The SGR repeal:

How bad politics ruined sound policy
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continued on next page

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The American College of Surgeons (ACS) is a complex, multifaceted, ever-growing organization, which manages a diverse range of programs and services designed to help surgeons provide their patients with the highest-quality care. Many of these programs are quite costly, and the revenue brought in through dues and program participation fees barely covers the costs associated with maintaining the organization’s initiatives, let alone producing an investment for further expansion.

ACS dues
Many Fellows assume that their dues dollars cover at least most of the College’s costs and programs. The reality is that dues account for approximately 22 percent of the ACS’ revenue. (See the figure on page 8 for a chart that displays College revenue sources and amounts for 2008–2013.) The money that the College brings in through dues largely goes toward ongoing projects and programs, such as advocacy, the Bulletin, the Advisory Councils, and so on, with very little left for educational programming or other quality initiatives.

It also is important to note that the number of dues-paying members has declined in recent years. This drop is partly a product of the Baby Boomers entering into retirement and attaining senior status within the organization. Senior Fellows are exempt from paying dues. Furthermore, younger surgeons who are members of Generation X have been less inclined to join organizations, putting an extra strain on those programs that are dues-supported.

Nonetheless, the number of Initiates last year was among the highest in the College’s 100-plus-year history. So, it is possible this trend is beginning to reverse as more young surgeons become aware of the many rewards associated with ACS Fellowship, including access to excellent educational programs, a patient-centered health policy and advocacy agenda, proven quality improvement programs, and so on.

Other sources of revenue
In recent years, ACS Quality Programs have contributed significantly to the College’s revenue stream. For example, the ACS National Surgical Quality Improvement Program (ACS NSQIP®) and the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program charge participating hospitals and other institutions an annual fee, which covers some but not all of the costs of running the databases, processing and analyzing the information, and assisting the facilities in applying the information to improve patient outcomes.

Clinical Congress brings in some money through exhibitor fees, ad sales, and the nominal admission fees that we have been charging attendees since 2009. Unfortunately, however, industry sponsorship has declined considerably in recent years. These reductions are attributable in part to the merger of many pharmaceutical and device manufacturers, meaning that there are simply fewer companies exhibiting and paying for ads in the Clinical Congress Program Book and the on-site newspaper. As a result, and to ensure that the Clinical Congress remains the premier surgical meeting that it always has been, we have been forced to occasionally increase registration fees.

The College also charges for some of its products, including various manuals we produce, webinars, educational CDs and DVDs, Selected Readings in General Surgery, and other offerings. As the chart indicates, these sales account for a small portion of the College’s revenue—some years more than Clinical Congress and other years less.

The final category in the chart centers on the College’s endowment. The revenues for this part of the College’s finances are derived from contributions and profits from other programs that contribute to ACS mission-aligned initiatives. Examples include investment in programs or initiatives that are exploratory for some future product or program, which may eventually have a revenue or funding source. However, many of these initiatives are unfunded. During product development, those program profits are needed to invest in and maintain the competitive edge for the product/program.

Fortunately, the significant decline in investment returns and market value during 2008 and 2009, and the resulting three-year impact due to the 36-month average calculation for the 5 percent endowment spending, are behind us. However, we still are left with smaller investment returns in this slow economy, restraining any growth in non-funded, mission-related initiatives.
The ACS Foundation

Clearly, dues revenue and industry contributions alone are insufficient to ensure the longevity and proliferation of many of these programs. Many College programs are supported solely through contributions to the ACS Foundation. Your contributions to the Sustaining Fund directly support the future of surgery by providing funding for scholarships, including the work of the Clinical Scholars in Residence, Operation Giving Back, patient education, trauma education and research, lectureships, fellowship awards, and other non-revenue-generating programs, such as the Surgeon Specific Registry.

A total of 11,732 of you, or approximately 15 percent of the ACS Fellows, have made a contribution to the College at some point. The number of contributors per year, however, is much smaller. In fiscal year (FY) 2013, for example, only 1,079 ACS Members (approximately 1 percent) contributed to the Foundation: 195 made donations of $1,000 or more, 76 gave $500 to $999, and 808 contributed $499 or less. Total gift income for FY 2013 was $1,829,707, whereas total expenditures from current and invested philanthropic funds were $2,983,367. (For details, see excerpts from the Foundation Annual Report, pages 30–47 of this issue).

I realize that many surgeons have considerable financial obligations, including paying off their student loans, paying for their children’s education, membership fees for other professional and social organizations, and so on. Many surgeons also are concerned about declining reimbursement and rising practice expenses.

However, I also know from conversations with ACS Members how much you value many of the programs mentioned previously that are supported through your contributions to the Foundation. Therefore, I encourage you to consider giving your financial support to the Foundation. To foster increased participation, the Foundation offers a variety of ways to give, depending on individual giving capacity: adding a donation to dues payments, multi-year pledges, and gifts through a will or an estate. Each investment makes an impact and will help to ensure the longevity and growth of these important programs and initiatives—all of which enable ACS Fellows to provide the finest care to surgical patients. ♦

If you have comments or suggestions about this or other issues, please send them to Dr. Hoyt at lookingforward@facs.org.
The SGR repeal:
How bad politics ruined sound policy
by John Hedstrom, JD
On April 1, President Barack Obama signed The Protecting Access to Medicare Act, P.L. 113-93, which contained yet another “doc fix,” or a one-year, short-term patch to the Medicare sustainable growth rate (SGR) formula, which the Centers for Medicare & Medicaid (CMS) uses to calculate physician payments and control health care spending.1 Gone was the potential to permanently repeal the SGR; partisan, election-year politics proved too difficult to overcome. The patch averts a 24.1 percent Medicare physician payment cut that was scheduled to take effect on April 1, 2014, and expires March 31, 2015. The American College of Surgeons (ACS) and most other national surgical and physician organizations have always opposed short-term patches and favored true, sustainable reform.

In addition to postponing the payment cut, the legislation comprises several other notable provisions, including the following:

• A 0.5 percent positive update to Medicare payments through December 31, 2014; rates are then frozen until March 31, 2015

• Delayed implementation of the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10), from October 1, 2014, to October 1, 2015

• A call for CMS to address misvalued physician service codes in 2017 through 2020 to produce approximately $4 billion in savings, which is about 25 percent of the cost of the short-term patch

The College’s immediate reaction to the proposed legislation was a strong rebuke and an all-out push to defeat the bill—the last highlighted provision means physicians, for the first time, will be forced to cover some of the costs of the patch. Because of the efforts of the College and other national and state physician organizations, the leadership in the House of Representatives was forced to delay a vote on the bill due to substantial opposition among the Republican and Democratic rank and file.

Behind-the-scenes political maneuverings by the House leadership, however, led to the bill’s passage. The House leadership—Republican and Democratic—agreed to pass the legislation via voice vote and not a recorded vote. Voice votes are usually only executed on noncontroversial bills; yet in 20 seconds, the House passed the contentious short-term patch on March 28. The Senate followed suit, passing companion legislation on March 31.

Congress has now spent nearly $170 billion on 17 short-term patches over the last decade, a price tag well above the current estimated cost to permanently repeal the SGR.

Missed opportunity

Perhaps the most troubling aspect of Congress’ decision to pass the temporary patch is that it delays action on legislation that offers a long-term solution to the problems associated with the SGR. On February 6, Congress reached a bipartisan, bicameral agreement on how to repeal the SGR and reform of the Medicare physician payment system. The SGR Repeal and Medicare Provider Payment Modernization Act of 2014 (the SGR Repeal Act), S. 2000/H.R. 4015, is the product of a yearlong, collaborative effort between Congress and key stakeholders, including the College.2 The ACS issued a letter voicing its strong support of the legislation and pushed for the bill’s passage as a means to permanently rid the Medicare physician payment system of the flawed SGR.3

Good policy then met with Washington politics, and invocation of inside-the-Beltway jargon and practices like “paygo,” the “Hastert rule,” and “filibuster” took place. Paygo, a shortened form of “pay-as-you-go,” is a budget rule requiring that any spending increase be
paid for by a cut in mandatory spending. The Hastert Rule—named after its architect, former Speaker of the House Dennis Hastert (R-IL)—is also known as the “majority of the majority” rule, an informal governing principle used by Republicans that holds that the Speaker of the House will not allow a vote on a bill unless most of the majority party supports the bill. A filibuster is a term for any attempt to block or delay Senate action on a bill by debating it at length, offering numerous procedural motions, or engaging in other obstructive actions. At least 60 votes are necessary to end a filibuster and move to debate on the actual legislation.

For the SGR Repeal Act, under the paygo rule, Congress had to identify more than $140 billion in cuts, likely from other Medicare providers—hospitals, pharmaceutical and medical device companies, and nursing homes—or other parts of the Medicare program to pay for the SGR Repeal Act. Unfortunately, Congress is split along partisan lines, and the Republican House and Democratic Senate were unable to agree on offsets to pay for the SGR Repeal Act. Instead, leadership in each chamber elected to use partisan offsets for the legislation, guaranteeing that neither bill would pass in the other chamber.

On March 14, the House passed H.R. 4015 by a 238–181 vote, with 12 Democrats joining Republicans in voting for a bill offset by a five-year delay in the implementation of the individual mandate. The individual mandate satisfied both the paygo and Hastert rules but was a complete non-starter in the Senate. Instead, leadership in each chamber elected to use partisan offsets for the legislation, guaranteeing that neither bill would pass in the other chamber.

A closer look at the SGR Repeal Act

For more than a decade, an outdated SGR formula has repeatedly threatened patient access to care with drastic Medicare provider cuts. Therefore, despite the political setbacks that occurred this spring, the College and other members of the physician community remain committed to achieving passage of the SGR Repeal Act. Physicians kept their promise and united around sound policy reforms that will help build a more sustainable, fair, and efficient Medicare physician payment system. The SGR Repeal Act will help create a learning-based health care system focused on continually improving patient outcomes. These reforms will stabilize the Medicare program and transition the payment system to one in which health care professionals are reimbursed based on the quality and value of the care provided rather than the quantity of procedures, services, or tests ordered.

The ACS played an instrumental role in the composition of the final bill by strongly opposing bad policy and lobbying for necessary changes to the legislation. Specific policies that the College addressed in its advocacy efforts include:

- The inclusion of an annual positive payment update from 2014 to 2018, when the alternative offered was a 10-year freeze.
The ACS played an instrumental role in the composition of the final bill by strongly opposing bad policy and lobbying for necessary changes to the legislation.

- The removal of a proposed tiered/tournament model of redistributing payments under which positive bonus payments to higher-performing physicians would have to be equally offset by cuts to lower-performing physicians. In its place is an incentive program based on physicians achieving a threshold or benchmark, making it possible for all providers to attain positive incentive payments.

- The removal of a provision (and its accompanying 10 percent penalty for noncompliance) that directly targeted surgical service codes under the perception that the global payment for surgical procedures is overvalued and overpays surgeons.

- The inclusion of appropriate pathways for surgeons to develop, test, and participate in alternative payment models, such as the Clinical Affinity Groups proposed in the ACS Value-Based Update plan, and to take advantage of the positive, incentive-based program.°

The SGR Repeal Act has its imperfections; however, it does provide a path for the College to advocate from a position of strength in the future and not one of financial weakness. For more information on the policy contained in the SGR Repeal Act, refer to the College’s SGR frequently asked questions document available at http://www.facs.org/ahp/sgr-faq.pdf.

Post-election efforts: One last shot at repeal

The fight for passage of the SGR Repeal and Medicare Provider Payment Modernization Act—a bill that would benefit America’s seniors, and offers a long-term solution to stabilizing the SGR—continues as of press time. On the evening the patch was enacted, Rep. Michael Burgess, MD, (R-TX), the lead sponsor of H.R. 4015 and Vice-Chairman of the Energy and Commerce Subcommittee on Health, addressed the ACS 2014 Leadership & Advocacy Summit attendees and vowed to continue to seek passage of the SGR Repeal Act. He stated, “This is not the end of my efforts. I will continue to work on this issue. We are farther than we’ve ever been toward repealing and replacing the SGR.” In addition, Senate Finance Committee Chairman Ron Wyden (D-OR) stated that he will continue his efforts to pass permanent SGR repeal this year.

There is a lesson to be learned here—politics matter. Surgeons must be willing to use the profession’s political power to leverage policy and hold members of Congress accountable. ♦

REFERENCES
The inaugural World Innovation Summit for Health (WISH), which took place December 10–11, 2013, in Doha, Qatar, proved to be a galvanizing experience for the global health and global surgery communities.

More than 1,000 international delegates from 67 nations convened for the WISH program, protected from the fierce desert sun by the imposing silhouette of an 800-foot steel sidra tree at the Qatar National Conference Centre, Doha. The summit brought together key health care visionaries, including members of royal households, political leaders, and health and finance ministers. Prof. Lord Ara W. Darzi, MD, MB, ChB, FACS, director of the Institute of Global Health Innovation at the Imperial College London, U.K., and co-author of this article, organized the event, and Her Highness Sheikha Moza bint Nasser, chair of Qatar Foundation, was the host.

Joining them were world authorities from clinical practice, academia, and industry. The shared goal of this group was to examine and debate the key policy challenges facing organized health care systems today and to identify practices, products, services, and business model innovations with the potential to elicit meaningful and universal health care transformation across the world. WISH’s leadership made headway in charging these communities to take a shared and proactive role in tackling some of the most pressing health care challenges experienced around the world today.

by Oliver P. Keown, MB, ChB; Hassan Ali Al-Thani, MB, ChB, FRCS; Maryah B. Al-Dafa, MSc; Carlos A. Pellegrini, MD, FACS, FRCSI(Hon); and Ara W. Darzi, MD, MB, ChB, FACS
Global health care crisis
The global burden of surgical need cannot be overstated. Surgical issues ranging from trauma and road traffic injuries to the systems within which surgical services are delivered, along with the prudent use of antimicrobial drugs, have an enormous impact on the population, health, and economies of low-, middle- and high-income countries. Sadly, the inequities in access to surgical services and the disparities in quality of care have a disproportionate effect on the world’s poorest citizens.1,2

Across the globe, high-impact examples of innovative policies, technologies, business models, and services are available that could drive transformative health care system improvements and benefit patients if appropriately diffused and adopted. WISH sought to celebrate and focus the international community on the successes and future potential of some of the individuals and organizations leading these efforts.

Speakers and sessions
An impressive and articulate group of keynote speakers offered their expertise and evidence regarding the major issues in global health care ranging from the human and workforce resources required to support health care systems to the need to adapt existing innovations and technologies in response to the financial crisis. These lecturers included: Nobel Peace Prize recipient Daw Aung San Suu Kyi, chair of the National League for Democracy, Myanmar, Burma; Simon Stevens, president of the Global Health Division and executive vice-president, UnitedHealth Group, based in Minneapolis-St. Paul, MN; and John Dineen, president and chief executive officer, General Electric Healthcare, based in Fairfield, CT.

Panel discussions drew together leading authorities for lively and facilitated discussions across eight key themes: big data and health, accountable care, end-of-life and palliative care, mental health, antimicrobial resistance, patient engagement, obesity, and road traffic injuries. For each of these globally pertinent topics, a forum of high-profile leaders assembled up to a year in advance in an effort to draw expert consensus, scan the horizon for innovations, and develop high-impact and universally applicable recommendations.

Identifying and promoting innovations that have been proven to work and have a positive impact across geographies and the range of world economies was a distinctive feature and aim of the summit. Through the reports and keynote presentations, emphasis was placed on the impact of low-cost and disruptive innovations that have been born of necessity in low-resource settings or adapted from existing technologies or practices in high-income settings, which have the potential for application and utility to a universal market.

Through these solutions and a strong list of attendees, surgery was well-represented at WISH. Four American College of Surgeons (ACS) Fellows attended, including Prof. Lord Darzi; Andrew Kingsnorth, MB, BS, FACS, a general surgeon in Plymouth, U.K.; John Maa, MD, FACS, President of the Northern California Chapter of the ACS and chair, University of California office of the president tobacco-related disease research program scientific advisory committee; and ACS President Carlos A. Pellegrini, MD, FACS, FRCSI(Hon), The Henry N. Harkins Professor and Chair, department of surgery, University of Washington, Seattle, and co-author of this article.

Operation Hernia, cofounded by Dr. Kingsnorth and Chris Oppong, MD, was recognized by the delegates at WISH for having significant global impact. Operation Hernia promotes professional and educational opportunities for hernia repairs in rural settings across Africa, South America, Eastern Europe, and Asia. The organization received significant attention in 2013 for using readily available mosquito nets as a frugal alternative to traditional mesh repair.3 Another high-impact innovation was the Solvatten solar-powered water purifier donated by a charitable organization in Sweden. Solvatten uses novel and low-cost technology to provide a sustainable fresh water supply for those in low-resource settings. Operation Hernia and Solvatten are just two of the 15 services, devices, and business model innovations showcased at WISH, due to their proven success and future global potential.
An impressive and articulate group of keynote speakers offered their expertise and evidence regarding the major issues in global health care ranging from the human and workforce resources required to support health care systems and the need to adapt existing innovations and technologies in response to the financial crisis.

Traffic-related trauma

Surgery was identified as crucial subject matter across several of the panel discussions and policy report topics at WISH. On day two of the summit, a plenary session chaired by Prof. Adnan Hyder, MD, PhD, of Johns Hopkins University, Baltimore, MD, convened five leading experts, including Gayle DiPietro, global manager, Bloomberg Philanthropies Global Road Safety Program at the Global Road Safety Partnership; Abdul Ghaffar, MD, PhD, executive director, Alliance for Health Policy and Systems Research, World Health Organization, Geneva, Switzerland; Kelly Larson, programme director, Bloomberg Philanthropies, New York, NY; Mohammed Fathy Saoud, PhD, senior advisor to the chairperson, Qatar Foundation; and Hassan Al-Thani, MB, ChB, FRCS, head of trauma, vascular, and general surgery, Hamad General Hospital, Doha, Qatar. These panelists debated key challenges and recommendations on road traffic injuries. Discussions at WISH highlighted the rising human and economic burden of road traffic injuries, which disproportionately affect low- and middle-income nations, as a significant global challenge and one requiring an international and multi-sectorial response.

Experts at WISH sought to challenge the global health community to treat road traffic injuries as it would any other public health crisis. It was proposed that to stratify defined etiological factors—including youth, gender and social status—it would be possible to develop a targeted framework for action. The panel discussion looked to emphasize the key baseline policies, including regulating the use of seatbelts, driving under the influence, and the use of helmets for motorcycles. The report also looked more broadly to the health care stakeholders that play a role in the management of affected patients. Surgeons, trauma care specialists, and prehospital health care providers were identified as crucial figures.

Areas highlighted for greater focus included the championing of best surgical practices and the promotion and diffusion of high-impact innovations, such as the use of tranexamic acid as a low-cost and effective treatment found to significantly reduce fatal bleeding associated with trauma. The panelists also advocated for surgeons to play a role in designing and promoting integrated trauma care systems, such as the successful model used in London, U.K.
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Additionally, repeated calls were issued for improved access to high-quality and appropriate training and education for surgeons, first responders, and prehospital care workers. Specifically, in rural and low-income settings more energy and resources are required to promote task-shifting and competence-building among community health care practitioners and the lay public. The purpose of this effort is to equip isolated and impoverished communities with the basic but essential skills for managing victims of trauma and road traffic injuries. The Lancet Commission on Global Surgery will further explore this issue in its report to be published later this year.8

**Stewardship**

Another panel session focused on antimicrobial resistance and accountability in health care. Conserving the limited numbers of antimicrobial drugs available, raising the awareness of drug resistance to both patients and practitioner colleagues, and promoting sanitation and infection prevention are all simple steps that WISH has determined are vital to combating the growing global threat of antibiotic resistance.9

The Accountable Care Forum focused on identifying means of achieving value and high-quality care within health systems. It challenged surgeons and health care providers to champion transparency of data and to develop and maintain robust outcome frameworks across surgical practice and patient pathways to support value-based reconfiguration of services.10

From antimicrobial resistance and accountable care to road traffic injuries and the summit’s spotlight on innovation, the 2013 WISH meeting highlighted the important role of surgery in many of the pressing global health care challenges faced today. The summit promises to become a meaningful and high-profile component of the global health initiative and will serve as a platform for surgeons and other health care providers to identify, discuss, and debate innovative solutions and recommendations. With a surgeon at the helm, the organization will undoubtedly remain an opportunity for the surgical community to further establish itself as a key stakeholder in global health care. ♦
Teaching the teacher:

An ethical model for international surgical missions

Niazy M. Selim, MD, PhD, FACS
As many surgeons now know, there is always a need for well-trained, well-educated, and dedicated health care professionals throughout the world. This need can exist in marginalized populations and rural environments in both developed countries and in less economically developed countries. Over the past decades, globalization has necessitated a greater understanding of international health care issues and the need to train a workforce that can address the needs of underserved populations.

Unfortunately, however, it has become increasingly difficult for international surgeons to conduct their postgraduate training in developed countries. The regulations permitting these physicians to work in countries such as the U.S. and the U.K. have been tightened considerably. Eligibility criteria now preclude non-European Union physicians from applying for training posts in the U.K., which had previously relied on these physicians, mainly from developing countries, to fill empty posts. In the U.S., the credentialing process and state board requirements for medical licenses are fairly prohibitive. Surgeons seeking advancement or extra training currently rely on traveling to American or European academic centers to observe operations but have limited opportunities to engage in direct patient contact.

Many surgeons and their organizations have made strides toward fulfilling the health care needs of underserved populations at home and abroad. Notably, the American College of Surgeons established Operation Giving Back in 2004 as a resource for surgeons who are interested in participating in international outreach. The discussion surrounding international surgical work is growing, and interested parties have offered models for international collaboration.

Residents in training also are expressing interest in participating in international programs. However, opportunities for residents are limited and often require personal funding and use of vacation time, and typically do not count toward graduation requirements as they are considered to be nonstandard rotations. The increased interest among surgery residents to complete an international rotation was surveyed and published by Powell and colleagues.

This article describes the ongoing health care needs of patients in low-resource nations, describes the shortcomings of current efforts to deliver this care and foster surgical education in the developing world, and offers an ethical model for training a sustainable global surgical workforce.

**Growing global need for surgeons**

Despite the demonstrated interest of many surgeons and residents to provide health care to resource-poor countries, patients in these areas around the globe continue to have significant difficulty receiving necessary health care services. Surgical literature has revealed the lack of health care in low-income and middle-income countries. It has been estimated that approximately 11 percent of the world’s disability-adjusted life years (DALYs) are the result of surgical illnesses, and mor-
An overarching goal of these missions is to produce a reasonably self-sufficient surgeon who is able to cope with most local surgical problems and is confident in managing advanced diseases and complex operations.

tality from preventable or treatable surgical conditions accounted for 10.9 percent of all DALYs.6

These reports have concentrated on the need for basic surgical services but did not address the need for advanced surgical expertise in low- or middle-income countries. Furthermore, little information has been published on the magnitude of advanced surgical disease or the percentage of qualified, well-trained surgeons who can manage these diseases in developing nations.

In 2006, the World Health Organization (WHO) reported the total health workforce density to be 2.3 and 24.8 per 1,000 population for Africa and the Americas, respectively. In addition, WHO reported a critical shortage of physicians, nurses, and midwives in 36 of 46 African countries, requiring a 139 percent increase in providers to meet estimated patient needs.7 One could argue that the health care professionals in these countries are not only overworked, but also may lack the resources to travel abroad to gain the skills or training necessary to manage advanced diseases or become more efficient practitioners.

An international teaching philosophy

The famous saying, “Give a man a fish, and you feed him for a day. Teach a man to fish and you feed him for a lifetime,” summarizes the guiding principle in the effort to provide surgical training to health care practitioners in low- and middle-income nations.

Although face-to-face interaction is still the gold standard in medical and surgical education, the evolution of online resources, including digital media archives and the development of telecommunications, have narrowed the knowledge gap between countries. Medicine and surgery have benefited greatly from improvements in this technology in recent years. The use of state-of-the-art equipment, resources, and techniques has helped surgeons to offer patients better outcomes and colleges to offer wider varieties of educational programs. Unfortunately, some countries still lack the infrastructure to support these advancements. Surgeons and patients in many developing nations are still on the verge of acquiring the modern equipment. Furthermore, time zone differences may inhibit the utility of telecommunications technology.

As surgeons in developed countries started to realize and identify the needs in underserved areas around the world, they often volunteered to travel and provide surgical care. These efforts have been traditionally arranged as missions through not-for-profit organizations, such as Operation Smile, or religious and non-governmental organizations.9 Although these missions benefit many patients, lack of resources and time commitments often prohibit health care professionals from providing these areas with the tools necessary to operate independently. To ensure patients have sustained access to care, international missions should focus on fulfilling the following objectives: teach new technology, improve research, and advance patient care through new procedures and surgical care management at the homes of patients and practitioners.
One of the benefits of international surgical teaching missions is that patients will receive medical care otherwise unavailable to them. In remote areas, these patients will have access to basic medical and surgical care. In urban regions, more advanced medical and surgical care can be provided, as these locations are more likely to have the resources needed to provide higher-level services.

Benefits to patients can be maximized when global missions respect the culture in which they are working, including the society’s political, social, religious, and economic forces. Health care providers participating in these missions need to be aware that social determinants, including education, occupation, income, gender, age, and ethnicity, will affect their patients’ morbidity and mortality; lower socioeconomic status typically is associated with poorer health.

An overarching goal of these missions is to produce a reasonably self-sufficient surgeon who is able to cope with most local surgical problems and is confident in managing advanced diseases and complex operations. To this end, local surgeons will receive one-on-one training from an expert who is familiar with new technology and minimally invasive procedures. Bringing this training to the surgeons’ homeland will mollify the necessity of travel to obtain the same skills and circumvents the licensing issues discussed previously.

Visiting experts will enjoy new, potentially once-in-a-lifetime experiences. These opportunities will satisfy surgeons’ desire to help others while gaining personal and career satisfaction. Visiting surgeons also will learn how to operate with limited resources and how to improvise during disasters or emergencies in their homeland.

Before traveling abroad, it is a good idea for health care providers to participate in an orientation program. Such a program can focus on the barriers to health care that exist in the visited country, including lack of infrastructure and cultural and linguistic issues. These programs can also help visiting surgeons become familiar with the availability and cost of medications in the country.

A glimpse of what may be involved in an international experience also can be obtained by attending international conferences or browsing the Web. Some students or residents are fortunate to have exposure to mentors and professors who have relocated and may seek their advice on pursuing these international opportunities.

Traveling to teach or learn requires considerable resources. Travel expenses, accommodation, meals, and daily spending can add up very quickly. Time off from regular practice, disruptions to partners’ schedules, and time away from family add to the hidden costs of the traveling party. Overseas travel also is associated with a great deal of exhaustion from long flight hours, jet lag, change in daily routines, and the mental strain of trying to adapt to an unfamiliar environment. Problems that might contribute to the failure of the program are listed in the table on page 21.

Ideally, though, the international program fosters a friendly, harmonious camaraderie among physicians and surgeons from different countries.
INTERNATIONAL SURGICAL MISSIONS

INTERNATIONAL SURGICAL PROGRAM CHALLENGES

- Difficulty in finding a mentor or a teacher
- Language barrier
- Locating the optimal international exchange programs
- Limited resources or equipment
- Lack of well-trained operating room team
- Perceiving the visitor as a competitor or a threat
- Condescending attitude toward local practitioners

Ethics of international teaching

Four ethical principles guide the international teaching model proposed in this article: respect for individuals, beneficence, non-maleficence, and justice. International health care missions begin with good intentions from all parties; however, good intentions alone do not ensure success or safety. International medical efforts, nonemergency surgery in particular, that lack the possibility of continued follow-up present an ethical concern. In a study published by Wall and colleagues, researchers note, “You have a moral obligation as a surgeon to insure that your patients receive appropriate postoperative care. It is unethical to perform complicated reconstructive operations only to have them fall apart because patients do not receive appropriate ongoing attention after you have gone.” Acute care and emergency surgery practices carry the same concerns. Positive surgical outcomes are the result not only of great surgical skills, but also meticulous pre-operative planning and excellent postoperative care.

A hierarchical system in international teaching would help allay concerns related to appropriate postoperative care. Teaching the teacher, who, in turn, spreads this knowledge, will lead to quality patient care. It is possible to think of this arrangement as a system that resembles the World Wide Web, with multiple nodes and peripherals, keeping in mind that, generally, a node or a peripheral is dynamically interchangeable. In the teaching the teacher model, nodes consist of the developed countries’ universities and traveling experts. The peripherals consist of the receiving communities in low- and middle-income countries. Once a mission is concluded, the local surgeons who acquired knowledge and experience will be available to provide short- and long-term follow-up care to these patients. They also will manage any complications that may arise during patient recovery. These surgeons also will spread their acquired knowledge to less fortunate communities nearby. Established communication and, hopefully, friendship between local providers and visiting teachers will facilitate continued telecommunication as needed.

This model may present some challenges, however. Surgeons are sometimes known to be hard-headed and to have big egos. Putting ego aside is the cornerstone of this program’s success. Visiting experts must exercise humility, understanding, and patience. They need to be fully aware of the circumstances and receptive to the challenges that local surgeons face. Visiting surgeons need to be complimentary rather than critical and to keep in mind that the local surgeons are doing their best with the available resources.

The model in action

The international teaching model described in this article was recently applied in a collaborative effort between two tertiary centers, with a design similar to that originally proposed by Riviello and colleagues in 2010. On the receiving end was the Maadi Armed Forces Hospital (MAFH) in Cairo, Egypt, built in 1960 to provide medical care to high-ranking U.S. Army officers and their families. At that time, it was one of the biggest hospitals in the Middle East. Eventually, the facility began providing tertiary care to soldiers and lower-rank officers and their families. Over the years, the MAFH became known for its excellent services and advanced care, which led to the hospital providing care to Egyptian civilians. The MAFH now has 1,200 beds in multiple buildings on one campus.

In its efforts to provide superior care, the hospital, which is supported by powerful military resources, began inviting experts from abroad in the early 1990s to help teach and promote certain in-demand specialties. One of the most active services in these collaborations is gastrointestinal surgery. Surgeons acknowledge that the rapid advances in the field of gastrointestinal surgery, paired with the advances in minimally invasive technology, has led to a gap between countries. The local surgeons at the MAFH, who strive to maintain a high standard of care, realized that the best benefits arise from group learning.
opportunities led by an invited expert for a period of two weeks every year.

The MAFH also has its own surgical residency program. The residents greatly appreciated the opportunity to learn from a visiting expert and were actively involved in preparing cases and presenting them during clinic or ward rounds.

On the other side of the world, the University of Kansas Medical Center has grown to become one of the largest medical centers in the Midwestern U.S. Its gastroenterology and gastrointestinal surgical program, as well as its superior care and advanced medical science, have received national recognition. Reaching outside the U.S. was perceived as an opportunity to carry the institution’s teaching mission to the next level.

The model described here includes no financial benefits to either party. Travel expenses, accommodation, and local transportation were provided by the Egyptian armed forces and government.

The six working days per week included the following clinical activities: two outpatient clinics, four operating days, daily inpatient rounding, and endoscopy. Patients who needed advanced surgical opinions, bariatric services, or had previously undergone complicated operations were encouraged to register for evaluation prior to this collaboration period. These patients were pre-screened by an MAFH surgery panel prior to the visit, and a thorough workup pertaining to each patient’s disease was obtained.

The attending surgeons who had helped to establish the two-week program as well as the surgery residents were present in every clinic. Interviewing, evaluating, and discussing the patients were done in a warm and respectful atmosphere. This close interaction allowed for great scientific discussions.

Cultural barriers between the patients and visiting experts were easier to surmount when native physicians were available. It is imperative to recognize that the approach to the patient may vary greatly between certain cultures. Fortunately, patient feedback was positive in regard to their experience.

Each operating morning, we all met to review the day’s cases before proceeding to the operating room (OR). The operating team was identified and consisted of the visiting expert plus a local surgeon. The learning needs were reviewed and recognized. The entire team was available for each of the 12 advanced cases in the OR—where the best learning is achieved—during a two-week period of time.

The program was closely monitored by the MAFH administrative leaders and the quality control department. They tracked the number of patients treated in the clinic, the number of surgical or endoscopy cases, outcomes and complications, patient satisfaction, and financial success. (The patients were primarily referred from other military and civilian hospitals.) The visiting expert was briefed on the results at the end of the visit, and feedback regarding the experience was reported to the visitor. The surgeons from the MAFH report that their patients have been very pleased with their outcomes and that the surgeons are now able to perform more laparoscopic and minimally invasive procedures. Because of these successes,
the author has been asked to return for another “teach the teacher” program.

Summary
Concerns linger about how to provide equitable global health care and how to address the great unmet health care needs in many countries. The burden of outreach mostly falls on universities. Universities and educational institutions by design are capable of defining the necessary directions for change. The challenge for universities participating in global health care and education is creating and sustaining robust health systems tailored to each community by evaluating the existing system and taking note of stakeholders, opinion leaders, and the availability of sustained resources in the milieu of the rapidly changing global health care structures.14

The model described here is rooted in educational theory and based on the belief that sharing surgical knowledge is the most effective way to improve access to necessary care for underserved patient populations. Positive changes can be made by developing relationships among health care personnel and new approaches to educational problems. This positive outcome was largely due to the development of new attitudes by professionals and their approach to education and collaboration.

Development of a systemic approach to global health care problems is a daunting task. The solution is neither simple nor easy, and the active participation of the assisted party is highly encouraged. ♦

Acknowledgment
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And the beat goes on:

Surgeons take a break from the OR to play in rock bands

They are surgeons engaged in a pressure-cooker of a profession, but they also believe in the magical powers of rock and roll.

by Jeannie Glickson
Cell Division
Consider the case of the four surgeons, all partners and friends, three plastic surgeons and one vascular surgeon, at the Plastic Surgery Center and the Institute for Advanced Reconstruction in Shrewsbury, NJ. Most days, these surgeons treat devastating trauma injuries, reconstruct breasts and nerves, and perform limb reattachments. Once every two or three months, though, they put down their scalpels, grab their guitar picks and drumsticks, and turn their attention to their rock band, Cell Division.

The band—whose members all played in teenage garage bands—performs covers, mainly of classic rock songs. Cell Division has three guitarists: Matthew R. Kaufman, MD, FACS, a head and neck specialist; Michael I. Rose, MD, FACS, a plastic surgeon with a special interest in peripheral nerve surgery, including neuropathy decompressions; and Andrew I. Elkwood, MD, FACS, who specializes in nerve reconstruction. Dr. Rose is also chief of the division of plastic surgery at Jersey Shore University Medical Center, Neptune. Dr. Kaufman is one of the few surgeons in the world who performs phrenic nerve surgery.

Keeping a steady beat on the drums is Jonathan M. Weiswasser, MD, FACS, a vascular surgeon who is also the band’s driving force. Dr. Weiswasser, a diehard Rolling Stones fan, grew up appreciating British-influenced rock music and American blues. As he took on the serious business of becoming a surgeon, music assumed a secondary role in his life. “During my residency and fellowship and then clinical work, my music was idle,” he said. But as he got more settled in his life and surgical practice, “the music bug hit me again,” he said, and he began the process of forming a band. He plays the drums for a number of bands in addition to Cell Division, including an Eagles tribute band called Eaglemania, which has performed shows in Massachusetts, Pennsylvania, Virginia, and

Cell Division (from left): Drs. Kaufman, Weiswasser, Elkwood, and Rose.

Dr. Weiswasser with Mr. Grohl.
parts of the Midwest. Next on Eaglemania’s agenda is a show in Los Angeles, CA, and possibly a tour of Japan.

Dr. Weiswasser is plugged into the larger rock scene, and he has interacted with some of the world’s most celebrated rock musicians, including Rolling Stones guitarist Keith Richards and the Foo Fighters’ multi-instrumentalist Dave Grohl. Dr. Weiswasser also plays an active role in the Rock and Roll Hall of Fame and Museum in Cleveland, OH, and is on the ballot to become a member of the Hall of Fame’s board of directors.

“You would be surprised that the rock-and-roll musicians I know are just normal people,” Dr. Weiswasser said. “They come to my house for tea and coffee,” he added. “They’re very concerned about their health, and they’re very interested in what I do as a surgeon.”

The interest is mutual, and the surgeons benefit from their connections to professional musicians. The surgeons also happily note the positive response to the band from their patients. “Cell Division brings a human element to our surgical practice,” said Dr. Rose, whose expertise lies in nerve decompression. “Patients come to the office, and next to the diplomas on the wall, they see a picture of the four band members with our arms around each other. All of a sudden, I’m a human being.”

It opens up communication, he said, and helps the practice connect with the local community. “What’s amazing to me is that I’ve saved patients’ arms and legs. We’ve all done some pretty miraculous things with trauma injuries, but most of the feedback from patients is about the band,” he said. “There’s something about the whole musician thing that people go wild over. Someone actually asked for my autograph, which very much amused me.”

Three of the band members met during their residency at New York University School of Medicine, which, Dr. Rose said, “was a tough program, and we had to work very, very hard. A lot was expected of us, and I think we learned to watch each other’s backs. That is why our friendship has endured.” Dr. Kaufman joined the practice after his residency at Mount Sinai Hospital, New York, NY.

Dr. Rose serves on the Cancer Support Community (CSC) Central New Jersey Board, and Cell Division’s first performance was for a charitable event on behalf of the local branch of CSC, a global organization that provides emotional and practical support and education to people affected by cancer. The crowd reacted with loud approval as Cell Division rocked the Wonder Bar, a popular club in Asbury Park. The positive response to their music exhilarated the band members.

“I brought a friend of mine, Earl Slick—a big name in his own right—to that first performance. He once played lead guitar for David Bowie and John Lennon,” Dr. Weiswasser said. “I cajoled Earl into coaching the guys,” Dr. Weiswasser said.

“Earl Slick is one of the nicest people on earth,” said Dr. Rose. “He helped us arrange the songs in a way that would make us all sound better. He’s a perfectionist and pointed out all the little things we could do to improve our sound, like the way the amplifier is adjusted and getting the timing right.”

Cell Division members opted to forgo the traditional black tie affair to raise money for cancer patients and instead created a Battle of the Doctors’ Bands. The two events raised more than $20,000, and, thanks largely to Mr. Slick’s mentoring, Cell Division won the battle both years.

Becoming a rock band is a natural progression for Cell Division, and it’s not that big a stretch, according to Dr. Rose. “We carry with him a lesson he learned from a former professor, that there are three activities that add up to a fulfilling human life: Use your brain. Use your hands. Help other people. “That’s why we became surgeons. We use our hands and our brains, and we have this fundamental drive to help people,” he said. Performing music before an appreciative audience, he added, satisfies the same needs.

No Evidence of Disease (N.E.D.)

Members of N.E.D. first counted gynecologic oncologists among their fevered base of fans.

“We had all gathered in 2008 for a professional meeting of the Society of Gynecologic Oncology, and the leaders wanted to know if entertainment could be pro-
vided by the membership. So, they asked a few of us to create a band. We came from different areas around the country, but we all kind of knew each other,” said N.E.D. bass and harmonica player William R. Robinson, MD, FACS, professor of clinical obstetrics and gynecology, department of obstetrics and gynecology, section of gynecologic oncology, Tulane Medical Center, New Orleans, LA.

The band members, a mix of six surgeons, became more intimately acquainted as they assumed their places on the rock-and-roll stage. Other gynecologic oncologist members of the band are John F. Boggess, MD, clinical research and gynecologic oncology program, University of North Carolina (UNC) at Chapel Hill, and associate professor, UNC (vocals, guitar); Joanie M. Hope, MD, founder and managing partner, Alaska Women’s Cancer Care, Anchorage (vocals); Nimesh P. Nagarsheth, MD, director of gynecologic oncology and associate director of robotic surgery, Mount Sinai Medical Center, New York, NY (drums, percussion); John T. Soper, MD, professor, division of gynecologic oncology, University of North Carolina Health Care, Chapel Hill (guitar); and William Winter III, MD, Compass Oncology, Portland, OR (guitar).

Playing in a band posed all-new challenges for these surgeons, but their first live performance and subsequent success as a band are the stuff of rock-and-roll dreams. After only one rehearsal, the members performed in front of the gynecologic oncology audience, and the response was electric. “We started getting requests from other groups,” said Dr. Robinson. A record label, Motéma Music, a company based in New York, NY, that focuses on jazz and world music, heard about the band and approached the members with the idea of recording a benefit CD, with proceeds going to a foundation for women’s cancer. Mario McNulty, a Grammy Award-winning producer, engineer, and mixer at Motéma, led the band through the recording process, and in about a week, they produced their first CD.

In November 2009, the release of the group’s first CD, consisting entirely of original songs, coincided with Gynecologic Cancer Awareness Month, and it sold more than 6,000 copies. Some of the songs relate to their own surgeon-patient experiences; others are songs about life and love. The band works hard to make good music, but the overriding goal of N.E.D. is to raise public awareness of gynecologic cancers, promote early detection, and support promising research.

“Most of our music is about gynecologic cancer, a subject that people don’t want to talk about,” Dr. Robinson said. “A cancer diagnosis is not easy. As a surgeon, you don’t like to have to see good people suffer.” A cancer diagnosis is a strain on everyone, he said: the patient, the patient’s friends and family members, and the surgeon. Dr. Robinson said that playing in a band provides welcome relief from the stress of treating cancer. “We rehearse virtually, and mix it all together for performances and the CD,” Dr. Robinson explained. Audio mixing technology allows the band to continue creating music while each member continues to conduct a busy surgical practice.

“We are considered adult contemporary and alternative rock,” Dr. Robinson said, “but we got charted

on country stations.” Then the band produced its second CD, this one even more quickly than the first, and it sold roughly 5,000 copies. Most proceeds from the sale of their CDs go directly to the N.E.D. fund of the Foundation for Women’s Cancer.

Nicole Strang, an ovarian and uterine cancer survivor and a social media expert, attended a local ovarian cancer walk in Raleigh, NC, in 2009, when she noticed a booth selling N.E.D. CDs. After attending one of the band’s concerts, she was sold on them. “The music is as important as the message,” she said. “The audience completely loved them. I began begging the band to let me help them with their social media.” N.E.D. now depends mightily on Ms. Strang, who volunteers to work around the schedules of the six surgeons and bring them all together, either for concerts or for recording new music for CDs. She also handles the sale and distribution of N.E.D. merchandise, including a logo and t-shirts.

“All of the surgeons have been involved in music their whole lives,” Ms. Strang said. “When you watch them on stage putting their heart into each performance, you realize that they’re getting as much enjoyment from it as their audience is.”

View N.E.D. on YouTube, at http://www.youtube.com/watch?v=B_Li53x curk. To learn more about the band, check out the group’s Facebook page at https://www.facebook.com/pages/NED/42697252281, or the group’s website at http://www.nedtheband.com.

**Malpractice**

In Erie, PA, a group of health care professionals/musicians have branded themselves as “Health Care with Attitude” and brashly call their band Malpractice. The band, which plays cover songs from the 1980s through the 2000s, includes the melodic sound of lead singer, general and trauma surgeon David W. Dexter, MD, FACS, University of Pittsburgh Medical Center (UPMC) Hamot, and medical director of Great Lakes Surgical Specialists in Erie. Dr. Dexter is an American College of Surgeons (ACS) Governor who represents the Northwestern Pennsylvania Chapter of the ACS and is a
member of the Governors’ Chapter Activities Domestic Workgroup.

“We’ve been together about two years now. Every summer UPMC Hamot has a big picnic for all its employees, and uses a deejay for entertainment,” Dr. Dexter said, explaining the band’s origin. “During a discussion with a hospital administrator, we decided it would be great if we could find providers who worked at the hospital interested in forming a band. The original thought was that we would play limited and specific functions and events only.”

Malpractice played its first gig only one year ago, but within a short time, the band has emerged as a significant rock band in the Erie region. The band’s members are Paul Mirone, MD, family medicine, guitar and vocals; Jeff Larson, CRNP, bass and vocals; Mike Marino, lead guitar, guitar instructor, musical instrument/professional audio sales, and whose wife is a Hamot nurse; and Rob Chandler, DO, family medicine, drums and vocals. The band has signed up for new gigs at many local venues and is currently booked through November 2014.

“We do it for fun and never dreamed that we would be doing this many performances,” Dr. Dexter said. In August 2013, the band enjoyed its biggest break. They performed at a yacht club next door to a popular bar. The bar owner liked what he heard and hired the band to play on Halloween and New Year’s Eve as well as for three summer shows.

For Dr. Dexter, the band represents a lifetime of musical interest. “I sang in a professional boys’ choir, starting at age eight,” he said. “I had extensive voice training, and one way or another, I always find my way back to music.” Music is an integral part of his family life too. His daughter is a singer and was the opening act for the first Malpractice show, and his son plays saxophone and drums. His wife attends all the performances and offers a critical eye and encouragement.

Dr. Dexter, who thoroughly enjoys performing before a live audience, is convinced that being involved with the band makes him a more well-rounded person and, therefore, brings balance to his stressful surgical life. “It would be a stretch to say it makes me a better surgeon,” he said. “But I think it does help to have this life away from work that I enjoy so much.”

Malpractice is an eclectic group whose members represent different age groups and musical tastes. “We’re at different stages of life, but we spend a lot of time together, and we enjoy each other’s company. We have become great friends. We enjoy discussing the songs we like and deciding what music to play,” Dr. Dexter said. The band is for fun—but it also raises funds for charity, including the Howard Hanna Children’s Free Care Fund. They performed at Howard Hanna’s annual Choo Choo Chow Chow Fundraising Campaign, where food and door prizes provided by Erie businesses raises money for the local Shriners Hospital. Howard Hanna Real Estate Services in Erie has sponsored the fundraising drive for 25 years, raising, in total, more than $8.3 million for local hospitals. The band also raises money for the Erie-based John Kanzius Cancer Research Foundation. This foundation, which works to raise awareness and the potential for cancer research through human trials, supports ongoing research for the Kanzius Noninvasive Radiowave Cancer Treatment project, a cancer treatment without side effects.

“I have to say that all the band members are very excited and very happy about the way things have turned out,” Dr. Dexter said. “We’re just having fun with it. Someday it will have to end, but we’re not thinking about that now.”

For more information, including videos of Malpractice performances, visit the group’s Facebook page: www.facebook.com/eriemalpracticeband.

**Reprieve from OR pressures**

Surgeons experience the full range of human challenges and emotions every day. Even in their pressure-filled, hectic lives, some surgeons have discovered, as rock superstar Bruce Springsteen regularly proclaims, “the power, the glory, and the ministry of rock and roll.”
On behalf of the American College of Surgeons Foundation, it is my pleasure to share with you the 2013 annual report. The following pages will demonstrate exactly why your support means so much to the College. You can take pride in knowing that you are a catalyst to College efforts that inspire, promote, and fulfill the very best of our profession: dozens of scholarships for promising young surgeons, optimized care for patients, outreach to the international surgical community, and support for innovative surgical research.

The recently launched 1913 Legacy Campaign, highlighted in this report, gives donors even more opportunities to ensure that critical surgical initiatives are addressed in the evolving health care environment. This special fundraising initiative offers Fellows and friends a range of College priorities to support, from rural surgery to the Codman Quality and Safety Fund. Each priority was vetted through the ACS strategic planning process.

The response to the 1913 Legacy Campaign to date has been truly encouraging and will continue to help us drive forward the College’s founding tenets of optimal quality care and surgical excellence. Times have changed since 1913, but the College’s commitment to these principles remains strong. If you have not done so, I hope you will consider joining this campaign endeavor.

Over this year, the ACS Foundation will continue to communicate to you the impact that your investments are making. We count you as a partner in our philanthropic efforts and strive for continuous improvement in keeping you informed and educated.

The Foundation welcomes your thoughts, and we look forward to a continuing friendship with you.

David B. Hoyt, MD, FACS
Executive Director, American College of Surgeons
President, American College of Surgeons Foundation
On behalf of the American College of Surgeons (ACS) Foundation Board of Directors, I am pleased to provide you with an update on the ACS Foundation’s financial progress. In the fiscal year that ended June 30, 2013, a total of $1,829,707 was generously donated for College programs and initiatives. Additionally, through current contributions and investment revenue from past philanthropic gifts, nearly $3 million was expended in the last fiscal year for College initiatives, including scholarships, nonrevenue programs, lectures, and other scholarly awards.

The numbers can only tell so much. I encourage you to take some time reading the full report, which has been mailed to ACS members, for details on how philanthropic investments have made specific impacts, including:

- Allowing a surgeon to take surgical techniques learned through Clinical Congress courses back to Nigeria
- Helping hundreds of patients better prepare for surgical procedures and postoperation care
- Ensuring Philippine medical workers could complete an ACS Advanced Trauma Life Support® course, which is proven to save lives

As my first year as Chair of the ACS Foundation Board comes to a close, I am deeply thankful for the generosity of Fellows and friends who believe in the College’s mission. It is encouraging to see new donors join the Foundation family, while longtime stalwarts continue their loyalty. Together, we are continuing the College’s legacy of Inspiring Quality into the next 100 years.

Amilu Stewart, MD, FACS
Chair, ACS Foundation
2013 AT A GLANCE: GIFT INCOME REPORT

Fiscal year ending June 30, 2013

TOTAL CONTRIBUTIONS:
$1,829,707

TOTAL EXPENDITURES FROM CURRENT CONTRIBUTIONS AND INVESTED FUNDS:
$2,983,367

Scholarships: $1,151,328

Archives, Patient Education, Operation Giving Back, Trauma Education and Research, and Other Nonrevenue Programs: $1,675,547

Lectureships and Other Awards: $156,492

Thank You - Your Support Matters!
YOUR SUPPORT IN ACTION

THE SUSTAINING FUND

Gifts made to the ACS Foundation’s Sustaining Fund directly support the future of the surgical profession by funding education and research. The purpose of unrestricted funds is to ensure stability and advancement of the College’s mission and provide a source of internal capital for College priorities. The Sustaining Fund supports program activities that are not directly aided by public or grant funding and do not have the ability to produce revenue. Examples of mission-critical activities supported through the Sustaining Fund and other donor-designated funding include:

Operation Giving Back

Operation Giving Back (OGB) was developed in response to the interest of the American College of Surgeons Board of Governors Committee on Socioeconomic Issues in volunteerism. This committee encouraged the College to more closely examine the extent of volunteer involvement and interest among ACS members. Their findings demonstrated great breadth and depth of engagement and that, in fact, many surgeons considered volunteering an integral component of their professional identity.

The program supports ACS members through informational resources, promotion, and networking.

Operation Giving Back Milestones

- More than $39,000 in humanitarian donations of Advanced Trauma Life Support® (ATLS®) materials has been facilitated through OGB to surgeons in 20 countries (Afghanistan, the Dominican Republic, Ecuador, Ethiopia, Gabon, Haiti, Liberia, Kenya, Malawi, Mexico, Nepal, Nicaragua, Pakistan, Peru, Philippines, Sierra Leone, Thailand, Uganda, Vietnam, and Zimbabwe).
- More than 200 volunteer opportunities are currently published on OGB, and 62 opportunities were newly created or updated in the past year.

Research Scholarship and Fellowship Awards

Beginning in 1957, the College has awarded research scholarships and fellowships to promising young surgeons to encourage them to pursue careers in academia. Since then, hundreds of these award recipients have benefitted from the College’s scholarship program, which currently disperses $1 to $2 million annually. The majority of this funding comes from philanthropic contributions from past and current College donors.

Today, many former award recipients serve as chairs of distinguished surgical departments, while others are developing innovative methods to provide better quality care to surgical patients.

“It is this freedom to explore new ideas that will allow surgeons to expand our horizons and advance our field with new technologies and discoveries rather than repackaging older ideas in new surgical wrappings.”

— Yolonda L. Colson, MD, PhD, FACS

Since receiving the George H.A. Clowes, Jr., MD, FACS, Memorial and Research Career Development Award, Dr. Colson has been awarded or filed three patents on polymermediated drug delivery and has received a total of 12 grants, including two current R01 grants from the National Cancer Institute (NCI), an Agency for Healthcare Research and Quality grant, and several foundation grants.

Dr. Colson
Beyond the patents and the grants, more than a dozen students (undergraduate to residency) have trained in Dr. Colson’s lab, and many of those students have changed career paths and chosen to pursue a surgical profession, a fact of which she is particularly proud.

“There isn’t a better recruitment tool for surgery than a surgeon loving their job, and this was much easier with support from the Clowes Award,” said Dr. Colson.

In addition to the research scholarships and fellowships, College philanthropic dollars annually fund dozens of other awards: international guest scholarships, traveling fellowships, and stipends for health policy and leadership courses. Please visit www.facs.org/acsfoundation for a complete listing of these awards and recipients.

Archives

The ACS Archives documents and preserves the history of the College through the records it has produced since it was established. The processed and cataloged records contain roughly 300 linear feet of materials, chiefly paper records, some of which are bound. It also includes photographs, photo albums, video recordings, audio taped oral histories, and artifacts. Fellows may request assistance with research from the Archives resources at no charge.

The Archives played a critical role in the recent ACS Centennial celebration and other initiatives that document the history of the surgical profession. During 2013, the Archives staff completed a large-scale inventory project of more than 2,000 books, including pieces from the history library and the collections of C. Rollins Hanlon, MD, FACS, and George Sheldon, MD, FACS.
PHILANTHROPY HIGHLIGHTS:

Patient Education

The American College of Surgeons Patient Education Program aims to help patients understand their treatment and self-care.

Lung cancer is the most common cause of cancer death in the United States. The treatment for early stages of lung cancer is surgery. As the surgical community strives to strengthen patient engagement, one clear solution is to ensure patients have easy access to evidence-based information to support their decision-making and active participation in their care.

With the support of an education grant from Ethicon, Inc., the Division of Education Surgical Patient Education Program initiated collaborative planning for the “Your Lung Operation” program. Members representing the Society of Thoracic Surgeons, American Association of Thoracic Surgery, Association of Peri-Operative Registered Nurses and the Commission on Cancer created “Your Lung Operation—Education for a Better Recovery.” The “Your Lung Operation” program uses scientifically derived skill development techniques, engaging instructional media, and checklists to carefully coach patients into becoming fully informed and active participants in their care and recovery. A booklet containing information on preoperative prep, cancer staging, procedure overviews, potential risks, discharge, and home care; an instructional DVD; and information sheets, including lung images, medication lists, exercise and pulmonary rehab activity guides, quit smoking resources, a survivorship plan, and a patient evaluation form are all part of the program. The program is meant to be delivered to the patient and his or her family by a member of the surgical team at the first meeting with the surgeon.

Initial outcomes identify high use, with more than 12,000 views from the ACS Patient Education website, www.facs.org/patienteducation, and 24,000 views of the video housed on the ACS YouTube site during the first year following the launch of the program. Evaluation by the public indicated:

- 98% would be satisfied/very satisfied if their surgeon provided them with the document.
- 95% would recommend this document to their family member.
- 100% felt they have learned the skills needed to have the best recovery.

In addition to the “Your Lung Operation” program, the planning task force and ACS Patient Education Committee identified the need for additional resources specific to quitting smoking before a surgical procedure. Together, they created a new patient handout titled “Quit Smoking Before Your Operation” and a professional training program for surgeons and other members of the surgical team.

Kathleen Heneghan, Assistant Director for Patient Education, identified that “education empowers patients. Programs such as this that support the entire surgical team, including the patient, with accurate and easy to understand information will contribute to clear communication and active participation in care and recovery.”

Olga M. Jonasson, MD, FACS, Lectureship

The ACS Foundation is pleased to announce that more than $100,000 has been raised to endow the Olga Jonasson Lecture at Clinical Congress. More than 130 donors generously gave in honor of Dr. Jonasson, the first woman to chair an academic surgery department in the U.S. By investing in the Jonasson Lectureship, these donors have helped ensure that her legacy will continue on to inspire future generations of surgeons, in training and in practice. Special thanks to the ACS Women in Surgery Committee, led by Immediate-Past Chair, Hilary A. Sanfey, MB, BCh, FACS, for its leadership in directing this fundraising effort.

Advanced Trauma Life Support®

In 2002, the Philippine College of Surgeons (PCS) submitted an official request to the American College of Surgeons to introduce the Advanced Trauma Life Support (ATLS) Program to their country. Due to organizational changes within the PCS, the ATLS site visit and initial training were postponed until 2012. By March 2013, the ATLS–Philippines group completed a successful site visit, an initial training in Singapore, and their inaugural course at the PCS headquarters. This ATLS Program was made possible thanks to support from generous donations to the ACS Trauma Education Fund.
The 1913 Legacy Campaign

As presented during Clinical Congress, the ACS Foundation Board of Directors and ACS Leadership have launched a special fundraising campaign for the American College of Surgeons…the 1913 Legacy Campaign.

This unprecedented fundraising challenge will accomplish two things: recognize and act on the milestone importance of the Centennial anniversary of the College, and secure transformative campaign initiatives that will benefit—the Surgeon, the Profession, and the Societal Good.

THE SURGEON

Investments in the development of innovative programs to advance simulation-based surgical education and training; funding to better engage and embrace international surgeons.

THE PROFESSION

Promoting best practices and quality improvements through the newly established Codman Quality and Safety Fund and programs for rural surgery and surgical ethics.

THE SOCIETAL GOOD

Funding opportunities for patient education programs and support for surgical volunteerism.

A unique lapel pin of the “Great Mace” was designed especially for 1913 Legacy Campaign donors. The Great Mace was presented to the American College of Surgeons by the Royal College of Surgeons in 1919 in appreciation of the North American surgeons’ assistance in the First World War. The ACS Secretary leads the Convocation Processional carrying the Great Mace and represents the spirit of fellowship between surgeons.
**FELLOWS and FRIENDS**

Dr. Suresh and Mrs. Deborah Agarwal  
John L. D. Atkinson, MD, FACS  
Dr. and Mrs. W. Gerald Austen  
Robert R. and Janet Bahnson  
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Dr. and Mrs. Charles M. Balch  
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Dr. Pon Satitpunwaycha  
Dr. Marshall Z. Schwartz  
Dr. Kenneth W. Sharp and Mrs. Jane E. Sharp  
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Shelton Viney, MD, FACS  
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Dr. and Mrs. Mark C. Weissler  
Steven D. Wexner, MD, PhD(Hon), FACS, FRCS, FRCSEd  
Dr. Mallory Williams  
Laura E. Witherspoon, MD, and Harold D. Head, MD  
Dr. Sherry M. Wren  
Dr. and Mrs. Michael J. Zinner  

CORPORATIONS and ORGANIZATIONS

Pacific Coast Surgical Association  
Foundation of the American Society of Transplant Surgeons  
American Society of Breast Surgeons  
South Carolina ACS Chapter  
Central Surgical Association  
ACS Section on Oral and Maxillofacial Surgery  
Henry Jackson Foundation for the Advancement of Military Medicine  
USU Surgical Associates  
Everett D. & Geneva V. Sugarbaker Foundation  
Eastern Virginia Medical School  
Region VII Committee on Trauma  
The Surgical Section of the National Medical Association  
Dana Foundation  
American Association for Thoracic Surgery  
Southwestern Surgical Congress  
Oral and Maxillofacial Surgery Associates
CAMPAIGN FUND HIGHLIGHT

Donors to the 1913 Legacy Campaign may choose from a number of campaign funds for their gift designation. One is the Rural Surgery Fund:

A growing issue in the surgical community is the lack of surgeons ready to serve the potential 60 million rural patients. Through the ACS Advisory Council for Rural Surgery, focused efforts are leading to new initiatives that will support the development of rural surgeon education, characterization of rural surgery through data analysis, and other plans to build the appeal and visibility of rural surgery.

A Rural Surgeon’s Observation by Tyler G. Hughes, MD, FACS
An excerpt from the Bulletin of the American College of Surgeons

Several times a year, I fly to Smith Center, KS, to assist Pamela Steinle, MD, FACS, in her operating room. One morning as I approached the airfield there, I was struck by how small the town appeared from the air and what resources were not available. There was no blood bank with many units of blood available in Smith Center. The large white building that composed the “skyline” of Smith Center was not a professional building full of cardiologists and intensivists—rather, it was a grain elevator. Dr. Steinle serves a population that represents the fifth oldest per capita in the U.S.

Despite these and similar “impediments,” that morning she and I excised a colon cancer in a giant incarcerated inguinal hernia in a 70-year-old man. The operation took less than two hours, and the patient left the hospital a few days later. The social implications of attempting this operation in a regional center were simply untenable. This elderly man—with very few monetary resources; a significant speech defect; an elderly, frail wife; and marginal coping mechanisms to wend his way through a large tertiary care facility—would have been emotionally and physically unable to endure an operation away from his familiar and supportive home. I flew home proud to be a rural surgeon.
THE MAYNE HERITAGE SOCIETY

Membership in the Mayne Heritage Society, named in honor of the College’s first planned gift donor, Earl Mayne, MD, FACS, recognizes Fellows who have provided a bequest or other “planned” gift of any size to the College through their estate plan. For those Fellows who believe that the future of surgery and the continued vitality of the American College of Surgeons are intertwined, an estate gift is an ideal form of investment.

DISTINGUISHED PHILANTHROPIST AWARD

The American College of Surgeons Foundation proudly acknowledges the philanthropy of individuals who have distinguished themselves through their extraordinary investment in the mission of the American College of Surgeons. We are pleased to honor them with the Distinguished Philanthropist Award.

Recipients

Dr. Elias S. Hanna (2013)
Dr. Murray F. Brennan (2012)
Dr. and Mrs. Norman M. Kenyon (2010)
Dr. and Mrs. Richard B. Reiling (2009)
Dr. Paul F. Nora (2008)
‘Dr. and Mrs. Maurice J. Jurkiewicz (2006)
Dr. Robert W. Hobson II* and Mrs. Joan P. Hobson (2005)
Dr. and Mrs. Robert E. Berry (2002)
Dr. Pon Satitpunwaycha (2001)
Dr. and Mrs. Paul H. Jordan, Jr. (1999)
Dr. and Mrs. LaSalle D. Leffall, Jr. (1998)
Dr. and Mrs.† Eric Lincke (1997)
Dr. and Mrs. Neil C. Clements (1996)
Dr. and Mrs. Scott W. Woods (1995)
The Abdol Islami Family and Foundation (1994)
Dr. Julius H. Jacobson II (1993)
‘Dr. Oliver H. Beahrs (1992)
‘Dr. John Conley (1990)
‘Dr. Armand Hammer (1989)

‘Deceased
Mayne Heritage Society
as of December 31, 2013

Kathryn and French Anderson—California
Dr. William A. Bernie—Florida
James G. and Cynthia G. Chandler—Colorado
Dr. and Mrs. Neil C. Clements—Arizona
Dr. Benjamin L. Crue, Jr.—Nevada
Dr. and Mrs. Martin L. Dalton, Jr.—Georgia
Gary S. Flom, MD, FACS, FAAP—Florida
Dr. and Mrs. Henry Gans—Florida
Dr. and Mrs. David E. Grambort—Arkansas
‘Dr. Wilfred Guerra—Maine
Dr. and Mrs. Peter S. Hedberg—New Hampshire
Dr.† and Mrs. Robert W. Hobson II—New Jersey
Dr. Robert T. J. Holl-Allen—United Kingdom
Mary and John Iacuzzo, MD, FACS—New Jersey
Dr. and Mrs. Paul H. Jordan, Jr.—Texas
‘Dr. and Mrs. M. J. Jurkiewicz—Georgia
The Estate of Samuel Kantor—Colorado
The Estate of Harry E. Keig—Florida
Dr. and Mrs. Norman M. Kenyon—Florida
‘Dr. William W. Kridelbaugh—Missouri
Yeu-Tsu Margaret Lee, MD, FACS—Hawaii
Dr. and Mrs. LaSalle D. Leffall, Jr.—District of Columbia
Dr.† and Mrs. Joseph H. Lesser—California
Dr. and Mrs.‘ Eric T. Lincke—Michigan
Dr. and Mrs. Richard A. Lynn—Florida
Dr. and Mrs. James V. Maloney, Jr.—California
‘Dr. Hector and Mrs. Ruth Marin—Florida
Richard W. and Pennie B. Martin—North Carolina
The Estate of Dr. Earl H. Mayne—New York
LaMar and Julia McGinnis—Georgia

Dr. Mary L. McKenzie—Florida
Estate of Harold H. Metz—Pennsylvania
‘Dr. Alvin W. Mooney—British Columbia
Dr. William R. Muir—New Jersey
Dr. and Mrs. Henry A. Norum—California
Dr. and Mrs. Frank T. Padberg, Sr.—Arkansas
‘Dr. Frederick W. Plugge IV—District of Columbia
Dr. and Mrs. Stuart M. Poticha—South Carolina
Dr. and Mrs. Richard B. Reiling—North Carolina
Danny and Paula Robinette—Alaska
Antonio and Vivian Robles—California
Dr. and Mrs. Martin C. Robson—Florida
Drs. Thomas R. and Nona C. Russell—California
Dr. and Mrs. Russell L. R. Ryan—Massachusetts
Dr. and Mrs. Paul R. Schloerb—Kansas
Drs. Pamela P. Scott and Razaullah A. Khwaja—Pennsylvania
Dr. and Mrs. Andrew G. Sharf—California
William Sternfeld, MD, FACS—Ohio
Dr. Amilu Stewart—Colorado
Dr. Hugh H. Trout III—Maryland
‘Dr. and Mrs. Irving W. Varley—Washington
‘Dr. Arie D. Verhagen—Ohio
Dr.† and Mrs. Alexander J. Walt—Michigan
The Estate of W. Merle Warman—West Virginia
Dr. and Mrs. Andrew L. Warshaw—Massachusetts
The Estate of Claude E. Welch—Massachusetts
Dr. and Mrs. David P. Winchester—Illinois
‘Dr. A. Stark Wolkoff—Missouri
Dr.† and Mrs. Scott W. Woods—Michigan

‘Deceased
FELLOWS LEADERSHIP SOCIETY

Philanthropy has been a tradition of the American College of Surgeons since its inception. In 1914, the leadership of the College initiated a campaign to secure gifts from members to establish an endowment fund. That spirit of giving continues today with gifts of all sizes from thousands of donors who support the numerous programs of the College through the ACS Foundation.

The Fellows Leadership Society recognizes Fellows and friends who have invested most loyally in the American College of Surgeons. Through their leadership in giving, members of the Fellows Leadership Society exemplify the philanthropic spirit of the College’s founders.

Recognition is provided based on cumulative giving history. Annual renewable membership is accorded to individuals whose contribution during a given fiscal year totals $1,000 or more. Categories of membership include:

- **Pinnacle Circle**
  CUMULATIVE gifts totaling $1,000,000 or more

- **Second Century Circle**
  CUMULATIVE gifts totaling $500,000 or more

- **Legacy Circle**
  CUMULATIVE gifts totaling $100,000–$499,999

- **Founders Circle**
  CUMULATIVE gifts totaling $75,000–$99,999

- **Presidents Circle**
  CUMULATIVE gifts totaling $50,000–$74,999

- **Regents Circle**
  CUMULATIVE gifts totaling $25,000–$49,999

- **Governors Circle**
  CUMULATIVE gifts totaling $10,000–$24,999

- **Donors Circle**
  ANNUAL gift of $1,000 or more
2013 Fellows Leadership Society Award Recipients

MAYNE HERITAGE
James G. and Cynthia G. Chandler
Gary S. Flom, MD, FACS, FAAP
Robert T. J. Holl-Allen, MD, FACS
William R. Muir, MD, FACS
Drs. Thomas R. Russell and Nona C. Russell
William Sternfeld, MD, FACS

LEGACY CIRCLE
William Sternfeld, MD, FACS
Amilu Stewart, MD, FACS
Dr. and Mrs. Andrew L. Warshaw

REGENTS CIRCLE
Ron and Lauren Maier
Carlos and Kelly Pellegrini
Martine B. and William P. Reed
Dr. and Mrs. J. David Richardson
Dr. Kenneth W. Sharp and Mrs. Jane E. Sharp

GOVERNORS CIRCLE
Dr. Suresh and Mrs. Deborah Agarwal
John L. D. Atkinson, MD, FACS
Kevin E. and Patti J. L. Behrns
Ernest F. J. Block, MD, MBA, FACS
Myriam J. Curet, MD, FACS
A. Willard Emch, MD, FACS
Dr. and Mrs. Kenneth A. Forde
Sharon M. Henry, MD, FACS
Dr. and Mrs. Masaki Kitajima
Dr. and Mrs. Nicholas P. Kovacevich
Dr. Charles W. Logan and Joyce W. Logan
David S. Mulder, MD, FACS
Dr. and Mrs. Clifford M. Phibbs, Jr.
Dr. David A. and Kathleen Sweetman Rothenberger
Michael J. Sutherland, MD, FACS
Patricia L. Turner, MD, FACS
Shelton Viney, MD, FACS
Steven D. Wexner, MD, PhD(Hon), FACS, FRCS, FRCSEd
Sherry M. Wren, MD, FACS

CORPORATE AND FOUNDATION GIVING
Legacy Circle (cumulative gifts between $1,000,000 and $5,000,000)
Coloplast Corp.
Ethicon, Inc.
Merck & Co.
WAYS OF GIVING

The 1913 Legacy Campaign aims to inspire donors to make significant gifts beyond their annual contribution. Planned giving vehicles often enable donors to make larger gifts than would otherwise seem possible. Planned or deferred gifts offer donors the opportunity to invest in the future of the American College of Surgeons while at the same time retaining control of assets and current income. From cash gifts to gifts that generate a stream of income for life, a multitude of options exist to tailor giving to meet individual needs and financial circumstances.

Outright Gifts

~ Cash or Credit Card:
You can donate through the mail by check or money order, payable to:
American College of Surgeons Foundation
633 N. Saint Clair St.
Chicago, IL 60611-3211

Please visit www.facs.org/acsfoundation and select the 1913 Legacy Campaign from the options to donate with a credit card.

Multi-year pledges are also available; please contact the ACS Foundation for details.

~ Appreciated securities
Contact your broker and provide required instruction authorizing the transfer of stock to the American College of Surgeons. Inform the ACS Foundation (312-202-5376, mwojcik@facs.org) of your intent to contribute stock, providing your full name; the name, address, and telephone number of your broker; the name of the stock(s) to be transferred; the number of shares; and the anticipated date of transfer.

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DTC: 226
Contact: Sue Ingraffia
Phone: 312-557-2912
E-mail: sr37@ntrs.com
ACS Tax ID: 30-0305504
ACS Foundation: 312-202-5338

~ Rollover IRA distribution
Deferred Gifts

The official legal bequest language for the ACS Foundation is: “I give and bequeath to the American College of Surgeons Foundation, Chicago, Illinois, the (sum of $--- or --- percent of the rest, residue, and remainder of my estate). This gift shall be used to further the educational mission of ACS in such a manner as the Board of Regents of the College may direct.”

~ Retirement plan
~ Gift of insurance
~ Charitable remainder trust
~ Charitable gift annuity
~ Charitable lead trust

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Medicare reimbursement penalties will continue to loom over the next few years for surgeons and other eligible professionals (EPs) who fail to participate in the Medicare Electronic Health Records (EHR) Incentive Program.

The EHR Program, established under the Health Information Technology for Economic and Clinical Health (HITECH) Act, authorizes the U.S. Department of Health and Human Services to provide financial incentives to EPs and hospitals that “meaningfully use” EHR technology.

First-time EPs who are unable to successfully begin participating in the EHR Incentive Program by July 1, 2014, or who began participation in calendar year (CY) 2011 or 2012 but could not participate during CY 2013, may receive a 1 percent penalty on their total Medicare Part B fee-for-service amount in CY 2015. These EPs should consider applying for an EHR hardship exception by July 1, 2014. This column discusses what surgeons need to know about the EHR Incentive Program to avoid penalties in 2015, as well as other program updates.

**What are the 2014 Medicare EHR Incentive Program reporting criteria?**

As discussed in the December 2013 Bulletin, EPs who participate in the EHR Incentive Program have different reporting options in CY 2014 than in previous years.*

Regardless of the reporting stage, EPs participating in the program will have the option of reporting on a quarterly basis. The Centers for Medicare & Medicaid Services (CMS) implemented the reporting change to allow EPs sufficient time to upgrade or adopt an EHR that meets the Office of the National Coordinator’s 2014 certification criteria, which allows EHR technology to be more efficient and provide improved security, interoperability, data portability, and other features.

EPs who began their first year of reporting in CY 2011, 2012, or 2013 may receive a 1 percent penalty on their total Medicare Part B fee-for-service amount in CY 2015. These EPs should consider applying for an EHR hardship exception by July 1, 2014. This column discusses what surgeons need to know about the EHR Incentive Program to avoid penalties in 2015, as well as other program updates.

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**What are the EHR incentive payments and penalty amounts?**

CMS began making Medicare EHR Incentive Program payments in CY 2011. EPs who began meeting the Stage 1 meaningful use requirement in 2011 or 2012 may earn an incentive payment totaling $44,000 over a five-year period. If EPs began reporting in 2013, they may earn a total incentive payment of $39,000 over a four-year period, and if EPs begin reporting in 2014, they may receive a total incentive payment of $24,000 over a period of three years. No incentives are scheduled for EPs who become first-time meaningful users in 2015 and beyond.

First-year program participants should report on any 90-day period. EPs have until July 1, 2014, to begin reporting and should submit their data by October 1, 2014, to avoid penalties in 2015. EPs who begin reporting after July 1, 2014, are still eligible to receive up to $24,000, which is the maximum payment available. However, they will also receive the 2015 program penalty of 1 percent of their Medicare Part B fee-for-service amount.†

---

surgeons will need to be able to achieve Stage 1 of meaningful use before then to avoid the payment penalty in 2015. Even though the incentive payments are set to end by 2016 for EPs who begin participating in the program by 2014, the penalties will begin in 2015 and will continue indefinitely. Table 2, this page, describes the incentives and penalties from 2011 through 2015 and beyond.

---

**What hardship exceptions are available to help me avoid the EHR Incentive Program penalty?**

Hardship exceptions are available to EPs in certain situations. If an EP claims an exception and CMS approves it, the EP will become ineligible to receive an incentive payment and will be exempt from any penalties. An exception must be filed by July 1, 2014, to avoid the 2015 penalty; EPs may need to reapply annually for most of these exceptions. See Table 3, page 50, for a list of the exceptions.

CMS has provided step-by-step instructions on how to apply for exemptions. EPs unable to upgrade to the 2014 EHR standards due to vendor-related issues should select “2014 vendor-related issues,” which CMS added under the “unforeseen and/or uncontrollable circumstances” hardship exception category in March 2014. EPs who began participating in 2014 will be granted a two-year hardship exception automatically and will not need to apply for an exception. CMS will look at provider data in the Provider Enrollment, Chain, and Ownership System to grant this exception to newly practicing EPs.

---

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

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

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

<table>
<thead>
<tr>
<th>CY</th>
<th>First CY in which the EP receives an incentive payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>$18,000</td>
</tr>
<tr>
<td>2012</td>
<td>$12,000 $18,000</td>
</tr>
<tr>
<td>2013</td>
<td>$8,000 $12,000 $15,000</td>
</tr>
<tr>
<td>2014</td>
<td>$4,000 $8,000 $12,000 $12,000</td>
</tr>
<tr>
<td>2015</td>
<td>$2,000 $4,000 $8,000 $8,000 $0; 1 percent of Medicare fee schedule (penalty)</td>
</tr>
<tr>
<td>2016</td>
<td>$2,000 $4,000 $4,000 $0; 2 percent of Medicare fee schedule (penalty)</td>
</tr>
<tr>
<td>2017</td>
<td>0 0 0 0 $0; 3 percent of Medicare fee schedule (penalty)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>$44,000 $44,000 $39,000 $24,000 $0</td>
</tr>
</tbody>
</table>

*A CY equals a payment year.

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

---

How can I avoid the 2015 payment penalty?

There is still time for EPs to avoid the 2015 payment penalty if they are in the following situations:

- If EPs began and/or continued to successfully report for the EHR Incentive Program in 2011, 2012, or 2013, they will avoid the 2015 payment penalty.

- If EPs are participating in the EHR Incentive Program for the first time, they should begin their 90-day Stage 1 reporting by July 1, 2014, and submit their attestation to CMS no later than October 1, 2014.

- If EPs began reporting for the EHR Incentive Program in 2011 or 2012, but for any reason were unable to continue reporting in CY 2013, they should consider applying for a hardship exemption, if applicable, by July 1, 2014.

- If EPs have never reported for the EHR Incentive Program and cannot begin by July 1, 2014, they should consider applying for a hardship exception, if applicable, by July 1, 2014.

What resources are available to help me?

The following are American College of Surgeons (ACS) and CMS EHR Incentive Program resources:

- The ACS EHR Web page: http://www.facs.org/ahp/ehr/index.html


- The CMS EHR help desk: 1-888-734-6433

- The ACS also has partnered with AmericanEHR Partners. ACS members may register with the AmericanEHR Partners to receive additional information on EHR vendor ratings, listen to podcasts, request proposals from vendors, receive e-newsletters, and more, at http://www.americanehr.com/Home.aspx.

Any changes that CMS may make to the 2014 deadlines will be reported in various ACS communications such as the Bulletin, NewsScope, and The ACS Advocate.

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**TABLE 3. EXCEPTIONS AVAILABLE FOR EHR INCENTIVE PROGRAM**

<table>
<thead>
<tr>
<th>Exception</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insufficient Internet access</td>
<td>EPs must demonstrate they practice in an area without sufficient Internet access or face insurmountable barriers to obtaining the necessary infrastructure (such as lack of broadband)</td>
</tr>
<tr>
<td>New EP</td>
<td>EPs who are new to practice and have not had time to become meaningful users may be granted a two-year limited exception to payment adjustments</td>
</tr>
<tr>
<td>Unforeseen and/or uncontrollable circumstances</td>
<td>Examples include a natural disaster or another unforeseeable barrier. Also, this category includes 2014 vendor-related issues such as if the EP’s EHR vendor was unable to obtain 2014 certification or the EP was unable to implement meaningful use due to 2014 EHR certification delays during CY 2014</td>
</tr>
<tr>
<td>Lack of patient interaction</td>
<td>EPs must demonstrate they meet the following criteria:</td>
</tr>
<tr>
<td></td>
<td>• Lack of face-to-face or telemedicine interaction with patients</td>
</tr>
<tr>
<td></td>
<td>• Lack of follow-up need with patients</td>
</tr>
<tr>
<td>Lack of control over availability of certified EHR technology (CEHRT)</td>
<td>Lack of control over availability of CEHRT for more than 50% of patient encounters for EPs at multiple locations</td>
</tr>
</tbody>
</table>

---

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Any changes that CMS may make to the 2014 deadlines will be reported in various ACS communications such as the Bulletin, NewsScope, and The ACS Advocate. ♦
Neoadjuvant cancer therapy: Benefitting patients and improving cancer care

by Lisa Bailey, MD, FACS, and Judy C. Boughey, MB, BCH, FACS

As cancer therapy has evolved, the oncology community has gained new insights into the characteristics of different cancers, developed more targeted cancer therapies, and is often able to diagnose cancers at earlier stages than in the past.

Surgery has been the first line of treatment for solid cancers for most patients for many years. Increasingly, however, systemic therapy is given before definitive surgical resection. Some tumors, unfortunately, are diagnosed at a more advanced stage. They may be operable but would require resecting a large amount of tissue and potentially adjacent structures. Others are inoperable because of involvement of adjacent anatomic structures.

Benefits of neoadjuvant therapy
The rationale for neoadjuvant therapy is to reduce the size or extent of the cancer before operating, making surgical procedures easier, reducing the amount of tissue that needs to be removed, and, therefore, reducing the morbidity associated with radical surgical resections. In addition to local effects, neoadjuvant therapy treats regional lymph nodes, converting positive nodes to negative nodes in a proportion of cases. The National Cancer Institute defines neoadjuvant therapy as “Treatment given as a first step to shrink a tumor before the main treatment, which is usually surgery, is given. Examples of neoadjuvant therapy include chemotherapy, radiation therapy, and endocrine therapy. It is a type of induction therapy.”

Neoadjuvant therapy has successfully reduced the size and extent of many cancers, benefitting our patients and allowing surgeons to perform better and safer operations. Neoadjuvant therapy can turn a tumor from unresectable to resectable by shrinking the volume of the tumor. Often it can be unclear which surrounding structures are directly involved in the disease, and there may be difficulty in differentiating those anatomic structures from inflammation on imaging. After administering neoadjuvant therapy, this differentiation often can be more easily achieved. Neoadjuvant therapy is sometimes given in anticipation that a response will be seen so that a decision can be made with regard to the next course of action. In addition, neoadjuvant therapy acts on micrometastatic disease and can therefore downstage tumors. Neoadjuvant therapy can lead to improved long-term survival for patients.

The use of neoadjuvant therapy has gained wide acceptance over the last decade, but it is not a new idea. Several milestones in the use of neoadjuvant therapy have occurred. In 1956, neoadjuvant therapy was used to treat choriocarcinoma. In 1968, the concept of perioperative chemotherapy for breast cancer was introduced. Neoadjuvant therapy for rectal cancer was presented in 1986 and for pancreatic cancer in 1990.

Tumor reduction with neoadjuvant systemic therapy can result in three patterns of response: concentric shrinkage of the tumor, concentric shrinkage of the tumor with surrounding small satellite lesions, or shrinkage of the tumor volume with residual multiple small satellite lesions.

Current trials
Clinical trials of drugs in the neoadjuvant setting allow assessment of new agents and novel therapeutic strategies. Studies in the neoadjuvant setting use pathologic complete response (pCR), a surrogate marker for survival, as the primary endpoint. This approach makes it possible for studies to enroll a significantly smaller number of patients and to attain results in a much shorter time frame. The old trials of large numbers of patients treated in the adjuvant setting and followed for...
Neoadjuvant therapy has successfully reduced the size and extent of many cancers, benefitting our patients and allowing surgeons to perform better and safer operations.

years for cancer events has been replaced by smaller studies in the neoadjuvant setting with quicker impact on drug development and clinical practice. Additionally, neoadjuvant studies allow assessment of the drug’s effects on the target tumor in the patient and development of biomarkers of response. Evaluation of residual disease after neoadjuvant chemotherapy can provide information on mechanisms of resistance to therapy.

In May 2012, the U.S. Food and Drug Administration (FDA) announced that pCR to neoadjuvant chemotherapy may be used as a surrogate endpoint as a component for accelerated approval of drugs. The FDA’s accelerated approval program allows patients to have access to these drugs while the confirmatory clinical trials are being conducted. In September 2013, the drug Pertuzumab was granted accelerated approval as part of the treatment regimen in the neoadjuvant setting for patients with early-stage breast cancer. Pertuzumab is the first FDA-approved drug for the neoadjuvant treatment of breast cancer based on pCR as the primary outcome. Improvement in survival is still required for regular approval.

One of the best ways to improve our knowledge of cancer therapy is through neoadjuvant clinical trials. Surgeons have the unique opportunity to discuss the concept of neoadjuvant therapy and the option of enrolling newly diagnosed cancer patients in a clinical trial. Responsiveness to a cancer therapy is understood more quickly through neoadjuvant therapy than through adjuvant therapy trials. Additionally, evaluation of the extent of surgery after neoadjuvant systemic therapy for optimal local control is the focus of several trials, and it is critical to inform clinical management of patients receiving neoadjuvant therapy.

The clinical trials through the Alliance of Clinical Trials in Oncology can be viewed on their website at http://www.allianceforclinicaltrialsinoncology.org. There are Alliance clinical trials available for patients who are appropriate candidates for neoadjuvant therapy. These trials include breast, gastrointestinal, genitourinary, and respiratory cancers. Information on how your institution can become a member of the Alliance also can be found on the website. Membership in any of the cooperative groups will enable surgeons to participate in these trials. Please consider offering these trials to your patients so we can learn today the best way to care for our patients tomorrow.

**Alliance clinical trials involving neoadjuvant therapy**

**Breast cancer**
- Alliance A011202: A Randomized Phase III Trial Evaluating the Role of Axillary Lymph Node Dissection in Breast Cancer Patients (cT1-3N1) Who Have Positive Sentinel Lymph Node Disease after Neoadjuvant Chemotherapy. Evaluates the best therapy for local control in women with residual nodal involvement after they have completed neoadjuvant chemotherapy. This study compares axillary lymph node dissection to axillary radiation for patients with positive sentinel node(s) after chemotherapy.
- Cancer and Leukemia Group B (CALGB) 40903: Phase II Study Neoadjuvant Letrozole for Postmenopausal Women with Estrogen Receptor Positive Ductal Carcinoma in Situ (DCIS). This study is designed to evaluate how well letrozole works in DCIS by evaluating the change in tumor volume on magnetic resonance imaging after three to six months of neoadjuvant letrozole for estrogen receptor-positive DCIS.

**Gastrointestinal cancers**
- American College of Surgeons Oncology Group (ACOSOG) Z5041: A Phase II Study of Preoperative Gemcitabine and Erlotinib Plus Pancreatectomy and Postoperative Gemcitabine and Erlotinib for Patients with Operable Pancreatic Adenocarcinoma. This study assesses the two-year survival rate in patients with pancreatic cancer treated with neoadjuvant and adjuvant gemcitabine and erlotinib.
- North Center Cancer Treatment Group (NCCTG) N1048: A Phase II/III trial of Neoadjuvant...
Surgeons have the unique opportunity to discuss the concept of neoadjuvant therapy and the option of enrolling newly diagnosed cancer patients in a clinical trial.

FOLFOX with Selective Use of Combination Radiation with Locally Advanced Rectal Cancer. This study compares chemotherapy to chemotherapy and radiation therapy in the neoadjuvant setting for rectal cancer with primary endpoints of R0 resection, disease-free survival, and time to local recurrence.

Genitourinary cancers
• CALGB 90203: This randomized phase III study examines neoadjuvant docetaxel and androgen deprivation prior to radical prostatectomy versus immediate radical prostatectomy in patients with high-risk, clinically localized prostate cancer. This study compares neoadjuvant therapy with surgery first in terms of biochemical progression-free survival in patients with high-risk, clinically localized prostate cancer.

Respiratory cancers
• CALGB 31102: Phase I study of accelerated hyperfractionated radiation therapy with concomitant chemotherapy for unresectable stage III non-small cell lung cancer. This study is designed to determine the side effects and response of specialized radiation together with chemotherapy in unresectable stage III non-small cell lung cancer.

REFERENCES
Wrong site, wrong procedure, and wrong person surgeries (WSS) continue to occur in health care organizations across the U.S. To help avoid these preventable errors, The Joint Commission strongly supports the Association of periOperative Registered Nurses’ (AORN) National Time Out Day on June 11.

National Time Out Day provides a timely opportunity for surgeons and their operating room (OR) teams to review the importance of conducting a safe, effective time out for every patient, every time. In addition, it encourages surgical team members to feel comfortable about speaking up for safe practices in the OR.

Risk factors
Some estimates place the national incidence rate of WSS at as high as 40 to 60 per week, which means that as many as 1,300 to 2,700 incidents occur annually, according to the Joint Commission Center for Transforming Healthcare.

The Center has found that several factors contribute to an increased risk of WSS, including:

• More than one surgeon is involved in the case, either because multiple procedures are contemplated or because the care of the patient is transferred to another surgeon
• Multiple procedures are conducted on the same patient during a single trip to the OR, especially when the procedures are on different sides of the patient
• Time-related issues occur, such as an unusual start time or pressure to speed up the preoperative procedures
• Unusual patient characteristics, such as a physical deformity or massive obesity, that might alter the typical process for equipment setup or positioning of the patient

In these instances, a time out that includes full participation by all OR team members can significantly reduce the risk of WSS.

Universal Protocol
The Joint Commission has long been a proponent of well-executed time outs as part of a multi-layered defense against WSS. In July 2003, The Joint Commission’s Board of Commissioners approved the original Universal Protocol for Preventing Wrong Site, Wrong Procedure and Wrong Person Surgery for all accredited hospitals, ambulatory care, and office-based surgery facilities.

The Universal Protocol, which became effective July 1, 2004, was developed to address the continuing occurrence of WSS within Joint Commission-accredited health care organizations. It expanded on a series of requirements under the National Patient Safety Goals from 2003 and 2004. The three principal components of the Universal Protocol include:

• Pre-procedure verification
• Site marking
• Time out

In 2010, the Universal Protocol was revised based on feedback from surgeons and other stakeholders. The revision was intended to address patient safety issues while also allowing health care organizations more flexibility in applying the requirements within existing work processes, taking into account the diversity of the health care organizations that need to follow the protocol.

Sentinel event
The Joint Commission has identified WSS as a sentinel event—an unexpected occurrence involving death or serious physical or psychological injury. This type of incident signals the need for immediate investigation, comprehensive analysis, and systematic
A LOOK AT THE JOINT COMMISSION

National Time Out Day provides a timely opportunity for surgeons and their operating room OR teams to review the importance of conducting a safe, effective time out for every patient, every time.

improvement. It requires a team response that stabilizes the patient, discloses the event to the patient and family, and provides support for the family, as well as for the staff involved in the event. The investigation produces a root-cause analysis that reveals underlying organizational systems and processes that can be altered to reduce the likelihood of such an incident occurring in the future.

The most common root causes of WSS reported to The Joint Commission’s Office of Quality and Patient Safety are ineffective leadership, poor communication, and human factors. Accredited health care organizations are strongly encouraged to voluntarily report WSS as a sentinel event to The Joint Commission. To help health care professionals through this process, The Joint Commission has established a Sentinel Event Hotline at 630-792-3700.

Surgeon involvement
Too often, surgical teams are unsure of what constitutes an effective time out. It is important for surgeons and leaders on the surgical team to consistently model a quality time out, not only on National Time Out Day, but all year long.

Surgeons and their teams should always follow a standardized time out practice to avoid any changes that may weaken the process. When the time out practice is carefully followed, team members should be recognized for supporting patient safety. Recognition may be included in performance evaluations or merit awards.

It also is important for surgeons to watch for any inconsistencies and to listen to concerns expressed by team members. Likewise, surgeons should encourage team members to take the time to listen to patients and their families, and to be on guard for any inconsistencies or other warning flags. The entire surgical team should feel comfortable voicing any and all concerns.

Additional resources
One WSS is one too many. The Joint Commission remains committed to reducing WSS. In February 2012, the Joint Commission Center for Transforming Healthcare launched its Targeted Solutions Tool (TST) for Wrong Site Surgery. The TST serves as a step-by-step guide for accredited health care organizations to identify, measure, and reduce risks in key processes that contribute to WSS.

The TST makes it possible for leaders at health care organizations, including surgeons, to address issues that might result in WSS. It is proven to be effective; use of the TST and implementing improvements reduced the number of cases with risks by 46 percent in the scheduling area, by 63 percent in pre-op, and by 51 percent in the operating room.*

Surgical patients deserve safe surgery. For more information on WSS, visit jointcommission.org or centerfortransforminghealthcare.org.

Natural buoyancy will not support the weight of most humans well enough to keep them afloat when submerged in water. For that reason, historically, mankind has looked for ways to prevent people from drowning. Gourds, inflated animal skins, wood, cork, kapok fibers, rubber, and synthetics have been used to make water-related activities safer.

In 1852 the U.S. Congress passed a law requiring ships to carry life preservers. Two years later, the U.K.’s Royal National Lifeboat Institution started using a cork life belt invented by Navy Commander J. R. Ward. In 1928, the SS Vestris, a British passenger steamer, sank and many of the dead passenger were found floating face down. The victims were buoyant but inverted as a result of the life preserver design.*

That same year, Peter Markus patented the first inflatable life preserver. Markus, a merchant in Minnesota, was an avid boater and fisherman and was all too aware of boaters who went overboard and subsequently drowned. These boaters refused to wear large, bulky cork vests that hindered their movement. His life vest weighed less than two pounds, was significantly less bulky, and went over and behind the neck to keep the user’s face up and out of the water. It had a manual pull cord and used liquid carbon dioxide to inflate the vest’s air pockets.

In World War II, American and British servicemen were issued these inflatable life preservers. When the front air pockets of the life vest inflated, it gave the appearance of a buxom woman, leading the troops to give it the affectionate nickname the “Mae West” in honor of the well-endowed actress of the time. Today, the military uses a form of this life jacket, and the basic model life vest carried on airplanes is based on this design.†

Staying afloat
This past winter has been particularly harsh for most of the U.S., and many people were excited when the warm weather finally arrived. June marks the official beginning of summer, and in many parts of the country, boating season is in full swing. This activity is not without potential danger. Even though modern personal flotation devices (PFDs) have come a long way, many individuals participating in water-based activities do not wear them. According to the Personal Flotation Device Manufacturers Association’s facts about life jackets, 90 percent of drownings occur in inland waters, within

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Even though modern PFDs have come a long way, many individuals participating in water-based activities do not wear them.

**HOSPITAL DISCHARGE STATUS**

![Pie chart showing hospital discharge status]

- **87%** Home
- **4%** Acute care/rehab
- **8%** Nursing home
- **1%** Death

a few feet of safety, and involve boats under 20 feet long; 80 percent of fatalities were not wearing a life jacket.‡

To examine the occurrence of injuries where a personal flotation device was involved in the National Trauma Data Bank® (NTDB®) research dataset for 2013, hospital admissions records were searched for the field “protective devices.” Specifically searched were records that contained a protective device field value of 3 (personal flotation device). A total of 100 records were found; 85 records contained a discharge status, including 74 patients discharged to home, three to acute care/rehab, and seven to skilled nursing facilities; one patient died. These patients were 62 percent male, on average 29.6 years of age, had an average hospital length of stay of 5.0 days, an intensive care unit length of stay of 5.9 days, an average injury severity score of 11.9, and were on the ventilator for an average of 6.2 days (see figure, this page).

Of note in this dataset is the extremely low mortality. Remember that these are the victims who actually used their PFD. The author has personally seen individuals being fished out of Lake Michigan thanks to the automatically inflating PFD that they were wearing at the time; none of them had a problem looking like Mae West for a brief period of time.

Throughout the year, we will be highlighting these data through brief reports in the Bulletin. The National Trauma Data Bank Annual Report 2013 is available on the ACS website as a PDF file 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.

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“Leadership is defined as the intentional process by which a person influences others to accomplish a specific goal,” said David B. Hoyt, MD, FACS, Executive Director of the American College of Surgeons (ACS), in his opening remarks at the third annual Leadership & Advocacy Summit, March 29 to April 1, at the JW Marriott, Washington, DC. “The goal of leadership training is to develop better awareness of self and others by focusing on personality and interaction styles,” added Dr. Hoyt, referring to emotional intelligence (EI)—a topic that was a central focus of the leadership program.

Part of a dual meeting held in conjunction with the Advocacy program, the 2014 Leadership program featured presentations on strengthening leadership and mentoring skills, chapter development and success stories, and the practical applications of EI skills to enhance personal and professional relationships.

Patricia L. Turner, MD, FACS, Director, ACS Division of Member Services, said a primary goal of the EI presentation was to give attendees “digestible and evidence-based” information on this emerging topic and how it relates to developing successful leadership skills.

The 2014 Leadership & Advocacy Summit drew a total of 427 attendees—up from 308 attendees last year—from all levels of ACS leadership, including Regents, Governors, Advisory Council members, chapter leaders, and others.

“This meeting provides an opportunity for you to develop a sense of camaraderie with your peers and to meet people who have the same challenges as you do,” said Dr. Turner. “These sessions offer you practical skill sets that you can take back home.”

**Successful mentoring**

In his presentation, Strategies for Successful Mentoring, John L. Rombeau, MD, FACS, emeritus professor of surgery, Perelman School of Medicine, University of Pennsylvania, Philadelphia, described the key differences between mentors, teachers, and role models.

“All mentors are teachers and role models, but a mentor is personally committed to the educational and professional successes of the mentee,” explained Dr. Rombeau. He suggested that mentors focus...
on mentee expectations rather than their own, engage in active listening, and work toward consensus and compromise when outlining solutions.

Dr. Rombeau presented what he called “new directions” in mentoring, including the “reverse academic mentoring pyramid” model. Mentoring is typically assigned to junior staff members, such as assistant professors, but he suggested tapping senior surgeons to fill the mentoring role. “I would argue that it is time to bring the gray hairs like me into the picture. We have the most knowledge, and, at this point in our careers, we probably have the most time to work with mentees,” said Dr. Rombeau. He also emphasized the importance of “mosaic mentoring,” which goes beyond the traditional one-on-one model to include nonsurgical mentors who can provide guidance on basic business skills, such as negotiating a contract.

Another new direction in mentoring is actually a model that harkens to surgical education practices of the past. “Let’s return to scrub sink mentoring, where we can discuss what operation is being performed, why we are doing it, how we are going to do it, and what evidence there is to support this operative decision,” said Dr. Rombeau.

Jennifer E. Rosen, MD, FACS, chief of endocrine surgery, vice-chair for research, MedStar Washington Hospital Center, Washington, DC, presented an update on the ACS Young Fellows Association (YFA) Mentorship Program. She said the mentorship program has expanded to 20 pairings, including two international pairs, with an expanded range of specialties, including surgical oncology, military plastics, urology, ophthalmology, cardiothoracic, transplant, and critical care.

The program’s primary objective, according to Dr. Rosen, is to strengthen engagement and participation in the ACS for both young surgeons and senior Fellows. “The mentoring program makes the College more accessible,” said Dr. Rosen. “It’s no longer this giant monolith, but rather, it becomes a personal experience with the College.”

The future of the ACS/YFA Mentoring Program will include the development of learning models and training, an expanded mentor base (including more subspecialties), and publication of program results data. Rebecca Britt, MD, FACS, associate professor of surgery and surgical director, Sentara Center for Surgical Education, Eastern Virginia Medical School,

“This meeting provides an opportunity for you to develop a sense of camaraderie with your peers and to meet people who have the same challenges as you do,” said Dr. Turner. “These sessions offer you practical skill sets that you can take back home.”
Norfolk, will also take over as the director of the program.

“Both mentors and mentees have responsibilities to reach out and stay in touch,” said Dr. Rosen, highlighting lessons learned from the program. “And stated goals are rarely the actual goals,” she said, emphasizing flexibility and open communication as keys to fostering a productive mentor/mentee relationship.

Mark A. Malangoni, MD, FACS, associate executive director, American Board of Surgery, Philadelphia, PA, and a member of the ACS Board of Regents, presented The Mentor's Perspective, in which he provided what he called “pearls” or guiding principles that surgical mentors should keep in mind when working with mentees, including the importance of a good match, and the ability to function in a relationship that can be, at times, unpredictable.

“Understand what you don’t control,” advised Dr. Malangoni. “It’s important to recognize that there are many uncontrollable factors in the lives of mentees. Be patient, and be a good, active listener. You are not there to tell someone what to do, you are there to listen and to provide guidance.”

Providing insights on his experience as a mentee, Giuseppe R. Nigri, MD, PhD, FACS, assistant professor of surgery, Sapienza University in Rome, Italy, said the ACS/YFA Mentoring Program helped him “understand the dynamics of the ACS.” Carlos Pellegrini, MD, FACS, FRCSI(Hon), then-Chair of the Board of Regents and current ACS President, became a mentor to Dr. Nigri, as did Chad Rubin, MD, FACS, Chair of the ACS General Surgery Coding and Reimbursement Committee. Today, Dr. Nigri, a former ACS International Guest Scholar, is the Italy Chapter Treasurer and a member of the International Relations Committee.

In his presentation, Dr. Rioux discussed the fundamental role of many key committees, including those focused on residents and associates, young Fellows, women in surgery, finance/audit, nominating, advocacy and health policy, continuing medical education, membership, and the ACS National Surgical Quality Improvement Program (ACS NSQIP®).

Dr. Rioux also underscored the importance of analyzing chapter metrics by using tools such as the College’s Chapter Performance Dashboard. “There are some tools that can help chapter leaders determine whether or not the chapter is meeting the needs of its members,” said Dr. Rioux. The dashboard is designed for individual chapters to evaluate their effectiveness, improve recruitment and retention, and help the ACS determine which areas of the College can assist in making the chapters more successful, such as through additional training.

Successful chapters, at their core, share five fundamental goals, according to Dr. Rioux: sustain membership, involve and recruit young surgeons, develop member enthusiasm, build strong administrative leadership, and promote ACS programs.
Chapter success stories
A new session at the Leadership program this year focused on chapter success stories. Officers representing three ACS chapters shared notable achievements over the last year—several of which were conceived at the 2013 Leadership program. Dr. Turner emphasized the fact that there were many chapter success stories over the last year, but due to time and schedule constraints, only a small number of chapters would be highlighted during this portion of the meeting. “At each Leadership program, we will aim to share success stories to highlight chapters and to provide ideas for other chapters to implement,” said Dr. Turner.

Massachusetts Chapter
Terry L. Buchmiller, MD, FACS, President of the Massachusetts Chapter, noted several accomplishments over the last year, including enhancements to the annual meeting and a theme-based state house advocacy day.

Recent additions to their annual meeting, now in its 60th year, include continuing medical education (CME) and Maintenance of Certification self-assessment, an online post-meeting survey, afternoon resident Top-Gun competitions (eight teams this past year), and the establishment of the Joseph Murray, MD, FACS, award for outstanding resident scientific talk. The late Dr. Murray was a member of the chapter and received the Nobel Prize for Medicine in 1990.

The theme for the 2013 State House Advocacy Day was inspired by the Boston Marathon bombing, with a focus on post-event assessment and enhanced infrastructure coordination, said Dr. Buchmiller. “Last year, during the Leadership Summit, all of our cell phones were going off with news of the Boston Marathon Bombing,” recalled Dr. Buchmiller, who noted the event was a call to action for surgeons in her state to advocate for improved trauma response policy. The chapter’s “ask” to state policymakers, according to Dr. Buchmiller, was for “state funding for a 1.5 full-time equivalent epidemiologist/statistician through the Department of Health for trauma data assessment.”

Other notable chapter accomplishments over the last year include the ongoing development of the Massachusetts Surgical Quality Improvement Collaborative, as well as the state’s pilot grassroots advocacy program.

Dr. Buchmiller said the chapter plans to implement new recruitment strategies over the upcoming year, including attendance at intern orientation programs across the state, and development of young surgeon practice management seminars.

Metropolitan Philadelphia Chapter
Francis D. Ferdinand, MD, FRCS, FACS, FACC, Past-President of the Metropolitan Philadelphia Chapter and an ACS Governor-at-Large, described several goals met by chapter leaders and members over the past year, including increased attendance at the chapter’s annual event, the development of a citywide mock oral boards program that more than 50 residents attended, and a renewed effort to encourage chapter leaders and members to foster statewide collaboration and communication.

To boost attendance at the annual dinner meeting, chapter leaders engaged in the “selection of non-specialty-specific national speakers and efficient partnering with industry to achieve an attendance of 135 surgeons from our chapter—and surrounding chapters—for our annual dinner meeting,” said Dr. Ferdinand. Chapter leaders also increased meeting attendance by holding applicant interviews immediately before the annual event. “This
allowed potential Fellows to see and experience the College at the local level and offered networking opportunities [for the applicants] as well,” he said. “This [initiative] led to an increase in meeting attendance by as many as 30 individuals, based on the number of applicants.”

Dr. Ferdinand also cited this year’s and last year’s Leadership program as a conduit for improved communication with other state chapters, including the Keystone Chapter, the Northwestern Pennsylvania Chapter, and the Southwestern Pennsylvania Chapter.

Puerto Rico Chapter
Carlos González MD, FACS, President of the Puerto Rico Chapter, summarized key chapter achievements from the last year, including promoting ACS NSQIP adoption in regional hospitals; organizing the 64th annual chapter meeting; and supporting ACS initiatives and committees. The annual meeting featured 16 guest speakers and included visiting professor grand rounds at the University of Puerto Rico, medical sciences campus, San Juan, with more than 200 medical students, residents, and faculty in attendance, said Dr. González.

Referring to one of the chapter’s primary goals, Dr.

González said that in early 2014 Hospital HIMA San Pablo Caguas received a three-year ACS Commission on Cancer accreditation as a comprehensive community cancer center—the third hospital in Puerto Rico to receive this accreditation.

The power of EI
Understanding emotional intelligence and how it can be used to foster successful relationships with individuals at all levels of an organization was the focus of a presentation by Scott Halford, CSP, an Emmy Award-winning writer and producer and longtime consultant to Fortune 500 executive teams.

EI is defined as a set of “non-cognitive capabilities, competencies, and skills that influence one’s ability to succeed in coping with environment demands and pressures,” explained Mr. Halford.

“Humans can’t fly or swim, and we’re generally not fast runners, so how do we survive? We survive, in part, by how we interact with each other,” said Mr. Halford. What separates humans from other mammals, according to Mr. Halford, is the prefrontal cortex, which he calls the “executive” or “moneymaker” part of the brain that regulates emotions and thought.

“EI is about inclusion and relatedness,” added Mr. Halford. “When we feel included, we perform at higher levels. EI is not fixed like IQ is. And EI, on average, peaks when people are in their 60s, because it grows with life experiences,” he said.

Emotions are a key component of the workplace for the following reasons:

• Essential to making our brains’ biochemistry work
• Give weight to ideas
• Help us discern what is true or false
• Focus and direct our attention
• Make it possible to make decisions

EI, in particular, is vital to successful, productive work environments because it “enlarges others rather than makes them feel diminished. EI is what people feel about you when you walk into a room,” he said.

For surgeons, realizing how they are perceived by those around them is essential in developing strong EI. When giving feedback, structure your body language, tone of voice, and other interpersonal cues so that it is received in a positive way and so that it
accomplishes what it’s intended to do—improve quality of care.

Emotionally intelligent people are aware of how they come across to others, according to Mr. Halford, and make adjustments accordingly. “A good IQ might get you in the door of professional schools and can help you get hired—but EI is why some people do well in life, while others fail,” he said.

Mr. Halford also described the role that oxytocin, a neurohormone, can play in fostering EI among members of surgical teams. Oxytocin, also known as the bonding hormone or the trust hormone, reduces threat states in the brain and allows people to connect. Laughter is a proven “activator” of oxytocin, according to Mr. Halford, as is the act of collaboration and working toward a goal as a team.

The top five EI attributes for successful surgeon leaders include the following:

- Independence
- Stress tolerance
- Empathy
- Impulse control
- Flexibility

Mr. Halford urged surgeons to shift their focus from themselves to others. “It will boomerang back to you.”

**EI: A different way of being smart**

“Emotional intelligence really makes a difference because it sustains effective leadership, maintains friendships, and fosters collegiality,” said Bruce Gewertz, MD, FACS, surgeon-in-chief, vice-dean of academic affairs, and vice-president, interventional services, Cedars-Sinai Medical Center, Los Angeles, CA, in Emotional Intelligence: Can It Enhance Your Professional and Personal Life? “Emotional intelligence is a different way of being smart,” he said, describing five ways EI can be used to achieve success:

- Use insight into feelings/emotions to make good decisions
- Remain hopeful and optimistic despite setbacks
- Manage moods and control impulses
- Know what people around you are feeling
- Persuade and lead others

According to Dr. Gewertz, one of the ultimate goals of fostering EI is to achieve “flow,” a concept developed by Hungarian psychologist Mihaly Csikszentmihalyi, PhD. Flow is similar to what sports psychologists sometimes call the “zone”; it is a state where emotions, feelings, thoughts, and actions are fully synchronized, allowing the individual to focus exclusively on completing a task or goal.

Developing EI and achieving flow are essential for effective leadership in surgery. Dr. Gewertz suggested that summit attendees strive to “manage their own emotional triggers and reactions to stressors” and to “understand how their actions are viewed by others” to enhance communication, and ultimately, improve outcomes.

**The holy grail of leadership**

In his lunchtime presentation, Dr. Pellegrini focused on understanding leadership as it has evolved today and provided practical applications for the practice of leadership. “I propose to you that leadership is something that all human beings have an opportunity to exercise,” said Dr. Pellegrini. “Lead from the soul—establishing and developing the moral center is the holy grail of leadership.”

The modern concept of leadership, according to Dr. Pellegrini, is “servant leadership”—a model that is defined by the following characteristics: courage, integrity, selflessness, empathy,
collaboration, and humility. “Real leaders—and people of strong character—generate and sustain trust,” explained Dr. Pellegrini. “I can’t overemphasize the importance of [leaders] encouraging openness, and even dissent. Leaders must be candid in their communications and show that they care.”

Leaders must be viewed as trustworthy, and Dr. Pellegrini outlined several ways to build other people’s confidence, including engaging in “deep listening,” which he called “the powerful dynamic of human interaction. Listening doesn’t mean agreeing, but it does mean having the empathic reach to understand another,” he said. He also encouraged surgical leaders to build trust by expressing confidence in followers, by acting with reliability and consistency, and by remembering the “wisdom of the crowds.”

“In the past, when I taught leadership, the concept was ‘follow the leader,’ follow the bird in front because he or she will lead you to food and water and shelter,” Dr. Pellegrini noted. “But now, the bird turns around and taps the talents of his or her followers, and then creates a vision plan.”

In addition to developing trust and supporting the contributions of others, the mark of a good leader is someone who can accept and manage missteps appropriately. “One has to be comfortable with failure; if you are not comfortable with failure you cannot lead,” asserted Dr. Pellegrini.

He encouraged surgeon leaders to be “talent magnets” rather than “empire builders.” “See what is native in the individual,” said Dr. Pellegrini. “Find their talent and what motivates them, and you will increase the output of the entire organization.” He also highlighted the importance of “removing the blockers,” those who hoard resources or underutilize talent. “Get rid of the prima donnas,” he said.

“The heart is more important than the brain. The way you reach followers is through the heart,” said Dr. Pellegrini.

State/regional meetings
Leadership program attendees convened again this year by geographic location, allowing group participants to identify areas for synergistic and unified efforts. Before adjourning for the day, a representative from each chapter and/or region gave a short report on how the chapter would move forward in the coming year, suggesting initiatives or ways that they could work together with chapters in neighboring states and/or regions.

Several common goals emerged from this year’s breakout session reports, including:

• Enhance collaboration with neighboring chapters (to develop CME, for example)
• Reverse mentoring programs to help more senior surgeons embrace technologies
• Increase marketing of chapter activities
• Create a committee to promote chapter engagement
• Develop a formal mentoring program
• Improve access to quality metrics
• Develop an advocacy program

Member Services staff are compiling the information presented in the breakout session reports and will provide a summary of these presentations later this year.

The next ACS Leadership & Advocacy Summit will take place April 18–21, 2015, in Washington, DC. ◆
The American College of Surgeons (ACS) hosted its third annual Advocacy program during the 2014 Leadership & Advocacy Summit, March 29 to April 1, at the JW Marriott in Washington, DC. More than 280 people registered for the Advocacy program.

Payment issues at top of agenda
The Summit took place when Congress was debating the future of the Medicare physician payment system and the flawed sustainable growth rate (SGR) formula used to calculate physician fees. Physicians have long lobbied for Congress to repeal and replace the SGR with a bicameral, bipartisan payment system that rewards value and quality over volume, and provides high-quality, patient-centered care. However, the legislation that Congress passed before a more than 24 percent pay cut was scheduled to take effect on April 1 instituted another one-year SGR patch. On April 1, President Barack Obama signed the Protecting Access to Medicare Act of 2014 into law.* (See related article, page 9.)

At the Advocacy program, Rep. Michael Burgess, MD (R-TX), Vice-Chairman of the U.S. House Energy and Commerce Subcommittee on Health, said, “This is not the end of my efforts. I will continue to work on this issue. We are farther than we’ve ever been toward repealing and replacing the SGR.”

Rep. Burgess also noted that the ACS Advocacy program offered a great opportunity for attendees to collectively learn about the issues facing surgery and take their message to Congress. More than 200 attendees from 44 states attended 229 meetings on Capitol Hill during Lobby Day on April 1, which concluded the Advocacy program. In addition to repealing and replacing the SGR, other topics discussed at congressional meetings included medical liability reform, research funding, the 96-hour rule, and trauma and emergency care, all issues that will become especially pertinent in the months ahead.†

The Advocacy program began on Sunday, March 29, with a reception and dinner featuring guest speaker Thomas Goetz, author of The Decision Tree: Taking Control of Your Health in the New Era of Personalized Medicine, and former executive editor of Wired magazine. Mr. Goetz’s presentation, The Invention of Innovation, centered on how invention and creativity have continued to help shape health care and other sectors. He spoke of several essential inventions, including the Kodak camera, the zipper, and the washing machine, and how they became increasingly more sophisticated over time.

For example, Mr. Goetz pointed to the discovery of the bacteria that causes tuberculosis (TB) in the 1800s as a groundbreaking finding.
"The most effective way to influence a lawmaker is for a constituent to talk to a legislator about how the policy will affect the person or a particular group," said Mr. Fitch.

that ultimately led to further important innovations. He spoke of how that discovery decreased mortality rates and the development of antibodies used to identify and neutralize foreign objects, and the progression of the various discoveries. "It's not just about having an idea," Mr. Goetz said. "It's about the idea catching on and demonstrating enough progress that begs the attention of other inventors."

The provider role in health care reform

In a presentation sponsored by the ACS Young Fellows Association, Thomas H. Lee, MD, chief medical officer at Press Ganey Associates, Inc., South Bend, IN, discussed the drivers of improvements in health care. Dr. Lee, who played a leadership role in the development and implementation of Massachusetts’ health care reform law, stressed the importance of strategy and tactics in health care advocacy. "The health care system is under duress, and some of the drivers are medical progress, an aging population, and the global economy," Dr. Lee said. However, the true challenge in the health care system for providers and patients is that "there are too many people involved. There is too much to do; there is no one person with all the information; and there is no one to hold
accountable,” Dr. Lee said, leading to gaps in the quality, safety, and efficiency of care. How can physicians and patients improve the health care delivery system? At the core of the solution, said Dr. Lee, is maximizing value for patients. “Providers must lead the way in making value the overarching goal...since, after all, we are advocating for patients, not doctors,” he explained. The ability to segment patients and become more transparent and accountable are two key drivers for improving value—which may be achievable with the use of patient-centered systems, focused on value-based payment, patient satisfaction, and other methods that are aimed at improving outcomes.

How to hug a porcupine

Brad Fitch, president and chief executive officer (CEO) of the Congressional Management Foundation, a nonpartisan, not-for-profit organization dedicated to helping members improve congressional operations and enhancing citizen engagement, discussed the importance of building relationships with lawmakers and their staffs. Mr. Fitch said that he would imagine that for many health care advocates, developing relationships with legislators is akin to hugging a porcupine. Nonetheless, these kinds of relationships are vital for change. “Capitol Hill is much like the emergency room,” Mr. Fitch said. “[Legislators and their staffs] work long hours, and they work hard,” he observed. On average, each Congressional office receives about 6,000 pieces of constituent mail per month, yet there has not been an increase in staff size since 1974, and Congress has cut their budget by 20 percent, said Mr. Fitch. The average staff size is 18, so finding ways to capture their attention is important.

Given these constraints, how do you get Congress to listen, and who is most likely to attract Congress’ attention? According to Mr. Fitch, legislators listen to expert constituents, passionate constituents, angry constituents, influential constituents, and their own conscience. Although e-mail and the Internet have made it easier for constituents to become involved in the public policy process, research shows that old-fashioned grassroots advocacy is still tried and true. In-person visits, followed by telephone or e-mail contact, and personalized letters are the three most proven ways to communicate with representatives and senators. “The most effective way to influence a lawmaker is for a constituent to talk to a legislator about how the policy will affect the person or a particular group,” said Mr. Fitch. He also suggests constituents participate in town hall meetings, as they provide a platform for voicing opinions that hundreds of other constituents will hear.

A house divided

David Wasserman, house editor of The Cook Political Report, was the keynote speaker at a luncheon sponsored by the ACS Professional Association’s political action committee (ACSPA-SurgeonsPAC). Mr. Wasserman discussed The Cook Political Report’s 2014 Election Road Map, highlighting some of this year’s congressional candidates and then providing his views on the current state of American politics. In a presentation that sometimes bordered on satire,
IN THEIR OWN WORDS
Several participants in the 2014 Advocacy program described their experience at the Advocacy program:

“As a newly elected Governor of the College, I came to the Leadership and Advocacy Summit to better prepare myself for my duties. What I experienced was a superlative program that was energizing and enlightening, fantastic speakers, active participants, a great mix of young and experienced surgeons, and a very well organized program. The trip to Capitol Hill to meet with my legislators was a very positive experience. I will definitely return next year. Kudos to the College for designing such a program.”

—Mark Kuhnke, MD, FACS, general surgeon, Springfield (IL) Clinic LLP

“The Advocacy Summit has provided me with the opportunity to network with other surgeons who are similarly interested in engaging in the political process and improving the profession and care for our patients. The program offers tangible opportunities to get involved in advocacy and health policy—even as a resident.”

—Nikki Perez, MD, third-year surgical resident, Atlanta Medical Center, GA

“As a practicing transplant and general surgeon, it was very beneficial

Mr. Wasserman pointed to some of the more unusual, recent political developments. One example is the candidacy of Clay Aiken, a Democrat running for Congress in North Carolina’s second congressional district. Mr. Aiken is best known as the 2003 runner-up in the television singing competition and reality show, American Idol.

The second example is Republican candidate Milton Wolfe, MD, who is running for Congress in Kansas. According to his website, “Milton Wolfe is a doctor, not a politician. He believes America must re-embrace the Constitution and the divinely inspired American idea of individual liberty, limited government, and free-market values. Want to drive Barack Obama crazy? Send his very own fearless conservative cousin, ‘the next Ted Cruz,’ to the United States Senate!” Whereas the two candidates seemingly have widely opposing political views, they serve as an example of the vast division of today’s U.S. government.

On a more serious note, Mr. Wasserman examined the current demographics of the Republican and Democratic parties, and indicated which races each party was likely to win. Factors that he said affect elections range from the types of retail stores—high end versus moderate—in a particular neighborhood to the level of education of a geographic area’s population. He also discussed some of 2013’s triumphs and failures and how each played a huge part in where both parties stand today.

Be brief, be clear
One of the most effective, time-honored ways of communicating with elected officials is through face-to-face contact. To ensure that the right message is presented at the most opportune time, it is essential that organizations sponsoring lobby days plan and prepare well in advance of scheduled visits. Between February and April, members of Congress and their staffs can expect as many as 10,000 to 15,000 advocates in Washington per week, so brevity and clarity are vital.

To help prepare participants for the ACS Lobby Day, several advocacy and health policy experts participated in the advocacy program. These advocates spoke on key issues and provided details on what attendees could expect before, during, and after Lobby Day.

Sara Rosenbaum, JD, founding chair of the department of health policy
at George Washington University, Washington, DC, presented details about aspects of the Affordable Care Act (ACA) that affect surgery and surgical patient care.

After providing a brief overview of the ACA, Ms. Rosenbaum spoke about specific provisions in the act, including the establishment of state health care exchanges, the preservation of employer-based coverage, and how cost is a major driver for families and providers. The overarching goal of the legislation is to ensure that patients have access to high-quality and safe health care services and affordable health insurance coverage, Ms. Rosenbaum said. Accessing affordable insurance plans is of particular concern to families living in costly areas such as Northern Virginia. She indicated that if surgeons and health care proponents want to change the health care system, then more needs to be done to control costs, such as increasing health care interventions and creating new delivery systems.

Next at the Summit, ACS advocacy staff briefed attendees on the key issues affecting surgical practice. The full list of issues on the ACS legislative agenda at the time of the meeting can be accessed at http://www.facs.org/ahp/summit/congressional-asks.pdf.

In addition, John Hedstrom, JD, Deputy Director, ACS Division of Advocacy and Health Policy, interviewed Beltway insider Brian Gavitt, MD, a Resident Member of the College and a former Senate staffer. Dr. Gavitt said that a typical day on Capitol Hill can involve a number of obligations, such as fielding phone calls, learning about new legislation and policy, meeting with constituents, and serving as a liaison with federal agencies to resolve constituent issues. Given their busy schedule, congressional staff are more receptive to individuals who are well-prepared for constituent meetings.

Because 2014 is an election year, candidates and members of Congress may be listening more intently to the needs of their constituents, according to Christopher Kush, grassroots expert and CEO of Soapbox Consulting, Washington, DC, which helped the College make arrangements for Lobby Day. Mr. Kush guided attendees through the process of preparing for Lobby Day, which involved setting up individual meetings with members of Congress and their staffs, analyzing state and

IN THEIR OWN WORDS (CONTINUED)

for me to spend time at the Advocacy program. I have gained further insight into some of the mechanics behind the new decisions and legislation facing surgery, and where surgery is headed. Overall, this has been an invaluable experience. I believe that every surgeon should attend this meeting.”

—William Kendall, MD, FACS, transplant surgeon, Sanford Health, Fargo, ND

“As a young surgeon that recently completed residency, I believe it’s important to get involved at the chapter and national level because the future of medicine and health care depends on what we do.”

—Amanda Arrington, MD, surgical oncologist, University of South Carolina School of Medicine, and University Specialty Clinics, Columbia

“In an effort to effect change that protects and enhances the medical and surgical professions while protecting the sanctity of the doctor-patient relationship, it is absolutely essential that we not only want to advocate, but to learn the most efficient way to advocate. That is why the advocacy program has been so meaningful to me.”

—Patrick Narh-Martey, MD, surgical resident, Northside Medical Center, Youngstown, OH
2015 ACPSA-SURGEONS PAC AWARD RECIPIENTS

State with the highest percent of participation:
Wyoming, with 10.11 percent

Total dollars raised:
California with $41,380

Outstanding achievement:
Advisory Council for Rural Surgery,
chaired by Tyler Hughes, MD, FACS

PAC most valuable player:
Sara Hartsaw, MD, FACS, Gillette, WY

TIPS FOR HANDLING PUSH-BACK ON LOBBY DAY

1. Stay present and listen carefully to their argument. This will be valuable as feedback.
2. Make one rebuttal or counter-argument, and then let it go and move on.
3. Remain steadfastly polite throughout the exchange.
4. Do not expect instant conversions.
5. Resolve to continue the dialogue over time. This is the key to changing opinions.
6. If you did not have a succinct rebuttal — that is OK. Work on some good comebacks in the shower, and you will have them the next time the question comes up.


Fundraising:
Asking without fear

Fundraising is vital to support the candidacies of individuals who support the surgical profession. “Asking for money is one of the most notable opportunities on earth,” said Marc Pitman, “The Fundraising Coach.” He said that fundraising is not about “the money,” but rather the opportunity to take part in solving a problem of great magnitude.

The first steps in fundraising are to be realistic and do the research. If the goal is to raise...
$100,000, said Mr. Pitman, don’t expect 10 peers to give $10,000 each. Mr. Pitman further suggested that PAC members:

• Conduct face-to-face meetings with potential donors, a time-honored tradition still favored among contributors

• When contacting donors via telephone, use a natural tone

• Get to know potential donors ahead of time and learn what matters to them

• Let your donor know what is unique about your organization

• Be clear. Do not confuse the donor by providing too many options

Such suggestions are especially useful for Fellows interested in helping to increase ACSPA-SurgeonsPAC dollars by participating in various state and federal level activities—or hosting their own event in their home state. Understanding how to fundraise increases the PAC’s chances for making a noticeable impact in the advancement of the practice of surgery and quality of life for patients.

Vehicles for surgeon advocacy
ACSPA-SurgeonsPAC provides the tools necessary to help reach the College’s advocacy goals and increase the profile of surgeons and surgical patients on Capitol Hill. The ACSPA-SurgeonsPAC enables the College to develop relationships with representatives and senators to educate them about the issues that affect the surgical practice environment. The ACSPA-SurgeonsPAC contributes to incumbents and candidates who act as champions for surgery, regardless of their party affiliation.

The ACSPA-SurgeonsPAC hosted several fundraising events at the Summit, raising more than $60,000 during the conference. Awards were also given to Fellows for their philanthropic efforts to help sustain ACSPA-SurgeonsPAC. The list of awards can be viewed on page 70.

One ACSPA-SurgeonsPAC event took place at the International Spy Museum. Attendees were able to tour the museum and hear an introduction from its founding executive director, Peter Earnest, a 35-year veteran of the Central Intelligence Agency (CIA). The event provided an opportunity for attendees to meet with members of Congress and discuss important advocacy issues currently affecting surgery.

Another advocacy resource available to ACS members is SurgeonsVoice, a nationwide interactive program that provides surgeons with the tools they need to influence federal and state legislation. Each Advocacy program attendee received a copy of the “SurgeonsVoice Advocacy Handbook,” a guidebook that describes how Washington works, surgical advocacy, getting involved, taking advocacy to the next level, and planning and staging successful meetings with elected officials. Fellows can log on to www.SurgeonsVoice.org for more information and to get involved.

The 2015 ACS Leadership & Advocacy Summit will take place April 18–21 at the JW Marriott, Washington, DC.
Drs. Frank Opelka and Patrick Bailey join ACS leadership team

The American College of Surgeons (ACS) has announced that Frank G. Opelka, MD, FACS, a colorectal surgeon and physician executive, and Patrick V. Bailey, MD, FACS, a pediatric surgeon, will join the ACS Division of Advocacy and Health Policy this summer. Dr. Opelka, who has worked on a number of College committees as well as with socioeconomic and state and federal health care quality organizations, will serve as the ACS Medical Director of Quality and Health Policy. Dr. Bailey, who has also been active on several ACS committees and in the legislative arena, will serve as the ACS Medical Director of Advocacy.

"I believe the addition of these two individuals to our leadership team will strengthen our presence in Washington, and I look forward to working with both of them as we face the changing landscape of health care delivery in the U.S. and abroad,” said ACS Executive Director David B. Hoyt, MD, FACS.

Leadership in redesigning health system
Dr. Opelka chairs the Surgical Quality Alliance, established by the ACS, and the American Medical Association Physician Consortium for Performance Improvement. He also plays a leadership role on the National Quality Forum’s (NQF) Consensus Standards Approval Committee and the NQF’s Measure Application Partnership.

He is currently executive vice-president of health care and medical redesign at Louisiana State University (LSU) System, Baton Rouge. Dr. Opelka spearheaded the redesign of Louisiana’s health care delivery system, which involved the privatization of a large public hospital system. He also fostered the development of a clinical data warehouse at LSU, which expanded service to a number of national specialty society registries.

Dr. Opelka is a native of Chicago, IL, graduated medical school from Rosalind Franklin University of Medicine and Science, Chicago, and completed his surgical residency with the U.S. Army.

An Arkansas native, Dr. Bailey is chief of pediatric surgery at Maricopa Medical Center in Phoenix, AZ. He currently serves as Vice-Chair of the American College of Surgeons Professional Association Political Action Committee and is a member of the ACS Health Policy and Advocacy Group. He is completing his work toward a master of legal studies degree at Arizona State University’s Sandra Day O’Connor College of Law and is a Captain in the U.S. Navy Reserve. Dr. Bailey completed medical school at the University of Tennessee College of Medicine, Memphis, his pediatric surgical training at Children’s Hospital in Buffalo, NY, and his general surgery and surgical critical care residency at St. Louis University, MO.

“The College is the beneficiary of members’ knowledge, talents, and commitment to quality patient care,” Dr. Hoyt noted. “It is very exciting that Dr. Opelka and Dr. Bailey, who personify these attributes, will bring their invaluable work and life experiences to address the challenges that face the College. I extend my deepest gratitude to them and to the entire ACS membership for their dedicated service ultimately to the patients we serve.”

V99 No 6 BULLETIN American College of Surgeons
Frank T. Padberg, Sr., MD, FACS, passed away peacefully, April 5, at age 96, surrounded by his immediate family. Dr. Padberg was the Director of Fellowship and Graduate Medical Education at the American College of Surgeons (ACS) for more than a quarter of a century and a recipient of the College’s Distinguished Service Award.

Passion for surgery and song
He was born in March 1918, in Canton, OK, to Albert F. Padberg, MD, the town’s general practitioner, and Mayme Padberg, a local schoolteacher. After graduating from Canton High School, he attended Wentworth Military Academy and College, Lexington, MO. A professionally trained baritone, he performed as a soloist during these years and considered a career in music. As the 1937 honor graduate from Wentworth, he was eligible for appointment to West Point but elected to pursue a medical degree at Northwestern University, Chicago, IL. He excelled at this institution and was elected to Alpha Omega Alpha, the academic medical honor society. He graduated from Northwestern in 1943 and was selected for an internship at the University of Michigan, Ann Arbor. That same year, on February 6, he married Helen Swan, from southern Oklahoma. My parents celebrated their 71st anniversary this year.

As a Captain in the U.S. Army Medical Corps from June 1942 to April 1946, he deployed to Bristol, U.K.; Cherbourg, France; and Liege, Belgium, with the 298th General Hospital. He then returned to Northwestern, where he completed a residency in surgery and neurosurgery training with Loyal Davis, MD, FACS, author of surgical and neurosurgical textbooks and Fellowship of Surgeons: A History of the American College of Surgeon, ACS President in 1962, as well as father of former First Lady Nancy Reagan.

Established neurosurgery program
After completing his training in 1952, Dad moved the family to Little Rock to bring the recently formulated specialty of neurosurgery to the University of Arkansas for Medical Sciences and Little Rock Veterans Affairs hospitals, where he achieved the rank of clinical professor. He practiced at Little Rock’s St. Vincent’s Hospital from 1952 to 1973. At this point in his career, he became a Fellow of the ACS and served as President of the Arkansas Chapter. The Arkansas State Nurses Association awarded him honorary recognition in 1969, and he was an active member of Rotary International and The Little Rock Club, which maintains a weekly lunch roundtable for civic leaders.

Dr. and Mrs. Padberg maintained dual residency in Chicago and Little Rock after he accepted the position as Director of Fellowship and Graduate Medical Education (now the Division of Member Services) at the ACS in 1973. He actively visited ACS Chapters and participated in the Committee on Applicants. Around this time, I became a Fellow of the College. Many who participated in these meetings fondly recall Dad’s visits.

He received the ACS Distinguished Service Award, the College’s highest honor, in 1988. “In gratitude for sixteen years of dedicated, vigorous contributions as Director of the Fellowship and Graduate Education Departments, representing this College nationally and internationally in exemplary fashion, the Board is pleased to award its highest honor,” reads the award citation.
dated October 27, 1988. He retired from the ACS in 1999. The Surgical Section of the National Medical Association honored him with its distinguished service award that same year. Dad was also a member of other distinguished surgical organizations, including the American Surgical Association, the Southern Surgical Association, the Southern Neurosurgical Society, The American Association of Neurological Surgeons, and the Congress of Neurological Surgeons.

Devoted to faith and family
As an active member of the Second Presbyterian Church in Little Rock, Dad served as an elder and was an active participant in the men’s Bible class; in Chicago he served as a deacon in the Fourth Presbyterian Church. At church services, his projected baritone voice supplemented the inspiration inherent in the hymns.

International travel was a frequent diversion, and he managed to visit every continent but Antarctica. As a gift to me for my professional achievements, he asked me to choose a destination; we went behind the Iron Curtain to visit the Soviet Union and other parts of Eastern Europe during the Cold War era. The entire family participated in several reunions with the Familienverband Padberg (the international Padberg family), attending several reunions in St. Louis, MO, as well as Berlin, Cologne, and Padberg, Germany. Dad maintained a relationship with the families in Canton, OK, and was a contributor to the church.

He inspired us with his elegant and distinguished persona. An honest character was coupled with a heart for charity and a gracious generosity to less fortunate associates. He was serious and focused in professional activities but had a lighter side, guaranteed to liven up any gathering. Those of you who asked him, “How are you?” will remember that he was always “medium well.”

Dr. Padberg was predeceased by his older sister Louise Souders, MD, and both parents. In addition to his wife, he is survived by the author and his wife, Sharon; his daughter, Kristen; and his grandson, Frank III. A celebration of his life took place Friday, April 11, at the Second Presbyterian Church in Little Rock.

Dr. Padberg with his ACS Distinguished Service Award citation, 1988.
The Royal College of Surgeons of Edinburgh (RCSEd) recognized the achievements of Andrew L. Warshaw, MD, FACS, President-Elect of the American College of Surgeons, and Jatin P. Shah, MD, FACS, at the 500-year-old Edinburgh College, U.K., on April 25.

Dr. Warshaw was awarded Honorary Fellowship from Britain’s oldest and largest Royal Surgical College, RCSEd, in recognition of his work in pancreatic surgery and for his surgical leadership throughout his career. Dr. Shah received the Honorary Fellowship from the RCSEd’s Faculty of Dental Surgery (FDS) in recognition of his contributions to medicine, particularly in the field of oral oncology.

Recognition of Dr. Warshaw’s achievements
Dr. Warshaw is the W. Gerald Austen Distinguished Professor of Surgery, Harvard Medical School; emeritus surgeon-in-chief and senior consultant for international and regional clinical relations at Massachusetts General Hospital (MGH) and Partners Healthcare; and medical director of the International Patient Center at MGH, Boston.

Commenting on Dr. Warshaw’s receipt of Honorary Fellowship in the organization, RCSEd council member and
“Dr. Warshaw is not only a leader in American surgery, but is recognized worldwide for his innovative contributions in the field of pancreatic surgery,” Mr. Garden added.

honorary consultant pancreatic surgeon O. James Garden, BSc, MB, ChB, MD, FRCSEd, said, “I have known Dr. Warshaw professionally for many years within our specialty. He is highly regarded as one of the major international names in pancreatic surgery.” Mr. Garden noted that Dr. Warshaw has authored or co-authored more than 400 publications relating specifically to the management of chronic pancreatitis, pancreatic cancer, and pancreatic cysts. He has also served on many editorial boards and is the editor of Surgery. “Dr. Warshaw is not only a leader in American surgery, but is recognized worldwide for his innovative contributions in the field of pancreatic surgery,” Mr. Garden added.

The President of the RCSEd, Ian Ritchie, MB, ChB, FRCSEd, said, “RCSEd has a long history of innovation, and Dr. Warshaw’s work exemplifies this quality. I take great pleasure in presenting this Fellowship to mark his outstanding contribution in advancing the field of surgery.”

“I am profoundly grateful that The Royal College of Surgeons of Edinburgh has offered me an Honorary Fellowship,” Dr. Warshaw said. “The RCSEd has been a leader in surgical training, innovation, and practice for a stunning five centuries. Among its Fellows and Members are many close friends and colleagues from Britain and elsewhere in the world. I am proud to be associated with those surgeons and their achievements.”

Dr. Shah’s achievements
In addition, the RCSEd recognized Dr. Shah’s achievements as a leading head and neck cancer surgeon. Dr. Shah is chief, head and neck service, Memorial Sloan-Kettering Cancer Center; and professor of surgery, Cornell University Weill Medical College, New York, NY. He also is chair of the Council of the International Academy of Oral Oncology. He has authored or co-authored more than 400 peer-reviewed publications and is an Honorary Fellow of the Royal College of Surgeons of Edinburgh, England, and Australia.

“Professor Shah is one of the most distinguished and leading figures worldwide in the field of oral oncology,” said Richard Ibbetson, BDS MSc, FDS RCSEng; FDS RCSEdin; and FF GDPU.K., dean of the RCSEd dental faculty. “His significant contribution to health care and education, particularly in the field of oral cancer, worldwide, deserves to be duly recognized, and I am delighted to welcome him to Edinburgh to be awarded the Honorary FDS of the Royal College of Surgeons of Edinburgh.”

“I am deeply humbled and sincerely grateful to the RCSEd for bestowing this distinguished honor upon me,” Dr. Shah said. “Recognition by colleagues from a different background is a high point in my career, and a unique privilege with a special meaning. Such recognition will go a long way towards strengthening the common platform created between surgeons from differing backgrounds involved in the care of patients with oral cancer, such as head and neck surgeons; otolaryngologists; plastic surgeons and dental/oral/maxillofacial surgeons.”

Established in 1505 and with a worldwide membership, the RCSEd is one of the world’s oldest and largest surgical establishments dedicated to the pursuit of excellence and advancement in surgical and dental practice, through its activities in education, training, and examinations. At the diploma ceremony, Drs. Warshaw and Shah joined surgeons and dental professionals who traveled to Edinburgh from around the globe to receive fellowship and membership diplomas. For more information, go to http://www.rcsed.ac.uk. ◆
ACS Inspiring Quality Forum in South Carolina focuses on surgical checklists

The American College of Surgeons (ACS) hosted a Surgical Health Care Quality Forum on April 1 in Columbia, SC. The event was part of a series of Inspiring Quality programs aimed at infusing community participation into the national discussion on surgical quality improvement. Speakers at the forum, which was presented in partnership with Safe Surgery 2015 and the South Carolina Hospital Association, examined the successes of the Surgical Safety Checklist and best practices now used in all of the state’s operating rooms (ORs).

Chad A. Rubin, MD, FACS, ACS Governor; Chair, ACS General Surgery Coding and Reimbursement Committee; and staff surgeon, Providence Hospitals, Columbia, hosted the South Carolina forum. Atul Gawande, MD, MPH, FACS, delivered the keynote address. Dr. Gawande is director, Ariadne Labs, Harvard School of Public Health (HSPH), Boston, MA; executive director, Safe Surgery 2015; general and endocrine surgeon, Brigham and Women’s Hospital, Boston; professor of surgery, Harvard Medical School; and professor, department of health policy and management, HSPH.

Dr. Gawande discussed the development of the World Health Organization’s OR checklist, implementation of the Safe Surgery 2015 approach to checklists, and how engaging all members of the surgical team affects quality.

Speakers at the forum offered comparisons of aviation
and surgical checklists and noted that their use requires a fundamental culture shift to sustain improved outcomes and safety. Participants at the forum who offered their perspectives on the potential benefits of surgical checklists and how they can be customized to meet the needs of each OR included:

- William Berry, MD, MPA, MPH, FACS, principal research scientist, HSPH; chief medical officer and surgery lead, Ariadne Labs; and program director, Safe Surgery 2015 Initiative
- Ashley Kay Childers, PhD, CPHQ, research assistant professor of industrial engineering, Clemson University, SC; Safe Surgery 2015: South Carolina
- David B. Hoyt, MD, FACS, ACS Executive Director
- William McDougall, commercial airline captain, Charleston, SC
- David L. Oliver, MD, medical director, patient safety and risk management, Palmetto Health; and staff anesthesiologist, department of anesthesiology, Palmetto Health Richland, Columbia

View photos and an archived video of the forum at http://inspiringquality.facs.org/national-tour/south-carolina/. E-mail InspiringQualityTour@facs.org with questions or for additional information.

**Register now for ACS Comprehensive General Surgery Review Course**

The American College of Surgeons (ACS) Comprehensive General Surgery Review Course, June 19–22 in Chicago, IL, is an intensive three-and-a-half-day review course covering essential content areas in general surgery, including abdomen, alimentary tract, endocrine, oncology, perioperative care, skin and breast, surgical critical care, trauma, and vascular operations. Course Chair John A. Weigelt, MD, DVM, FACS, and a distinguished faculty will use didactic and case-based formats for a comprehensive and practical review. Dr. Weigelt is Medical Director of the ACS Surgical Education and Self-Assessment Program®, professor of surgery, chief of the division of trauma and critical care, and associate dean of clinical quality at the Medical College of Wisconsin, Milwaukee.

The course will feature a variety of self-assessment materials as well as five monthly online modules following the course. Organized by the ACS Division of Education, this course will help fulfill the requirements for Maintenance of Certification, Part 2, and should be helpful to surgeons preparing for recertification examinations. Self-assessment credit will be available. Space is limited and registration will be accepted on a first-come, first-served basis. For more information and to register for the course, view the ACS website at http://www.facs.org/education/reviewcourse.html, e-mail ulangenscheidt@facs.org, or call 312-202-5018.
Dr. Hall appointed co-chair of NQF Admissions and Readmissions Committee

American College of Surgeons’ (ACS) nominee Bruce Lee Hall, MD, PhD, MBA, FACS, was recently appointed co-chair of the National Quality Forum’s (NQF) Admissions and Readmissions Standing Committee. The NQF is a multi-stakeholder, not-for-profit organization that builds consensus on national priorities and goals for performance improvement. The expert panel will review measures addressing length of stay and all-cause admissions and hospital readmissions from applicable settings and will conduct an ad hoc review of the hospital-wide, all-cause, unplanned readmissions measure. For details about the appointment, go to http://www.qualityforum.org/Project_Pages/All-Cause_Admissions_and_Readmissions_Measures.aspx#t=1&s=&p=.

Dr. Hall is professor of surgery at Washington University School of Medicine, professor of healthcare administration at Washington University’s Olin Business School, vice-president of patient-centered outcomes for BJC HealthCare in St. Louis, MO, and associate director of the ACS National Surgical Quality Improvement Program. He also has served on other NQF committees, including the Hospital-wide Readmission Measure Steering Committee and the Planned Readmissions Measures Technical Expert Review Committee.

Dr. Sachdeva delivers Ira A. Ferguson, MD, Lecture at Emory

Ajit K. Sachdeva, MD, FACS, FRCSC, Director of the American College of Surgeons Division of Education, delivered the Ira A. Ferguson, MD, Lecture at Emory University School of Medicine, Atlanta, GA, in April. The title of Dr. Sachdeva’s presentation was Preparation of Residents for Independent Practice: Challenges, Opportunities, and New Directions. The presentation focused on issues involving the preparation of surgery residents for independent practice, new directions in residency education and training in surgery, and national programs to address transitions in surgical careers.

This annual lectureship was established in honor of Dr. Ferguson (1896–1970), a Fellow of the ACS and a renowned colon-rectal surgeon in Atlanta. Dr. Ferguson served as chief of surgery at Grady Memorial Hospital and played a pioneering role in integrating Grady, Emory, and Atlanta Veterans Affairs hospitals to create the Emory University-affiliated program.
The American College of Surgeons (ACS) Committee on Trauma (COT) announced the 15 winners of the 37th annual Residents Trauma Papers Competition at its Annual Meeting, March 20–22, in Philadelphia, PA. Each winner received a $500 prize, with an additional $500 awarded to the second-place winners in each category and an extra $1,000 awarded to the two first-place winners.

The competition is open to surgical residents and trauma fellows. Submissions describe original research in the area of trauma care and/or prevention in one of two categories—basic laboratory research or clinical investigation. The Eastern and Western States COTs, Region 7 (Iowa, Kansas, Missouri, and Nebraska) and the ACS provided funding for this year’s competition.

Submissions begin at the state or provincial level, and winners are then judged at regional competitions. Each region is then eligible to submit two abstracts to a panel of COT judges who make the final selection for presentation at the Scientific Session of the COT Annual Meeting. Raul Coimbra, MD, PhD, FACS, San Diego, CA, Vice-Chair of the COT and Chair of the COT Regional Committees, moderated the session.

The 2014 competition winners are as follows:

• First Place, Basic Laboratory Research: Michaela C. Kollisch-Singule, MD, Syracuse, NY (COT Region 2): Airway Pressure Release Ventilation (APRV) Reduces Alveolar Duct Micro Stress/Strain in Acute Lung Injury

• First Place, Clinical Investigation: Hunter B. Moore, MD, Denver, CO (COT Region 8): The
The competition is open to surgical residents and trauma fellows. Submissions describe original research in the area of trauma care and/or prevention in one of two categories—basic laboratory research or clinical investigation.

Fibrinolytic Response to Trauma and Hemorrhagic Shock: Pathologic of Physiologic

• Second Place, Basic Laboratory Research: Matthew W. Ralls, MD, Ann Arbor, MI (COT Region 5): Acute Nutrient Deprivation and Intestinal Environmental Variation: Potential Mechanisms that Drive Intestinal Mucosal Inflammation

• Second Place, Clinical Investigation: Vanessa J. Fawcett, MD, MPH, Seattle, WA (COT Region 10): Characteristics of Elderly Patients Readmitted after Trauma: A Competing Risk Analysis

Additional selected surgical residents and the papers they presented are as follows:

• David W. Fink, MD, Boston, MA (COT Region 1): Pre-Hospital Treatment of Non-Compressible Hemorrhage with a Self-Expanding Polymer Foam: Three Injury Models and Chronic Survival

• Taryn E. Travis, MD, Washington, DC (COT Region 3): The Application of Pressure Reduces Hypertrophic Scar Pathology: A Gross, Cellular and Molecular Analysis Using a Validated Animal Model

• Yann-Leei Larry Lee, MD, Mobile, AL (COT Region 4): Oxidative Mitochondrial (mt) DNA Damage as a Mechanism for Trauma-Induced mtDNA DAMP Production

• Arham Ali, MD, Galveston, TX (COT Region 6): Propranolol Administration Curbs Blood Loss during Burn Excision

• Jared A. Konie, MD, Columbia, MO (COT Region 7): Gene Expression of Selected Members of the Toll-Like Receptor Pathways and Suppressor of Cytokine Signaling Correlate with Micro-RNA 146a and 155 in Trauma Patients with Hemorrhagic Shock

• Ammar Hashmi, MD, Tucson, AZ (COT Region 9): The Protective Effects of Remote Ischemic Conditioning in a Septic Mouse Model

• Markus T. Ziesmann, MD, Winnipeg, MB (COT Region 11): STARTT—Development of National, Multi-Disciplinary Trauma Crisis Resource Management Curriculum: Results from the Pilot Course

• Chethan Sathya, MD, MSc(C), Toronto, ON (COT Region 12): Do Children with Penetrating Versus Blunt Trauma Receive Better Care at Adult or Pediatric Trauma Centers?

• CPT Mia D. DeBarros, MD, Tacoma, WA (COT Region 13): The Efficacy and Effects of Tranexamic Acid in a Porcine Model of Severe Shock and Metabolic Acidosis

• Maria Victoria Nieto Ángel, MD, Bogotá, Colombia (COT Region 14): Epidemiological Description of 2,695 Deaths Due to Electrical Injury in Colombia from 2000 to 2009

• Mina Cheng, MB, BS, MRCS, Hong Kong, (COT Region 16): Management of Haemodynamically Unstable Pelvic Fractures: An 18-year Experience in a Level I Trauma Center◆
**China-Hong Kong Chapter**
The China-Hong Kong Chapter of the American College of Surgeons (ACS) and the department of surgery at the University of Hong Kong welcomed ACS President Carlos Pellegrini, MD, FACS, FRCSI(Hon) to their meeting December 5, 2013. Dr. Pellegrini was honored at a reception held at the Queen Mary Hospital, after which he delivered a lecture on the Future of Surgery and Surgeons.

**UAE hold first chapter planning meeting**
The United Arab Emirates (UAE) Chapter held a planning meeting December 28 in the Hilton Abu Dhabi Hotel. According to Chapter President Safwan Taha, MD, FACS, FRCSGlasg, issues discussed at the meeting included the formation of chapter subcommittees, communication with the ACS, and possible future activities of the chapter. The UAE Chapter is the most recent chapter to be admitted to the College, joining the ACS in February 2013.

**Tennessee Chapter advocates in Washington, reports successful quality collaborative**
Members of the Tennessee Chapter attended the 2014 Leadership & Advocacy Summit in Washington, DC, and participated in Capitol Hill visits with senators and representatives from their state on April 1. In these meetings, the Tennessee delegation, which included both ACS Resident Members and Fellows, advocated emphatically for the repeal of the sustainable growth rate formula used to calculate Medicare physician fees and for trauma care funding. The Tennessee surgeons also shared with legislators the results of an initiative being carried out through the Tennessee Surgical Quality Collaborative (TSQC), which uses the ACS National Surgical Quality Improvement Program (ACS NSQIP®) to improve patient outcomes and reduce unnecessary spending. Implementation of the TSQC has resulted in a “significant decline in surgical morbidity, postoperative complications, and decreased costs of nearly $30 million,” according to Joe Cofer, MD, FACS, Tennessee Chapter President and professor of surgery and residency program director, University of Tennessee Health Science Center-Chattanooga.

**New York Chapter and Manhattan Council hold strategic planning session**
Leaders from the New York Chapter and the Manhattan Council participated in a strategic planning session February 22 at the Harmonie Club in New York, NY. Former ACS Regent Mary McGrath, MD, MPH, FACS, facilitated the session, and Donna Tieberg, ACS Chapter Services Manager, organized and planned the event. During the session, council members discussed updating the chapter mission statement and goals for the future, including the continuation of a strong advocacy program in New York State, better alignment with specialty surgical groups, and further chapter educational programming.

**Record-breaking attendance at 2014 Leadership Summit**
The third annual ACS Leadership & Advocacy Summit took place March 29 to April 1, in Washington, DC, at the JW Marriott. The Leadership program began on Saturday evening with a well-attended Welcome Reception. A record-breaking crowd of more than 427 attendees, including domestic and international ACS leaders, gathered on Sunday to hear presentations on leadership and mentoring skills, emotional intelligence, and chapter development. In addition, current and past Presidents of the Massachusetts, Metropolitan Philadelphia, and Puerto Rico Chapters relayed stories about their group’s continued on page 84
Tennessee advocates at the Leadership & Advocacy Summit. From left: Keith Gray, MD, FACS, general surgeon and associate professor of surgery, University of Tennessee Health Science Center-Knoxville; Sen. Lamar Alexander (R-TN); Rebeccah Baucom, MD, surgery resident, Vanderbilt University Medical Center, Nashville; Wanda McKnight, CAE, Chapter Administrator; Sen. Bob Corker (R-TN); and Dr. Cofer.

China-Hong Kong Chapter meeting, from left: Prof. See Ching Chan, MB, BS, FACS; John Hoong Boey, MD, FACS; Prof. Way Lun Law, MB, BCH, FACS; Prof. Simon Ying-Kit Law, MB, BCH, FACS; H. T. Luk, MB, BS, FACS; Prof. Chung Mau Lo, MB, BS, MS, FACS; Dr. Pellegrini; Timothy Teoh Sim Chuan, MB, BS, FACS; P. C. Tam, MB, BS, FRCS, FRACS; and Prof. Richard Kwongyin Lo, MD, FACS.

China-Hong Kong Chapter meeting, from left: Drs. Pellegrini and Lo; and Jensen Tung Chung Poon, MB, BS, FACS.

UAE Chapter President Dr. Taha.

Tennessee advocates at the Leadership & Advocacy Summit. From left: Keith Gray, MD, FACS, general surgeon and associate professor of surgery, University of Tennessee Health Science Center-Knoxville; Sen. Lamar Alexander (R-TN); Rebeccah Baucom, MD, surgery resident, Vanderbilt University Medical Center, Nashville; Wanda McKnight, CAE, Chapter Administrator; Sen. Bob Corker (R-TN); and Dr. Cofer.
successes from the past year. Attendees convened again this year by state and/or region to identify areas for synergistic and unified efforts for the future. Before adjourning for the day, a representative from each of the states and regions reported on their plans moving forward in the coming year. For further details on the Leadership program, see the article beginning on page 58.

The Advocacy Summit, March 31–April 1, began with a dinner and speaker and was followed the next day by comprehensive and specialized education sessions, offered by volunteer leaders and advocates, which focused on the tools needed for effective leadership. Interactive advocacy training and coordinated visits with congressional offices followed these sessions. For more details on the Advocacy Summit, see the article that begins on page 65.

Planning has already begun for the next Leadership & Advocacy Summit, which will take place April 18–21, 2015, in Washington, DC.

Governors welcome international attendees to Leadership & Advocacy Summit
Raymond Price, MD, FACS, Chair of the ACS Governors Chapter Activities International Workgroup; Patricia L. Turner, MD, FACS, Director, ACS Division of Member Services; and Ms. Tieberg welcomed workgroup members and ACS international governors and chapter leaders to the 2014 Leadership & Advocacy Summit. Those at the Saturday meeting included Esteban Foianini, MD, FACS, a new ACS Governor from Bolivia; Dimitrios Linos, MD, FACS, Governor from Greece; and Luis Samuel Mon, MD, FACS, Governor from Panama. Also at the meeting was Giuseppe Nigri, MD, PhD, FACS, Treasurer and Chapter Administrator of the Italy Chapter, who gave a presentation at the Leadership program on his experiences as a participant in the Young Fellows Association Mentoring Program.

International Governors and chapter leaders will convene again at the 2014 ACS Clinical Congress to discuss issues relevant to international Fellows.

Connecticut Lobby Day
ACS members, including (from left) Alan Meinke, MD, FACS, Chapter Treasurer; Kathleen LaVorgna, MD, FACS, Chapter President; Philip Corvo, MD, FACS, Chapter Past-President and Quality Committee member; Scott Kurzman, MD, FACS, Connecticut Governor-at-Large; and Michael Deren, MD, FACS, Chapter President-Elect, gathered at the Connecticut Lobby Day, March 20, at the state capitol in Hartford.
ACS Women in Surgery Committee seeks new members

The American College of Surgeons (ACS) Women in Surgery Committee is seeking candidates interested in serving an initial three-year term on the committee beginning in October. Applications are due by June 30, 2014.

The mission of the Women in Surgery Committee is to enable women surgeons of all ages, specialties, and practice types to develop their individual potential as professionals; promote an environment that fosters inclusion, respect, and success; develop, encourage, and advance women surgeons as leaders; and provide a forum and networking opportunities to enhance women’s surgical career satisfaction. Surgeons interested in advancing the role of women in the ACS and encouraging and mentoring women in surgery should apply. The committee encourages representation by individuals of diverse cultural, racial, and ethnic backgrounds.

Applicants should submit a summary curriculum vitae of five pages or less and a letter of interest highlighting their skills and expertise, along with contributions they would like to make to the committee, to Connie Bura at cbura@facs.org by the June 30, 2014, deadline. Eligible candidates will be selected and notified by the committee in July or August and will be invited to attend the committee meeting on Monday, October 27, in conjunction with the 2014 Clinical Congress in San Francisco, CA.

ACS Committee on Diversity Issues seeks new members

The American College of Surgeons (ACS) Committee on Diversity Issues, chaired by Anthony G. Charles, MB, BS, FACS, University of North Carolina Medical Center, Chapel Hill, studies the educational and professional needs of underrepresented surgeons and surgical trainees and the impact that its work may have on eliminating health disparities among diverse population groups in the U.S. and globally.

The committee currently seeks candidates to serve an initial three-year term, which would begin in October 2014. Surgeons interested in advancing cultural competency in surgical care and in developing efforts to expand diversity among the ACS membership are encouraged to apply. The committee seeks representation by individuals of diverse cultural, racial, and ethnic backgrounds.

Applicants should submit their curriculum vitae and a letter of interest highlighting their skills and expertise along with contributions they could make to the committee to Connie Bura at cbura@facs.org by June 30, 2014. The committee will select eligible candidates and notify them in July and August. Those selected will be invited to attend the committee meeting that will take place during the 2014 Clinical Congress in San Francisco, CA, October 26–30.
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A total of 17 surgeons will attend the Leadership Program in Health Policy and Management at Brandeis University, Waltham, MA, in June. Each 2014 Health Policy Scholar receives funding to participate in the intensive, weeklong course and then is expected to provide a year’s service in a health policy-related capacity to the College and the surgical specialty society cosponsoring the awardee.

The following is a list of this year’s scholars and their cosponsoring society (where applicable):

- ACS Health Policy Scholar for General Surgery: Carla C. Braxton, MD, MBA, FACS, Michael E. DeBakey Veterans Affairs Medical Center, Houston, TX
- ACS Health Policy Scholar for General Surgery: Mark T. Savarise, MD, FACS, University of Utah, South Jordan
- ACS/American Association of Neurological Surgeons Health Policy Scholar: Cormac O. Maher, MD, FACS, University of Michigan, Ann Arbor
- ACS/American Academy of Otolaryngology-Head & Neck Surgery Health Policy Scholar: James C. Denneny III, MD, FACS, University of Missouri, Columbia
- ACS/American Association for the Surgery of Trauma Health Policy Scholar: Randall Friese, MD, MSc, FACS, University of Arizona, Tucson
- ACS/American Pediatric Surgery Association Health Policy Scholar: Max R. Langham, Jr., MD, FACS, University of Tennessee College of Medicine, Memphis
- ACS/American Surgical Association Health Policy Scholar: Prabhakar K. Baliga, MB, BS, FACS, Medical University of South Carolina, Charleston
- ACS/American Society of Breast Surgeons Health Policy Scholar: Jane Hulvat, MD, FACS, University of Virginia, Charlottesville
Each 2014 Health Policy Scholar receives funding to participate in the intensive, weeklong course and then is expected to provide a year’s service in a health policy-related capacity to the College and the surgical specialty society cosponsoring the awardee.

Melissa C. Hulvat, MD, FACS, Bass Breast Center, Kalispell Regional Healthcare, MT

• ACS/American Society of Colon and Rectal Surgeons Health Policy Scholar: Amit Merchea, MD, Mayo Clinic Florida, Jacksonville

• ACS/American Society of Plastic Surgeons Health Policy Scholar: Lynn Jeffers, MD, FACS, University of Southern California, Los Angeles

• ACS/American Urogynecologic Society Health Policy Scholar: Samantha J. Pulliam, MD, Massachusetts General Hospital, Boston

• ACS/American Urological Association Health Policy Scholar: Timothy D. Averch, MD, FACS, University of Pittsburgh Medical Center, PA

• ACS/Eastern Association for the Surgery of Trauma Health Policy Scholar: Jason W. Smith, MD, PhD, FACS, University of Louisville, KY

• ACS/New England Surgical Society Health Policy Scholar: David McAneny, MD, FACS, Boston Medical Center, MA

• ACS/Society for Surgery of the Alimentary Tract Health Policy Scholar: Jeffrey M. Hardacre, MD, FACS, Case Western Reserve University School of Medicine, Cleveland, OH

• ACS/Society of Thoracic Surgeons Health Policy Scholar: Aaron W. Eckhauser, MD, University of Utah, Salt Lake City

• ACS/Society for Vascular Surgery Health Policy Scholar: Eleftherios S. Xenos, MD, PhD, FACS, University of Kentucky Medical Center, Lexington

Dr. Jeffers
Dr. Pulliam
Dr. Averch
Dr. Smith
Dr. McAneny
Dr. Hardacre
Dr. Eckhauser
Dr. Xenos
The International Relations Committee of the American College of Surgeons (ACS) is pleased to announce the availability of 2015 Community Surgeon Travel Awards for surgeons ages 30 to 50. The deadline for applications is July 1, 2014.

These awards, in the amount of $4,000 each, provide international surgeons with the opportunity to attend and participate fully in the educational activities of the ACS Annual Clinical Congress. They are intended to specifically assist surgeons who work in community or regional hospitals or clinics in countries other than the U.S. and Canada or who are from struggling academic departments of surgery in low- or middle-income countries.

Each awardee will receive gratis registration to the annual Clinical Congress and to one available Postgraduate Course at the conference. Assistance will be provided to obtain preferential housing in an economical hotel in the Clinical Congress host city. The 2015 Clinical Congress will take place October 4–8 in Chicago, IL.

Basic requirements

• Applicants must be graduates of schools of medicine.

• Applicants must be 30 to 49 years old on the date that the complete application is filed.

• Candidates must submit their applications from their intended permanent location. Applications will be accepted for processing only when the candidates have been in surgical practice, teaching, or research for a minimum of one year at their intended permanent location following completion of all formal training, including fellowships and scholarships.

• Applicants must show evidence of commitment to high-quality surgery, to surgical teaching, and to improving access to surgical care in their community.

• Applicants must submit a fully completed application form provided by the College on its website at http://web2.facs.org/csta/. The application and accompanying materials must be typewritten and in English. Submission of a curriculum vitae only is not acceptable.

• Preference will be given to applicants who have not already experienced training or surgical fellowships in North America.

• Applicants must submit independently prepared letters of recommendation from three of their colleagues. One letter must be from the chair of the department in which they hold a clinical or academic appointment or from a Fellow of the ACS who resides in their country. The chair’s or the Fellow’s letter must directly address the applicant’s commitment to high-quality surgery, surgical teaching, and improving access to surgical care locally. Letters of recommendation should be submitted by their writers.

• The Community Surgeon Travel Awards must be used in the year for which they are designated. They cannot be postponed.

• Awardees are expected to provide a written report upon their return home, specifically focusing on the value of the visit to the awardee and the potential beneficial effect to patients in the country of origin.

• Unsuccessful applicants may reapply only twice and only by completing and submitting a current application form provided by the College together with new supporting documentation.

In order to qualify for consideration by the selection committee, all of the requirements must be fulfilled. All applications for the year 2015 and all of the supporting documentation must be received by the International Liaison no later than July 1, 2014, for consideration by the selection committee. All applicants will be notified of the selection committee’s decision in November 2014. Applicants are urged to submit their completed applications and supporting documents as early as possible to provide sufficient time for processing. Supporting materials and questions should be directed to the International Liaison at kearly@facs.org or 312-202-5021 (fax).
The American College of Surgeons (ACS) offers International Guest Scholarships to young surgeons from countries other than the U.S. or Canada who have demonstrated a strong interest in teaching and research. The deadline to apply for the 2015 International Guest Scholarships is July 1, 2014.

The scholarships, in the amount of $10,000 each, provide the recipients with an opportunity to visit clinical, teaching, and research programs in North America and to attend and participate fully in the ACS Clinical Congress.

This scholarship endowment was originally provided through the legacy Paul R. Hawley, MD, FACS(Hon), former College Director, left to the College. More recently, gifts from the family of Abdol Ismaili, MD, FACS, the Stavros Niarchos Foundation, and others have enabled the College to expand the number of scholarship awards.

Scholarship requirements

- Applicants must be graduates of schools of medicine.
- Applicants must be 35 to 45 years old on the date that the completed application is filed.
- Candidates must submit their applications from their intended permanent location. Applications will be accepted for processing only when the candidates have been in surgical practice, teaching, or research for a minimum of one year at their intended permanent location following completion of all formal training, including fellowships and scholarships.
- Applicants must have demonstrated a commitment to teaching and/or research in accordance with the standards of the applicant’s country.
- Early careerists are deemed more suitable than those who are serving in senior academic appointments.
- Applicants must submit a fully completed application form provided by the College on its website. The application and accompanying materials must be typewritten and in English. Submission of curriculum vitae only is not acceptable.
- Applicants must provide a list of all of their publications and must submit three complete publications (reprints or manuscripts) from that list.
- Preference may be given to applicants who have not already experienced training or surgical fellowships in the U.S. or Canada.
- Applicants must submit independently prepared letters of recommendation from three of their colleagues. One letter must be from the chair of the department in which they hold academic appointment or a Fellow of the ACS residing in their country. The chair’s or the Fellow’s letter is to include a specific statement detailing the nature and extent of the teaching and other academic involvement of the applicant. Letters of recommendation should be submitted by their writers.
- The application form is structured to assist the Scholarship Selection Subcommittee and assists the applicant in submitting structured curriculum vitae.
- The International Guest Scholarships must be used in the year for which they are designated. They cannot be postponed.
- Applicants who are awarded scholarships will provide a full written report of the experiences provided through the scholarships upon completion of their tours.
- An unsuccessful applicant may reapply only twice and only by completing and submitting a current application form provided by the College, together with new supporting documentation.

The scholarships provide successful applicants with the privilege of participating in...
American College of Surgeons Official Jewelry & Accessories designed, crafted and produced exclusively by Jim Henry, Inc.

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  - #S1 Single Gold-Filled: $60
  - #S2 Solid 14K Gold: $350
- Cuff Links
  - #S3 Single Gold-Filled: $190
  - #S4 Solid 14K Gold: $1100
- Key (shown actual size of 3/4")
  - #S5 Single Gold-Filled: $85
  - #S6 Solid 14K Gold: $750
- Miniature Key (Not Shown)
  - #S7 Single Gold-Filled: $70
  - #S8 Solid 14K Gold: $550
- Charm (Not Shown)
  - #S9 Single Gold-Filled: $75
  - #S10 Solid 14K Gold: $525
- Miniature Charm
  - #S11 Single Gold-Filled: $65
  - #S12 Solid 14K Gold: $350
  - #S13 Sterling Silver w/ 180 Sterling Silver Neckchain: $65
  - #S14-1 Sterling Silver Charm: $50
- Sterling Silver Neckchain $65
- Charm (Not Shown)
  - #S13: Single Gold-Filled: $70
  - #S14: Solid 14K Gold: $2250
  - #S14.1 Solid 10K Gold: $1650
  - (Indicate finger size)
- Ring
  - #S14: Solid 14K Gold: $2250
  - #S14.1 Solid 10K Gold: $1650
- Tie Bar
  - #S15 Gold-Filled Emblem: $65
- Necktie
  - #S16A Dark Blue: $35
  - #S16B Light Blue: $35
  - #S17 Maroon: $35
  - Extra long add $5.00
- Diploma Plaques
  - #S18 Satin Gold Finish: $340
  - #S19 Satin Silver Finish: $340
  - 8-1/2" x 12" metal plaque on 11" x 14-1/2" walnut. Specify name, day, month, year selected.
- Men's Bow Tie (Untied)
  - #S22 Dark Blue: $35
  - #S23 Maroon: $35
- Women's Scarf - Silk (Not Shown)
  - #S24 36" x 36" cream w/ dark blue and maroon border $35
- Rollerball Pen - Chrome
  - #S25 Cross Townsend Medalist with 23/K Gold Plated Emblem: $135
- Money Clip (Not Shown)
  - #S26 With Gold-Filled emblem: $75
- Desk Set (Not Shown)
  - #S27 Solid Walnut with Cross Gold-Filled Pen & Pencil/Gold-Filled emblem; name and year elected a Fellow engraved on gold polished plate: $325
- Wallet (Not Shown)
  - #S28 Black cowhide with Gold-Filled emblem: $100
- Blazer Buttons (Not Shown)
  - #S29 Gold Electroplated (set of 9): $35
- Blazer Patch
  - #S30 Hand embroidered: $35
- Shipping/Handling/Insurance
  - Domestic (48 contiguous states): $15
  - Alaska, Hawaii, Puerto Rico: $30
  - Foreign: $40

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The scholarships, in the amount of $10,000 each, provide the recipients with an opportunity to visit clinical, teaching, and research programs in North America and to attend and participate fully in the ACS Clinical Congress. To qualify for consideration by the selection committee, all of the requirements must be fulfilled.

The application for American College of Surgeons International Guest Scholar is posted online at www.facs.org/memberservices/igs.html. Completed applications for the International Guest Scholarships for the year 2015 and all of the supporting documentation must be received at the office of the International Liaison Section no later than July 1, 2014, for consideration by the selection committee.

Applicants are urged to submit their completed applications and supporting documents as early as possible in order to provide sufficient time for processing.

Applicants will be notified of the selection committee’s decision in November 2014. Questions about and application materials for this scholarship should be sent to kearly@facs.org.
Calendar of events

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

JUNE

Oregon and Washington Chapters
June 12–15
Sunriver, OR
Contact: Harvey Gail,
harvey@spiremanagement.com,
www.oregonchapteracs.org,
http://www.wachapteracs.org/

Maine and New Hampshire Chapters
June 13–15
Bretton Woods, NH
Contact: Jennifer Starkey,
jennifer@acschapters.com,
www.mainefacs.org,
http://www.nhfacs.org/

Austria-Hungary Chapter
June 25–27
Graz, Austria
Contact: Albert Tuchmann,
albert.tuchmann@wienkav.at

Latin American and International Chapters
July 28–31
Cartagena, Colombia
www.ascolcirugia.org

AUGUST

Tennessee Chapter
August 8–10
Buchanan, TN
Contact: Wanda McKnight,
wanda@tnacs.org/

Georgia Society Chapter
August 22–24
St. Simons Island, GA
Contact: Kathy Browning,
kdb@georgiaacs.org,
www.georgiaacs.org

SEPTEMBER

Kansas Chapter
September 6
Wichita, KS
Contact: Gary Caruthers,
gcaruthers@kmsonline.org,
www.kansaschapteracs.org/

New Mexico Chapter
September 12–13
Albuquerque, NM
Contact: Gloria Chavez,
gchavez@nmms.org

Arkansas Chapter
September 13
Little Rock, AR
Contact: Linda Townsend,
LATownsend@uams.edu

Kentucky Chapter
September 16
Louisville, KY
Contact: Linda Silvestri,
lslv2@email.uky.edu

Illinois Chapter
September 18–20
Champaign-Urbana, IL
Contact: Luann H. White,
lhwhite26@gmail.com,
http://www.ilchapteracs.org/

FUTURE CLINICAL CONGRESSES

2014
October 26–30
San Francisco, CA

2015
October 4–8
Chicago, IL

2016
October 16–20
Washington, DC