revolution? (DuCoin), 99, 11:20

Surgical education and training at the crossroads between medical school and residency (Kulaylat, McKinley, Kenning, Zheng), 99, 8:24

Surgical training abroad: It’s not about the cases (Cloyd, Wren), 99, 9:42

What does the ACA mean for residents and their future practice? (Leichtle, Sangji, Ward, Iyer), 99, 8:17

The YFA Essay Contest: Introduction (Farrokhi), 99, 10:29

YFA essay submissions, “Promise of a profession,” due May 1, 99, 3:54

ELECTRONIC HEALTH RECORDS (see also: LEGISLATION: Federal)

What surgeons should know about... Avoiding the 2015 Medicare EHR Incentive Program penalty (Gokak), 99, 6:48

ETHICS

Distinguishing QI projects from human subjects research: Ethical and practical considerations (Raval, Sakran, Medbery, Angelos, Hall), 99, 7:21

Transplant in a patient with comorbid psychiatric illness: An ethical dilemma (Boyum, Brown, Zihni, Keune, Hong, Kodner, Ray), 99, 11:40

EVIDENCE-BASED MEDICINE (see: QUALITY OF CARE and VALUE-BASED CARE)

GLOBAL HEALTH CARE

Building a global perspective at International Surgical Leaders forum (Moye), 99, 1:58

Dispatches from rural surgeons: Rural surgery is a global issue: The perspective of an Argentine surgeon (Ledesma, Hughes, Pellegrini, Puls), 99, 4:38

Founding surgeon reflects on 25 years of UNICAR, the Guatemalan Heart Institute (Robicsek), 99, 9:38

From residency to retirement: RAS-ACS International Exchange Scholarship Program provides unique opportunity for global collaboration (Mouawad, Iyer, Grant, Spaniolas), 99, 4:42

Lancet Commission on Global Surgery convenes, 99, 2:52

Preoperative telemedicine evaluation of surgical mission patients: Should we use it routinely? (Latifi, Mora, Bekteshi, Rivera), 99, 1:17

Surgical training abroad: It’s not about the cases (Cloyd, Wren), 99, 9:42

Teaching the teacher: An ethical model for international surgical missions (Selim), 99, 6:17

World Innovation Summit for Health provides a global perspective on surgery (Keown, Al-Thani, Al-Dafa, Pellegrini, Darzi), 99, 6:13

GUIDELINES AND STANDARDS (see also: THE JOINT COMMISSION)

Surgeons, anesthesiologists develop resource standards for optimal pediatric care, 99, 4:57

HEALTH CARE REFORM (see: LEGISLATIVE AND GOVERNMENT ISSUES, REIMBURSEMENT, and VALUE-BASED CARE)

Dual eligible beneficiaries: Roles for surgeons under health care reform (Murthy, Weissman, Grabowski, McDonald, Kaups, Meara), 99, 4:10

Health care entitlement reform: A look at the future, 99, 2:10

Implementation of the ACA: Turning federal law into state-level reality (Ackerman, Rosen), 99, 5:23

Medicaid expansion likely to affect the delivery of surgical care (Raykar, Mandigo, Nagengast, Coftron, Hanks, Meara, Tracci), 99, 3:10

Medicare reform: A look at the House Ways and Means proposal (Sangji, Hedstrom, Meara, Martin), 99, 2:11

Merging Medicare Parts A and B: Potential effects on beneficiaries, surgeons, and other stakeholders (Gutnik, Smith, Goldszer, Bailey, Meara), 99, 2:19

HISTORY (see also: AMERICAN COLLEGE OF SURGEONS: Archives)

Headstone honoring Ernest A. Codman, MD, FACS, placed at Mount Auburn Cemetery, 99, 9:72

Hugh Agnew Gamble, MD, FACS: A legacy to the College (Trotter), 99, 12:43
IN MEMORIAM (see: AMERICAN COLLEGE OF SURGEONS: In memoriam)

INFORMATICS (see also: AMERICAN COLLEGE OF SURGEONS: Informatics)

The ACS Accredited Education Institutes Fellowship Program: Training leaders in simulation-based education (Sweet, Goldman, Johnson), 99, 7:17

Dispatches from rural surgeons: ACS rural listserv: An “underdog” success story (Caropreso), 99, 7:48

Preoperative telemedicine evaluation of surgical mission patients: Should we use it routinely? (Latifi, Mora, Bekteshi, Rivera), 99, 1:17

Surgeons see future applications for Google Glass (Peregrin), 99, 7:9

What surgeons should know about...Avoiding the 2015 Medicare EHR Incentive Program penalty (Gokak), 99, 6:48

THE JOINT COMMISSION

A look at The Joint Commission: Action urged to prevent retained surgical items, 99, 1:53

A look at The Joint Commission: Blameless or blame-worthy errors: Does your organization make a distinction?, 99, 3:41

A look at The Joint Commission: Hospital Engagement Networks target surgical site infections, 99, 11:54

A look at The Joint Commission: JCI can be a resource for patients receiving care abroad, 99, 9:61

A look at The Joint Commission: The Joint Commission reports increase in robotic surgery- related sentinel events, 99, 10:46

A look at The Joint Commission: National Time Out Day focuses on every patient, every time, 99, 6:54

A look at The Joint Commission: New draft guideline to prevent SSI, 99, 8:59

A look at The Joint Commission: Physicians invited to play a larger role in standards process, 99, 4:51

A look at The Joint Commission: Physicians play important role in on-site survey process, 99; 5:49

A look at The Joint Commission: Renewed awareness of infection control during surgery, 99, 7:56

A look at The Joint Commission: Updated compendium of strategies to prevent health care-associated infections, 99, 12:49

LEADERSHIP

2014 Leadership program: Emotional intelligence, mentoring are keys to effective performance (Peregrin), 99, 6:58

Building a global perspective at International Surgical Leaders forum (Moye), 99, 1:58

Chapter leadership succession planning helps to build stronger chapters (Rioux), 99, 4:65

Health policy program produces surgeon advocates and leaders (Steinberg, Zinner, Ellison), 99, 3:22

LEGISLATIVE AND GOVERNMENT ISSUES (see also: MEDICARE/MEDICAID, PROFESSIONAL LIABILITY, and REIMBURSEMENT)

Affordable Care Act

–Implementation of the ACA: Turning federal law into state-level reality (Ackerman, Rosen), 99, 5:23

–Preparing for implementation of the Physician Payments Sunshine Act (Ollapally), 99, 3:28

–Trauma and emergency care under the Affordable Care Act (Sangji, McDonald), 99, 4:20

–What surgeons should know about...The Patient-Centered Outcomes Research Institute (Sage), 99, 10:35

–What surgeons should know about...Physician Payments Sunshine Act data scheduled for release (Agrawal), 99, 9:48

Federal

–Liability reforms needed to provide timely care to disaster victims (Sangji, Sutton, McDonald, Weireter, Jr.), 99, 5:10

State

–Liability reform, scope of practice, trauma topped state legislative agendas in 2014 (Ackerman, 99, 12:37

–Northern California Chapter engages in ongoing legislative activities (Kaups, Maa, Garry, Upadhyaya, Hindsdale), 99, 3:51

–Preserving MICRA and patient access to surgical care in California (Maa, Sutton), 99, 10:60
Subject index

–Reading the tea leaves for state legislatures in 2014 (Sutton), 99, 1:24

LIFESTYLES
And the beat goes on: Surgeons take a break from the OR to play in rock bands (Glickson), 99, 6:24

MEDICARE/MEDICAID (see: ELECTRONIC HEALTH RECORDS and REIMBURSEMENT)
MILITARY SURGERY (see: TRAUMA)

OPERATING ROOM ENVIRONMENT
The SAGES FUSE program: Bridging a patient safety gap (Fuchshuber, Robinson, Feldman, Jones, Schwatzberg), 99, 9:18

OUTCOMES (see: QUALITY OF CARE and VALUE-BASED CARE)

PATIENT EDUCATION AND PROTECTION (see also: THE JOINT COMMISSION, OPERATING ROOM ENVIRONMENT, and QUALITY OF CARE)
ACS commemorates 50-year anniversary of Surgeon General’s report on smoking and health (Greene, Johnstone, Strand), 99, 8:69

PERFORMANCE MEASUREMENT (see: AMERICAN COLLEGE OF SURGEONS: National Surgical Quality Improvement Program and THE JOINT COMMISSION and MEDICARE/MEDICAID and QUALITY OF CARE)

PRACTICE MANAGEMENT (see also: QUALITY OF CARE and REIMBURSEMENT)
The benefits of PQRS participation and what the College is doing on your behalf (Mabry, Gokak), 99, 9:28
Coding and practice management corner: Frequently asked questions about coding for breast surgery (Barney, Savarise, Whitacre), 99, 9:52
From residency to retirement: Surgeons as employees: Is the lining always golden? (Copeland), 99, 1:48
What surgeons should know about...Avoiding the 2015 Medicare EHR Incentive Program penalty (Gokak), 99, 6:48
What surgeons should know about...The benefits of attending a 2014 ACS Surgical Coding Workshop, 99, 1:44

PROFESSIONAL LIABILITY
Liability reforms needed to provide timely care to disaster victims (Sangji, Sutton, McDonald, Weireter, Jr.), 99, 5:10

PROFESSIONALISM
2012 annual RAS-ACS essay contest: Treating the difficult patient, 99, 1S:5
Adverse behaviors and their effect on credentialing and licensure (Bechamps, Kurtzman), 99, 10:32
Avoid getting kicked (Jones), 99, 1S:10
Doctor heal thyself...because we won’t (Schwartz), 99, 1S:13
Familial ties in treating the difficult patient (Matthews), 99, 1S:6
Finding my friend’s heart in the difficult patient (Moore), 99, 1S:12
Patience with the difficult patient (Garcia), 99, 1S:9
Pregnant with hematemesis (Donovan), 99, 1S:7
Punched in the face (Sigman), 99, 1S:14
Treating the difficult patient can be a long journey (Kaplan), 99, 1S:11
Treating the difficult patient may require stepping out of your comfort zone (Soans), 99, 1S:15
Under your nose (Fayanju), 99, 1S:8

QUALITY OF CARE (see also: AMERICAN COLLEGE OF SURGEONS: Inspiring Quality campaign; and AMERICAN COLLEGE OF SURGEONS: National Surgical Quality Improvement Program; and HEALTH CARE REFORM)
Accepting accountability and moving forward (Brownson), 99, 1:11
The aging surgeon: When is it time to leave active practice? (Garrett, Kaups), 99, 4:32
Annual RAS-ACS essay contest: Dealing with surgical complications, 99, 1:9
Complications are shared experiences (Yi), 99, 1:16
Consequences (Wright), 99, 1:15
Distinguishing QI projects from human subjects research: Ethical and practical considerations (Raval, Sakran, Medbery, Angelos, Hall), 99, 7:21
From residency to retirement: The quest for safe surgical care: Are we missing the obvious? (Shuhaiber), 99, 2:42
How surgeons deal with complications: Introductory remarks (Winfield), 99, 1:10
Is your office helping you prevent wrong site surgery? (Clarke), 99, 4:28
Mea maxima culpa—Dealing with surgical complications (Swain), 99, 1:14
New program aims to improve quality of surgical care in Illinois, 99, 2:51
Presidential Address: Achieving our personal best—Back to the future of the American College of Surgeons (Warshaw), 99, 12:9
Responding to, reflecting on, and moving forward from a surgical complication (Kim), 99, 1:12
Talk it out, and slow it down (Serrano), 99, 1:13
Vascular practice develops night float call system to improve attending well-being without decreasing productivity (Chambers, Wolk, Mansour, Cuff, Slaikeu, Wong, Mix), 99, 5:30
What surgeons should know about...The Patient-Centered Outcomes Research Institute (Sage), 99, 10:35
REGULATORY ISSUES (see: LEGISLATIVE/GOVERNMENT ISSUES)
REIMBURSEMENT (see also: PRACTICE MANAGEMENT)
2014 fee schedule and CPT code changes will affect surgical practice (Barney, Gokak, Jackson, Savarise, Sage, Ollapally), 99, 2:27
Coding and practice management corner: Frequently asked questions about coding for breast surgery (Barney, Savarise, Whitacre), 99, 9:52
Coding and practice management corner: Reporting patient safety indicator-15 (Barney, Mabry, Ollapally, Savarise, Senkowski), 99, 5:39
Dispatches from rural surgeons: ACS intervenes to resolve questions about the 96-hour rule (Savarise), 99, 10:40
Gundersen Health System studies effect of modifier 22 on reimbursement for complex operations (Jarman, Georgieff, Kallies, Mathiason), 99, 3:31
Optimizing the OR for bundled payments: A case study (Bosco, Shah, Iorio, Slover, Torrance), 99, 11:29
Preparing for implementation of the Physician Payments Sunshine Act (Ollapally), 99, 3:28
The SGR repeal: How bad politics ruined sound policy (Hedstrom), 99, 6:9
What surgeons should know about... Avoiding the 2015 Medicare EHR Incentive Program penalty (Gokak), 99, 6:48
What surgeons should know about...Billing for services performed by nonphysician practitioners (Barney, Nicoletti, Savarise), 99, 5:36
What surgeons should know about...The FY 2015 Inpatient Prospective Payment System final rule (Agrawal, Sage, Ollapally), 99, 11:45
What surgeons should know about...The ICD-10 delay (Gokak), 99, 7:46
What surgeons should know about...The Measure Applications Partnership (Sage), 99, 4:36
What surgeons should know about...PQRS reporting in 2014 (Gokak), 99, 3:37
What surgeons should know about...Repealing the SGR (Hedstrom), 99, 2:39
RESIDENTS (see: AMERICAN COLLEGE OF SURGEONS: Resident and Associate Society of the American College of Surgeons (RAS-ACS) and EDUCATION AND TRAINING)
RETIREMENT ISSUES
The aging surgeon: When is it time to leave active practice? (Garrett, Kaups), 99, 4:32
RURAL SURGERY
Dispatches from rural surgeons: ACS intervenes to resolve questions about the 96-hour rule (Savarise), 99, 10:40
Dispatches from rural surgeons: ACS rural listserv: An “underdog” success story (Caropreso), 99, 7:48
Dispatches from rural surgeons: Rural surgery is a global issue: The perspective of an Argentine surgeon (Ledesma, Hughes, Pellegrini, Puls), 99, 4:38
Dispatches from rural surgeons: Students need exposure to the joys of rural surgery (Swendiman), 99, 1:46
Register now for 2014 Rural Surgery Symposium, May 9–10, in Chicago, 99, 4:59
Subject index

S

SOCIAL MEDIA (see: INFORMATICS)

SPECIALTIES

ACS and other specialty surgical organizations release *Physicians as Assistants at Surgery* report, 99, 1:64

T

TECHNOLOGY (see: EDUCATION AND TRAINING and INFORMATICS)

TRAUMA (see also: AMERICAN COLLEGE OF SURGEONS: Trauma, and DISASTER MANAGEMENT)

ACS-supported trauma legislation discussed at press conference, 99, 10:58
ACS supports December *Health Affairs* theme issue on emergency care, 99, 2:53
Hartford Consensus in action: Law enforcement gets equipment, training to control bleeding, 99, 4:55
Liability reforms needed to provide timely care to disaster victims (Sangji, Sutton, McDonald, Weireter, Jr.), 99, 5:10
Trauma and emergency care under the Affordable Care Act (Sangji, McDonald), 99, 4:20

V

VALUE-BASED CARE (see also: QUALITY OF CARE)

*HealthLeaders Media*: Accreditation improves bariatric outcomes, 99, 4:56
Register now for 2014 Outcomes Research Course, December 4–6, in Chicago, 99, 10:63

VOLUNTEERISM

Fellows honored for volunteerism (Rose), 99, 9:67
Past recipients of the ACS/Pfizer Surgical Volunteerism and Humanitarian Awards: Where are they now? (Rose, Sanders), 99, 10:24
Preoperative telemedicine evaluation of surgical mission patients: Should we use it routinely? (Latifi, Mora, Bekteshi, Rivera), 99, 1:17
Teaching the teacher: An ethical model for international surgical missions (Selim), 99, 6:17

W

WORKFORCE ISSUES

Vascular practice develops night float call system to improve attending well-being without decreasing productivity (Chambers, Wolk, Mansour, Cuff, Slaikeu, Wong, Mix), 99, 5:30
Will acute care surgery and surgicalists help to avert an emergency care crisis? (Slappy, Sweeney, O’Shea, Maa), 99, 2:34

Y

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 www.facs.org/events or http://web2.facs.org/ChapterMeetings.cfm.

### DECEMBER

**Brooklyn-Long Island Chapter**  
December 3  
Uniondale, NY  
Contact: Teresa Barzyz, acsteresa@aol.com, www.bliacs.org

**China-Hong Kong Chapter**  
December 5  
Hong Kong, China  
Contact: John Wong, jwong306@gmail.com

**Massachusetts Chapter**  
December 6  
Worcester, MA  
Contact: Elizabeth Chouinard, echouinard@prri.com, www.mcacs.org

**New Jersey Chapter**  
December 6  
Iselin, NJ  
Contact: Andrea Donelan, njsurgeons@aol.com, www.nj-acs.org

**Montana and Wyoming, Idaho Chapters**  
January 23–25  
Big Sky, MT  
Contact: Cyan R. Sportsman, csportsman@msurgical.com

**South Florida Chapter**  
January 26  
Fort Lauderdale, FL  
Contact: Bill Bouck, bill@bouckmgmt.com, www.sfc-acs.org

**Iran Chapter**  
January 28–30  
Kish Island, Iran  
Contact: H. Kalbasi, h_kalbasi@yahoo.com

**Patient-Reported Outcomes in Surgery**  
January 29–30  
ACS 20 F Street Conference Center, Washington, DC  
Contact: Katie Sommers, ksommers@plasticsurgery.org, www.thespf.org

### MARCH

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

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

### FEBRUARY

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

### FUTURE CLINICAL CONGRESSES

- **2015**  
  October 4–8  
  Chicago, IL

- **2016**  
  October 16–20  
  Washington, DC

- **2017**  
  October 22–26  
  San Diego, CA