Lessons in collaboration:
New York surgeons look back at Superstorm Sandy
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Many American College of Surgeons (ACS) members and staff were deeply saddened to learn that the College’s former Executive Director, Thomas R. Russell, MD, FACS, died August 4 after a four-year battle with cancer. Tom was a very personable, optimistic, and dedicated leader, and he accomplished a great deal in the 10 years in which he served as Executive Director.

**Overcoming challenges**

He assumed that role in January 2000—a time of considerable strife within the organization. Furthermore, the Institute of Medicine was set to release the seminal report *To Err Is Human: Building a Safer Health System*, which brought to light the number of complications and deaths resulting from medical and surgical error. It was clearly a time for a leader with a bold vision, integrity, and compassion.

Dr. Russell fit the bill and led the College through a decade of change that centered largely on refocusing the organization on its core mission of promoting quality, establishing standards of care, and putting the patient first. He began by implementing a strategic planning process, which resulted in the reorganization of the College into four core divisions: Education, Research and Optimal Patient Care, Advocacy and Health Policy, and Member Services—now the pillars of this organization.

**Key accomplishments**

Perhaps one of Dr. Russell’s most significant accomplishments was bringing the Veterans Affairs (VA) National Surgical Quality Improvement Program into the private sector as ACS NSQIP®. This program launched in 2004 and is now credited with helping nearly 550 hospitals discover systemic problems and understand the steps they need to take to achieve better outcomes, reduce costs, and save lives. He also was a driving force in the creation of the Clinical Scholars in Residence Program, which provides surgical residents with opportunities to work on-site on the College’s quality improvement programs to develop innovative solutions to problems in patient care.

Dr. Russell also led the charge to enhance the College’s educational programming, including a redesign of the Clinical Congress to help surgeons meet new and evolving Maintenance of Certification requirements. In addition,
Perhaps one of Dr. Russell’s most significant accomplishments was bringing the VA National Surgical Quality Improvement Program into the private sector as ACS NSQIP.

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Lessons in collaboration:
New York surgeons look back at Superstorm Sandy

by Amit Khithani, MD;
Allison Barrett, MD;
Omar Bholat, MD, FACS;
John Degliuomini, MD, FACS;
and Marc Wallack, MD, FACS
The damage that Superstorm Sandy inflicted on lower Manhattan, NY, in late October 2012 resulted in an unusual merger by necessity of two of the city’s hospitals: Bellevue Hospital Center and Metropolitan Hospital Center. Guided by lessons learned from the September 11, 2001, attacks and the response of the now-defunct St. Vincent’s Hospital in Manhattan, surgeons and surgical residents at Bellevue and Metropolitan led a synchronized effort to ensure adequate care for patients in both hospitals. Bellevue—located at the south end of Manhattan and founded in 1736—is the oldest continuously operating hospital in the U.S. and one of the premier public medical centers in the world. Metropolitan, founded in 1857, is its smaller counterpart to the north. To mark the second anniversary of the storm, this article recounts the events that took place at each hospital, as well as their collaborative efforts to provide safe care to their patients in a disaster situation.

Sandy hits
Superstorm Sandy began as a tropical wave in the North Atlantic on October 19, 2012. On October 24, Sandy became a Category 1 hurricane in the waters just south of Jamaica. After its sustained winds increased to more than 90 mph that night, National Hurricane Center officials reclassified the storm as a Category 2 hurricane. Shortly after midnight on October 25, Sandy’s winds rose to 110 mph, and by dawn, the eye had passed over the eastern parts of Jamaica and Cuba.

Between October 25 and October 28, Sandy continued northward but declined in intensity and was reclassified as a Category 1 hurricane, then later as a tropical storm. But after passing over the Bahamas and traveling parallel to the coastline of the southern U.S., the storm had again grown, now into a Category 3 hurricane. On October 29, the storm curved westward toward the Mid-Atlantic states and by 8:00 pm made landfall near Atlantic City, NJ, with maximum sustained winds of 100 mph.

Winds circulating around the low-pressure centers of a cold air mass and of Hurricane Sandy began to mix. This interaction pulled part of the cold air mass to the south of the hurricane and turned the jet stream, separating the two systems westward and subsequently drawing Sandy sharply toward the New Jersey coast. After the cold air had wrapped around and mixed with the warm air of the hurricane, both systems merged and effectively transformed the hurricane into a sprawling post-tropical storm.*†

Lights out at Bellevue
On October 29, all of southern Manhattan lost power by 9:00 pm, due to a Con Edison power substation explosion. This incident caused the lights in Bellevue to flicker, but its power was quickly restored by a backup generator. As a result, the overhead lights and red outlets worked in the intensive care unit (ICU), recovery room, operating room (OR), and hallways, but the

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patient rooms and emergency department (ED) went dark and all the elevators were out of service.

Outside, Superstorm Sandy’s wind and rain continued to rage, and the storm surge, which arrived at high tide, rose to an unprecedented 14 feet in New York City. Within an hour, Bellevue’s basement and sub-basement were filled with water from Manhattan’s East River, located just east of the hospital. The retaining wall was quickly overwhelmed. The generator was running on fuel reserves, and the transfer pump was completely inundated with saltwater. Once the cement barriers were breached, the fuel pumps ceased to function, leaving the generator to rely only on its existing fuel stores.

Just before these events, at approximately 11:00 pm, the Bellevue ICU staff met to discuss the situation—Bellevue had just hours of fuel left to power its generators. Physicians and nurses were asked to make lists of critical patients, define the organ systems that were failing them, and itemize the resources they needed. Once flashlights were distributed, critical patients were moved into adjacent ICU rooms where power was still being maintained. Intravenous drips were set to manual and charts were made of their dilutions and rate. Collectively, hospital staff braced for the worst. Communication systems were marginal, with intermittent cell phone service and the in-house phone system working only to call other Bellevue numbers. Communication within Bellevue and between other hospitals, including Metropolitan, became problematic.

At 3:00 am the morning of October 30, the City of New York delivered a diesel fuel tanker to Bellevue. Because the basement and sub-basement were flooded, there were no operational pumps to move the fuel to the 13th floor generator room. Social workers, nurses, medical students, radiology technicians, physicians, and secretaries passed open buckets of diesel fuel up a packed and sweltering stairwell in a human assembly line to keep the generators working.

A Bellevue hospital administrator was able to initiate a 9-1-1 call to request fuel delivery and patient assistance. The call was routed to the closest fire station. The individual who took the call, in turn, passed it on to a fireman who was on active duty in the U.S. Army National Guard, which responded quickly and arrived with a small team to take over the vital task of moving fuel up to the auxiliary generators.

As Sandy finally passed, the sun rose and the flood waters receded, revealing the devastating damage to Bellevue. With no power, running water, or a fresh supply of oxygen, it became clear that Bellevue needed to evacuate the 736 inpatients in the 21-story hospital. As Metropolitan had sustained less damage from the storm, it was well-positioned to help.

On October 30, the critically ill inpatients, ED patients, and dialysis-dependent patients left first, carried downstairs on backboards by medical students and residents. Handwritten discharge summaries and lists of medications were paper-clipped to patients’ gowns as they were carried away by ambulance. At the bottom of the stairwell, triage attendants in red jackets with clipboards took down the names of the patients and the receiving hospitals.

With no “official” evacuation order in place yet, the process of discharging patients that first day was slow. The policy of a “shelter in place” remained in effect while administrators focused on keeping the hospital open and restoring services. Because Bellevue was in its network—the New York City Health and Hospital Corporation (HHC)—Metropolitan Hospital Center issued an “open-door policy” for all Bellevue patients even before the formal evacuation was announced. In fact, it was clear that the administrative process had not caught up to the disaster, which would become a lesson learned for future events.

On October 31, 539 patients were still awaiting triage, including hundreds of psychiatric patients and 80 prisoners. The medical teams were told to triage and discharge any patients remotely ready to leave. As a result, 224 patients were sent home or to shelters without medication because the hospital pharmacy was closed and all clinics were closed to follow-up visits. The remaining patients could not be safely discharged and required transfer to other hospitals. Each medical and surgical team created a list of patients with diagnoses, specific inpatient requirements, bed type, and priority status. These lists were submitted to the hospital incident command center—now a guarded, fortified room bus-
With no power, running water, or a fresh supply of oxygen, it became clear that Bellevue needed to evacuate the 736 inpatients in the 21-story hospital. As Metropolitan had sustained less damage from the storm, it was well-positioned to help.

At approximately 9:00 pm on the night of the storm, a partial power outage occurred due to flooding of some of the generators near the East River, although some portions of the hospital were spared. Because no patients were on ventilator support, a quick check of the surgical ICU (SICU) rooms provided assurance that all was quiet and stable. Fortunately, the power outage spared some elevators and the post-anesthesia care unit (PACU), which was located a floor above the SICU. In contrast to the situation in the SICU, across the hall in the medical ICU (MICU), five patients were on ventilator support and in critical condi-

Flood waters inside the Bellevue Hospital basement.
tion. The ventilator batteries had kicked in and their respiratory status was stable. Oxygen cylinders were quickly switched with backup at the patients’ bedside. It was imperative that these patients be transported to another unit with enough power to keep the respirators working. The PACU had power, so it was the obvious choice. Two residents from the surgical service who were most familiar with PACU and the nurses quickly rallied both medical and surgical residents and ICU nurses and identified the four MICU patients who needed to be moved first.

Surprisingly, the initial chaos faded as staff began the job of moving patients. Two teams were created—one that would ready patients for transfer and another that would physically move the patients. Each team had a medical and surgical resident, a nurse for intravenous administration, and a respiratory therapist to manage airways. A portable ventilator was used during transfer, with all settings documented before transport. This information was relayed to the PACU team on patient arrival. The PACU team consisted of a nurse and a medical resident. Five patients on ventilator support were transported to the PACU, along with two non-critical adult patients and one pediatric patient. Once in the PACU, these patients’ primary teams took charge of their care. As the elevators were all being used to transfer patients, simultaneous transport of ICU beds, drips, and personnel was challenging, but teamwork made it happen.

In compliance with the disaster preparedness plan, orders and medication lists had already been printed before the temporary outage, and handwritten paper orders were initiated because the electronic health record (EHR) system was unavailable even on the floors that had power. All of this activity occurred as the storm hit Manhattan and as Bellevue was on the threshold of losing power throughout the facility. Metropolitan staff knew that if the hospital maintained power, then they would be receiving many of the Bellevue patients.

As the East River flooding progressed through the night on October 29, the surge inundated First Avenue at 96th and 97th streets and flooded a residence hall and a parking lot filled with vehicles belonging to nurses, residents, and faculty. Metropolitan staff became concerned that the hospital’s generators would be flooded. Fortunately, work performed by Metropolitan’s engineering department and Con Edison protected the hospital’s power supply against this flooding, and the power was back to full capacity as the storm subsided overnight.

Even though the area east of Metropolitan Hospital was flooded, the ED—which is on the ground floor—was unaffected. It is located approximately 50 feet above sea level, which kept that area of the hospital out of harm’s way, and all the patients who arrived before Sandy were accommodated in the ED overnight.

At approximately 4:00 am on October 30, the storm and the floodwaters started to recede. The worst was over, but we now had to face the storm’s aftermath. The parts of Metropolitan affected by the outage slowly regained power, allowing the hospital to return to somewhat normal function within hours.

Metropolitan started preparing for the arrival of Bellevue patients at 6:00 am. Even during the worst parts of the storm, we were in limited communication with our Bellevue counterparts and knew that, if we remained functioning, we would be responsible for many of their patients. The following day, the ambulance bay next to the ED was converted into a triage center and clinic run by medicine and surgery residents, along with medical students, to help the ED decant all of the additional Bellevue outpatients seeking continuity of care. This triage bay was constructed...
What ensued on October 31 was an organized pandemonium of telephone calls, ambulances, and EMTs, evacuation sleds by the dozens, and approximately 250 men and women in uniform joining medical students, residents, and faculty in an effort to carry patients down as many as 20 flights of stairs. Over a period of 24 hours after the storm and served at least 600 patients, allowing the ER to deal with more urgent and critically ill patients.

**Evacuation and transfer**

Meanwhile, plans were being developed at Bellevue for its evacuation. Patient handoffs were accomplished over the phone between the residents at both institutions, with the chiefs of surgery providing oversight. As a result of ongoing phone calls between the chiefs, select Metropolitan surgeons were granted temporary access to the Bellevue EHR system while hospital employees, especially physicians and nurses, were getting credentialed to work at Metropolitan. Records were transferred to Metropolitan and printed, and it was agreed that 24 of the sickest surgical patients would be transferred to Metropolitan on October 31.

The National Guard provided support for carrying out the evacuation plan. What ensued on October 31 was an organized pandemonium of telephone calls, ambulances, and emergency medical technicians (EMTs), evacuation sleds by the dozens, and approximately 250 men and women in uniform joining medical students, residents, and faculty in an effort to carry patients down as many as 20 flights of stairs. Complicating the process was the simultaneous evacuation of several other HHC facilities, including Coney Island Hospital and Coler-Goldwater Specialty Hospital and Nursing Facility, which decreased the number of available beds. However, Metropolitan had prepared for this possibility.

The command centers at Bellevue, HHC Central Office, and Metropolitan were in constant contact by telephone as these transfers became reality. Conference calls at 8:00 am and 5:00 pm were equivalent to physician rounds and ensured continuity of care and that all facilities were effectively communicating their needs and what they could offer. Despite the chaos and confusion, this process worked, and patients were transferred vertically without any real dis-
Over a 24-hour period on Halloween Day, patients left Bellevue Hospital, an average of one every 3.4 minutes. New York City had not seen this type of medical and surgical challenge since September 11, 2001.

ruption in care. Throughout this entire process, the chiefs of surgery at Bellevue and Metropolitan were in contact at least three or four times at all hours, and even managed neurosurgery, otolaryngology, and urology services.

It is important to note that EMTs and ambulances arrived from across the East Coast to help move patients, and this extra transportation helped in getting patients evacuated expeditiously.

As the storm subsided, the prisoners at Bellevue were triaged back to Riker’s Island or transferred to the HHC hospitals with an additional temporary male prison unit that was set up at Harlem Hospital. A total of 38 pediatric patients were transferred, the youngest just two days old. Those pediatric patients who did not require hospital care were sent home, while those who did require care were sent to Kings County Hospital Center in Brooklyn. Another 38 patients were triaged from inpatient rehabilitation. The psychiatry department transferred the most patients, a total of 331, who were sent to several HHC hospitals, although most were sent to Metropolitan. The influx of patients to Metropolitan increased the demands on staff. It became clear that staff from Bellevue would need to be deployed to meet this need. Bellevue surgeons and residents were immediately credentialed. Whereas none of the Bellevue surgeons had clinical and operative privileges at Metropolitan, their credentialing paperwork was expedited by the Metropolitan administration. This process usually takes many weeks, and instead was accomplished in hours. This emergency credentialing process had never occurred before in New York City.

Over a 24-hour period on Halloween Day, patients left Bellevue Hospital, an average of one every 3.4 minutes. New York City had not seen this type of medical and surgical challenge since September 11, 2001.

As patients were transferred to Metropolitan, the entire clinical staff of the hospital, under the direction of the chief executive officer and the chiefs of medicine, surgery, emergency medicine, and psychiatry, orchestrated efforts to ensure continuity of care for all of the patients coming from Bellevue while maintaining the same level of care for the patients already housed in the hospital. Medical students, residents, and faculty reviewed transfer notes, and ordered labs and radiologic studies as needed.

During this catastrophe, Bellevue staff attempted to call patient families to alert them to the transfer, but without working computers, reliable phone service, or a functional interpreter system, the task of giving appropriate information regarding transferred patients was impossible and was ultimately given to the medical director’s office to be completed when power returned.

By the evening of November 1, with a Nor’easter blowing in, only two patients remained at Bellevue and neither could be moved safely down the stairs. One had a ventricular assist device and was too critical to move, and the other was morbidly obese. As a result, the decision was made to wait for the Bellevue basement to be pumped out and for restoration of elevator power and service, so that both patients could be moved three days later. These two patients were given extra staff to maintain their safety.

The aftermath

Metropolitan’s admitting department was informed of the transfers, and the patients were admitted to either the SICU or to the eighth floor of the main hospital. The eighth floor at Metropolitan had three inpatient units—A, B, and C. Preceding Sandy, 8B was the only open and active unit, and 8C was used only for respiratory isolation cases. The 8A unit was opened within 12 hours of Sandy to receive all surgical patients from Bellevue. The Metropolitan staff worked day and night to prepare the floors and the rooms, ensure EHR access, and stock supplies in 8A. Many of the patients had critical surgery at Bellevue and were in postoperative recovery in surgical wards but required transfer because they were not ready for discharge. Additional inpatient wards were reopened and Metropolitan’s operating census was close to 100 percent of capacity.

Some of the other patients were nonoperative under the care of the surgery team. The most complicated of these cases included a patient with a partial colectomy and a concomitant liver resection, a patient with duodenal perforation secondary to a motor vehicle accident, and a patient who had a reversal of an ileostomy secondary to treatment of inflammatory bowel disease.
These patients were at various stages of recovery at Bellevue, which made the handoffs to Metropolitan extremely important.

With the sudden increase in patient volume, resources were bolstered by the integration of evacuated physicians, nurses, and technicians—especially those health care professionals with operating room experience. Many urgent cases had already been booked by Bellevue surgeons, and these patients were rescheduled and underwent their operations at Metropolitan in the immediate aftermath of the storm. When the famous Bellevue ED reopened, several months before the rest of the hospital, patients seen in the Bellevue ER who required immediate surgery were transferred to Metropolitan and operated on by Bellevue and Metropolitan surgeons.

The remainder of the week was spent assessing Bellevue’s infrastructure, patient care, and resident education needs. In the coming months, Bellevue’s electrical systems were rebuilt, plumbing lines were flushed, and all mechanical devices located in the basements were replaced. The basement and the sub-basement were emptied of infested river waters, the generators were reconfigured, and the entire infrastructure thoroughly cleaned. HHC President Alan Aviles stated that a total of $810 million would be needed to repair the damage to the city’s public hospital facilities, most of which was to be spent at Bellevue—the hospital most affected by the storm.‡

Over the next few days, many of the patients transferred were discharged with disposition plans because this handoff system was successful. Moreover, several patients who needed surgery underwent their operations as Metropolitan added two ORs for teams of Bellevue surgeons, with the two chiefs of surgery and the two departments of anesthesia organizing the effort.

Within two weeks, Bellevue’s operating teams were using assigned block times in the Metropolitan OR and in the outpatient clinics at Metropolitan. General surgeons and subspecialists from surgical oncology, plastic surgery, urology, neurosurgery, vascular surgery, and otolaryngology were quickly credentialed and performed procedures in two to three operating rooms, five days per week, specifically dedicated to Bellevue patients and entirely staffed by their own surgery, anesthesiology, and nursing teams. Within 10 days of Superstorm Sandy, two separate surgery teams—one from Bellevue and one from Metropolitan—worked in tandem within the expanded Metropolitan perioperative service and departments of surgery. This type of cooperation has never been reported secondary to an emergency event in New York City.

**Grand reopening**

The Bellevue ER was fully functional within four weeks, and other areas of the facility reopened on February 7, 2013—99 days after it was evacuated. There were balloons, banners, press releases, and smiles all around. Six months after Superstorm Sandy, the hospital had returned to its centuries-old tradition of caring for New York City’s injured and disenfranchised. Now fully operational, the hospital continues to address what went right and what went wrong regarding the preparation, evacuation, and recovery efforts in the wake of Superstorm Sandy.

Since its founding in 1736, Bellevue had never been without patients until Sandy shuttered her doors on November 3, 2012. Against overwhelming odds, the largest-ever vertical evacuation of a hospital was successfully accomplished because two hospitals came together to accomplish what was necessary in order to provide continuous care to patients.

Even in dire circumstances, the staffs of both institutions were resourceful, adaptable, and persistent, working in tandem toward a common goal. Cited by some as a “once in a hundred years” event, Sandy has proven that there is no such thing as over-preparation. The time to ready for the next storm event is now, as we repair, rebuild, and upgrade our infrastructure. More importantly, these lessons have resulted in improvements in HHC hospitals, especially Bellevue, to protect vital hospital infrastructure and be better equipped to treat patients when disaster strikes again.◆

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The American College of Surgeons (ACS) Chapter Lobby Day Grant Program began in 2010 and continues to provide chapters with the support they need to engage their membership in grassroots advocacy at the state level. Participating chapters are eligible to receive up to $5,000 in grant funds from the College and are required to match every $2 received. Participation has been wide-ranging, with more than 20 chapters hosting a state lobby day since the inception of the program.

Lobby day events help raise the profile of chapters in their respective states and educate state legislators on matters of importance to surgeons. Issues discussed at lobby days in 2014 ranged from trauma funding, to scope of practice, to telemedicine. In addition, these meetings enable chapters to build relationships—perhaps the most critical component of grassroots advocacy—with legislators, members of the judicial branch, and other health policy stakeholders.

This article summarizes the 2014 ACS chapter lobby days, provides an overview of current advocacy issues in each state, and highlights how some chapters organize their day at the state capitol program.

Alabama
The Alabama Chapter of the ACS hosted its lobby day on February 20 in conjunction with the Medical Association of the State of Alabama. The event began in the morning with breakfast and training across the street from the state capitol. Attendees heard from political pundit and former Alabama state legislator Steve Flowers (R) on lobbying and politics and received tips on effective advocacy from David Mowery of the Mowery Consulting Group. Participants then attended a hearing of the Senate Committee on Health and participated in a working lunch where a question-and-answer session was held with state Sen. Greg Reed (R) and state Rep. Jim McClendon (R). The afternoon was spent meeting with legislators, during which surgeon attendees focused their discussion on the statewide trauma system, trauma care, and funding. The legislators were receptive to the issues and
expressed an interest in working with the surgeons and maintaining contact. The surgeons met with a total of 15 legislators.

**Connecticut**

The Connecticut Chapter of the ACS, in conjunction with the Connecticut State Medical Society, sponsored a lobby day in Hartford on March 20. Several ACS Fellows attended and advocated on current legislation, including bills pertaining to scope-of-practice expansion for advanced practice registered nurses (APRNs) and the establishment of a legislative definition of surgery. The day began with a breakfast reception for legislators and staff that was attended by members of both political parties. Following the reception, the group listened to remarks from a Connecticut State Medical Society lobbyist and transitioned into meetings with individual legislators. Chapter leadership attended meetings with Donald Williams, Jr. (D), President pro tempore of the Senate, and Brendan Sharkey (D), Speaker of the House of Representatives.

**Florida**

The Florida Chapter of the ACS hosted its White Coat Wednesday in March. The event coincided with the State Committee on Trauma meeting and drew nearly 20 participants. The event began with a dinner on March 4 that included a presentation from Chris Nuland, Chapter Lobbyist, who updated attendees on the current composition of the Florida legislature and provided background on the key health care legislation that would be discussed in their meetings. White Coat Wednesday kicked off with a breakfast reception that provided an opportunity for attendees to interact with their legislators in a less formal manner. Participants then headed over to the state capitol where they met with their legislators. The main topics covered in these meetings included licensing issues related to telemedicine and scope of practice.

**Indiana**

The Indiana Chapter of the ACS hosted its annual Day at the Capitol on January 27. The event began with a series of speakers in the morning, including Rep. Ed DeLaney (D) who described how to be an effective advocate in the Indiana legislature. Other topics included a review of the current legislative issues by Michael Rinebold, a lobbyist from the Indiana State Medical Association; a review of the challenges to Indiana’s medical liability damages cap from consultants Libby Goodknight and Krieg DeVault; a review of the status of Indiana politics by T.K. Wall, a local reporter; and an overview of how to successfully interact with elected officials from Tory Castor, vice-president of government affairs at Indiana University Health. The group discussed the following bills in their meetings with their legislators: S.B. 222, Student Athlete Concussions; S.B. 50, Minors and Tanning Devices; and H.B. 1097, Immunity for Providing Volunteer Health Care Services.

The Day at the Capitol was well attended, with more than 20 surgeons meeting with their legislators.

**Kansas**

The Kansas Chapter of the ACS, in conjunction with the Kansas Medical Society, hosted a state lobby day in Topeka on January 22. The event included in-depth briefings on state and federal advocacy, the current legislative environment in Kansas, and medical liability. In addition to the briefings, several legislators attended the meeting with the goal of speaking with attendees, including Robert P. Moser, MD, Secretary of the Kansas Department of Health and Environment, and legislators who serve on the Senate Public Health Committee, and the House Health and Welfare Committee. After the briefings, members met with their state legislators and voiced their views on scope-of-practice expansion legislation for APRNs and podiatrists, tanning bed restrictions, and medical liability rate increases. The tanning legislation, banning use by people younger than 18 years old, was heavily advocated for by Joshua Mammen, MD, FACS. Dr. Mammen worked with his local legislator to get this bill introduced in the state House of Representatives. The bill did not pass, but
thanks to Dr. Mammen’s advocacy, the groundwork has been set for the bill to be re-introduced in 2015.

**Brooklyn-Long Island and New York**

The New York Chapters of the ACS, Brooklyn-Long Island and New York, in conjunction with the New York State Medical Society and several other state specialty organizations, hosted a lobby day in Albany on May 20. The event included various legislative and advocacy presentations, followed by meetings with legislators. Fellows lobbied against allied health scope-of-practice expansion and medical liability rate increases, and for truth-in-advertising legislation.

**Tennessee**

The Tennessee Chapter hosted its lobby day at the capitol in Nashville on March 12 in conjunction with the Tennessee Medical Association. More than 200 physicians attended the event, with surgery well-represented by the chapter. Participants attended a meeting of the Senate Health and Welfare Committee and heard from Gov. Bill Haslam (R), who welcomed them to the Capitol and encouraged attendees to remain involved in the advocacy process. Meetings with legislators were held throughout the day, and the chapter’s participants focused their discussions on the work of the Tennessee Surgical Quality Collaborative (TSQC) and on the initiatives of the medical association. Surgeons had the opportunity to meet with all members of the House and Senate Health Committees, who reportedly found the work of the TSQC impressive.

**Virginia**

The Virginia Chapter of the ACS, in conjunction with several other surgical medical societies, hosted a lobby day in Richmond on February 12. The day began with a briefing and an advocacy presentation from one of the lobbyists for the Medical Society of Virginia. After the briefing, Fellows headed to the capitol for meetings with their state legislators. These meetings were productive and covered a variety of legislative topics, including Medicaid expansion, various scope-of-practice issues, and cancer prevention and treatment.

**Washington**

The Washington Chapter participated in its first lobby day on February 10 by having an organized presence at the Washington State Medical Association’s (WSMA) Annual Legislative Summit. Beginning with a chapter council meeting the evening before the lobby day, leadership of the chapter had the opportunity to share in policy briefings with their WSMA colleagues, receive helpful tips for meeting with state legislators, and enjoy the political camaraderie of a lobby day. Priority issues included:

- Legislation addressing notification concerns regarding the 90-day grace period for patients who fall behind on their health insurance premiums, which became law March 27
- Requirements that insurers that cover a clinical service on a face-to-face basis must also cover the same service when it is provided using video technology; that bill died in the Senate
- Prohibition of the use of tanning devices by children and teens under age 18, which became law March 27
- Expansion of the list of tests a medical assistant phlebotomist may perform, which became law March 28

Most state legislatures have finished their legislative business for the year, and lawmakers have shifted their focus to re-election efforts and the 2015 legislative sessions. At this time, it is imperative that chapters begin to plan for the upcoming sessions by creating an advocacy strategy. The lobby day program is one of the best tools that the ACS offers, and the State Affairs team is available to assist with planning a lobby day or helping chapters with other grassroots advocacy initiatives. Contact the State Affairs team at state_affairs@facs.org with questions or concerns. ◆
The ACS NSQIP Geriatric Surgery Pilot Project:

Improving care for older surgical patients

More than one-third of all inpatient operations in the U.S. involve patients ages 65 and older. In 2010, the cost of hospitalization with an operating room (OR) principal procedure for this patient population was $72 billion. Because surgical care for older adults is common and consumes enormous amounts of resources, understanding the relevant outcomes and their key determinants for geriatric patients is vital.

The American College of Surgeons (ACS) National Surgical Quality Improvement Program (ACS NSQIP®) is the preeminent outcomes-based program designed to measure and improve the quality of surgical care in the U.S. ACS NSQIP was developed with the goal of providing risk-adjusted surgical outcomes data for adults. In 2010, ACS NSQIP introduced the first National Quality Forum (NQF)-endorsed measure to track surgical outcomes in patients greater than 65 years of age. The geriatric measure uses standard ACS NSQIP risk variables to track traditional patient- and procedure-adjusted surgical outcomes, such as postoperative complications and 30-day mortality. Although this measure has proven to be a significant step forward in improving care in this vulnerable population, recent literature suggests that standard risk factors and traditional outcomes may not provide a complete enough picture through which to focus improvement strategies targeting older surgical patients.

At the 2011 ACS NSQIP National Conference in Boston, MA, David B. Hoyt, MD, FACS, Executive Director of the College, moderated a plenary session to emphasize the need to “achieve optimum surgical care” in a variety of specific areas, including geriatrics. It was clear from the audience response that many hospital systems from across the U.S. and Canada shared the challenge of understanding what constitutes “optimum” outcomes in older patients and how to achieve these results.

Development of the pilot project

With the obvious need for more data, ACS NSQIP and the ACS Geriatric Surgery Task Force worked together to determine how these data could be collected and analyzed by forming a ACS NSQIP Geriatric Surgery Pilot Project. The pilot project is predicated upon two goals: (1) to determine if the inclusion of geriatric-specific preoperative variables and outcome measures...
in the existing ACS NSQIP models will add to our ability to more accurately predict relevant outcomes, and (2) to provide a platform for introducing new interventions designed to improve these outcomes.

Participant hospitals were recruited from among task force member institutions and at a follow-up geriatric breakout session at the 2013 ACS NSQIP National Conference in San Diego, CA. Representatives of 23 hospitals, including academic centers and community-based systems from the U.S. and Canada, participated in the meeting.

Choosing the variables

Candidate variables were reviewed by task force members and ACS NSQIP staff primarily for relevance and for ease of extraction from the medical record. To be relevant, the new preoperative variable set needed to address characteristics unique to the older adult. In contrast to younger adults (<65 years old) in whom surgical risk is estimated by summing comorbid conditions, the presence of frailty is rapidly emerging as a primary factor that defines increased risk in the older surgical patient.\(^3\)\(^4\)

Frailty is defined as “a biologic syndrome of decreased reserve and resistance to stressors, resulting from cumulative declines across multiple physiologic systems...causing vulnerability to adverse outcomes.”\(^5\) Although there are many different ways of identifying a frail individual, most characteristics of frailty are not routinely assessed in clinical practice. Consideration was given to those variables that could best describe the frail state, such as evidence of impaired cognition, functional dependence, and reduced mobility.

The new outcome variables are needed in order to capture the outcomes that are common and important to older patients, including postoperative delirium and functional decline. Postoperative delirium occurs in approximately one-half of older patients undergoing

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<tr>
<th>Preoperative variables</th>
<th>Intent of variable (definition)</th>
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<tbody>
<tr>
<td>Origin from home with support</td>
<td>To determine baseline functional status (lives alone at home, lives with support in home, origin status not from home)</td>
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<tr>
<td>Use of mobility aid</td>
<td>To quantify baseline mobility (uses a walking aid—yes/no)</td>
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<tr>
<td>History of prior falls</td>
<td>To define the presence of a geriatric syndrome prior to admission (prior fall—yes/no)</td>
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<tr>
<td>History of dementia</td>
<td>To determine baseline cognition (history of dementia—yes/no)</td>
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<tr>
<td>Competency status on admission</td>
<td>To define significant cognitive impairment (consent signed by patient or by surrogate—yes/no)</td>
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<tr>
<td>Palliative care on admission</td>
<td>To identify patients admitted from palliative care or hospice (from palliative care/hospice—yes/no)</td>
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<tr>
<th>Postoperative occurrences</th>
<th>Intent of variable (definition)</th>
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<tr>
<td>Postoperative pressure ulcer</td>
<td>To define the presence of a geriatric syndrome at discharge (a pressure ulcer is present at discharge; did it occur during the hospital stay—yes/no)</td>
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<tr>
<td>Postoperative delirium</td>
<td>To define the presence of a geriatric syndrome during the hospital stay (delirium is present if there are one or more episodes of acute confusion during hospitalization—yes/no)</td>
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<tr>
<td>Do not resuscitate (DNR) order during hospitalization</td>
<td>To capture changes in DNR status during the hospital stay (was there a new DNR order during hospitalization—yes/no)</td>
</tr>
<tr>
<td>Palliative care consult</td>
<td>To understand treatment goals of patients with short life expectancy (palliative care consult obtained during hospitalization or patient made comfort care—yes/no)</td>
</tr>
<tr>
<td>Discharge functional health status</td>
<td>To determine functional status at discharge (ability to perform activities of daily living at discharge—dependent/partially dependent/independent)</td>
</tr>
<tr>
<td>Fall risk on discharge</td>
<td>To quantify mobility at discharge (define fall risk at time of discharge—high/low)</td>
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<tr>
<td>Need of mobility aid on discharge</td>
<td>To understand a patient’s mobility at discharge (new use of mobility aid walker/cane at time of discharge—yes/no)</td>
</tr>
<tr>
<td>Discharge with/without services</td>
<td>To capture care needs at discharge (home alone with self-care, home alone with skilled care, home with support and self-care, home with support and skilled care)</td>
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</tbody>
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In contrast to younger adults (<65 years old) in whom surgical risk is estimated by summing comorbid conditions, the presence of frailty is rapidly emerging as a primary factor that defines increased risk in the older surgical patient.

major operations and is associated with increased rates of all other major complications, a need for institutional discharge, and death. Interventions to decrease postoperative delirium do exist, and efforts are under way to establish evidence-based guidelines. To date, however, delirium is not routinely recognized as a surgical complication in older adults and, therefore, is not tracked.

Functional decline following surgery is often more of a concern to the older surgical patient than the risk of mortality, but because it is rarely measured, there is a lack of data allowing surgeons to counsel older patients on its risks. In addition, ACS NSQIP currently lacks a robust method for identifying patients who are undergoing surgery for palliative intent, for whom the risk may not be well captured by traditional variables (palliative care is a more common primary objective in geriatric surgery compared with surgery on younger patients). The outcome variables for the ACS NSQIP Geriatric Surgery Pilot Project were chosen to specifically identify changes in postoperative cognition, functional decline, and a need for transition to palliative care.

Once appropriate variables were selected, the Clinical Support team from ACS NSQIP developed strict definitions of these variables, in a manner consistent with all of the other variables in the program. The variables and definitions were then reviewed a final time by task force members before commencement of data collection.

**Current status of the pilot project**

The ACS NSQIP Geriatric Surgery Pilot Project includes 23 hospitals, and features 14 new variables specifically chosen for their relevance to geriatric surgical patients (see table, page 22). ACS NSQIP staff members including Matt Fordham, Project Coordinator, ACS NSQIP; James Wadzinski, ACS NSQIP Director of Operations; Melissa Latus, ACS NSQIP Clinical Support Services Manager; and Amy Hart, ACS NSQIP Product Operations Manager, have provided invaluable assistance to making the pilot project a success, as well as Sanjay Mohanty, MD, one of the ACS Clinical Scholars in Residence (2013–2015), who is analyzing the data. Data collection began on January 1, 2014, and an interim analysis of the project’s efforts was presented at the ACS NSQIP National Conference in New York, NY, in July. Both the viability of data collection and the ability of these new variables to provide additional insight into the care of geriatric patients will be assessed.

The ultimate goal of this pilot project is to evaluate specific geriatric variables for incorporation into the ACS NSQIP set of essential variables collected by all participating hospitals. These variables may then be used to measure the effectiveness of interventions designed to mitigate geriatric-specific surgical risks and improve outcomes.

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**REFERENCES**


Past recipients of the ACS/Pfizer Surgical Volunteerism and Humanitarian Awards: Where are they now?

by Devin Rose and Betty Sanders, MBA, PMP

Dr. Price (center, front row) in Mongolia.
Every year, the ACS/Pfizer Surgical Volunteerism and Humanitarian Awards recognize and celebrate ACS Fellows and members whose altruism, vision, leadership, and dedication provide models to emulate and whose contributions have made a lasting difference. Since the initiative began in 2003, 38 individuals have won awards, including four this year. The Bulletin will be providing periodic updates on some of the past recipients of these awards and their accomplishments since they were honored. This article is the first installment in that series.

Raymond R. Price, MD, FACS
2012 International Volunteer Award

Raymond R. Price, MD, FACS, a general surgeon at Intermountain Medical Center in Murray, UT, received the Surgical Volunteerism Award in 2012 for his international outreach efforts to improve surgical care in Mongolia and other countries. Since receiving the award, Dr. Price has continued to improve access to surgical care and anesthesia in Mongolia through the Dr. W.C. Swanson Family Foundation, based in Ogden, UT, where he continues to serve as the director of medical programs.

Dr. Price implemented a two-week, hands-on basic laparoscopic cholecystectomy course in Darkhan, Mongolia, taught by members of the foundation and the Society of American Gastrointestinal and Endoscopic Surgeons (SAGES), of which he is a member. With the help of those two organizations, Dr. Price also taught an advanced laparoscopic course to professors at the Health Sciences University of Mongolia (HSUM) in Ulaanbaatar that covered colectomy, Nissen fundoplication, adrenalectomy, splenectomy, and ventral and inguinal hernia.

In addition, Dr. Price held meetings with the World Health Organization (WHO) and other Mongolian health organizations. These interactions led to the signing of a memorandum of understanding between the ACS Committee on Trauma (COT) and the Health Development Department of Mongolia to teach the Advanced Trauma Life Support® (ATLS®) course to all of the physicians in that country. For his volunteer efforts in Mongolia over the previous nine years, Dr. Price received the Presidential Friendship Medal, the highest honor given to a foreigner. In addition to his work in Mongolia, Dr. Price has accomplished the following:

- Organized a national e-mail campaign to support a World Health Assembly resolution highlighting the importance of surgery and anesthesia for basic health care
- Spoke at and participated in the fifth biennial meeting of the WHO Global Initiative for Emergency and Essential Surgical Care, where he was appointed vice-chair of the group
- Co-authored a global surgery chapter in the 10th edition of Schwartz’s Principles of Surgery, which was published this year, and also co-authored a trauma chapter in the Disease Control Priorities 3rd edition, which is currently open for public comment and is expected to be published early next year by the World Bank
A recent Ruben J. Williams Foundation mission trip to rural Western Kenya: two neurosurgical teams, from Moi University and Johns Hopkins, operating together to treat a young child with an extra-axial tumor.

Dr. Hayanga

George F. Ellis III, MD, FACS
2005 Domestic Volunteer Award

George F. Ellis III, MD, FACS, a urological surgeon at Orlando Regional Medical Center, FL, received the Surgical Volunteerism Award in 2005 for his contributions to medically underserved residents in Orange County, FL. Since then, Dr. Ellis has continued to volunteer at the Orange County Medical Clinic (OCMC), a facility that provides medical care to uninsured patients. Dr. Ellis says it has been an enlightening experience, and the most essential element has been to help patients in need of health care services and to practice medicine without the interference of health insurance plans.

The OCMC is part of Primary Care Access Network (PCAN), a collaborative among local government, health care centers, agencies, and hospitals that Dr. Ellis founded in 2000. Dr. Ellis is keeping PCAN’s activities consistent with the U.S. Department of Health and Human Services (HHS) Health Resources and Services Administration’s goal of providing 100 percent access to care with zero percent disparity. The OCMC also has an outpatient clinic, where Dr. Ellis discusses cases with the residents who are providing the care. In addition to these efforts, Dr. Ellis has accomplished the following:

- Began developing plans for his newest initiative, the Florida Health Fund, which will be a charitable foundation to provide education and further assist people who are in need of health care services
- Inspired both of his sons to do volunteer work of their own; his oldest son, a budding fiction author, leads a writers’ club, and his younger son does clean-up and maintenance for a municipal park system north of Orlando

Awori J. Hayanga, MD, MPH
2009 Resident Volunteer Award

Awori J. Hayanga, MD, MPH, an Associate Fellow and cardiothoracic surgeon at Spectrum Health DeVos Heart & Lung Transplant in Grand Rapids, MI, received the inaugural Surgical Volunteerism Award for resident service in 2009 for his founding role and ongoing work with the Ruben J. Williams Foundation, based in Seattle, WA, which fosters networks of academic medical institutions in sub-Saharan Africa, Europe, and the U.S. Over the last five years, the foundation has conducted four annual trips to Kenya and engaged the local surgical community in more than 100 hours of continuing medical education. The
trips brought together surgeons, nurses, anesthesiologists, technicians, and volunteers to provide care to more than 200 local patients. Postoperative follow-up was facilitated through audio-visual applications in real time, which allowed ongoing remote surgical collaboration. Kenyan residents had one-on-one time with visiting professors and participated in case presentations and research talks. Dr. Hayanga said these mentoring initiatives have led to several Kenyans being accepted into surgical residency and fellowship training positions in the U.S. and South Africa. In 2011, the foundation began a new initiative to support five physician graduate scholars from resource-poor countries currently enrolled at the Johns Hopkins School of Public Health, Baltimore, MD.

The foundation has also accomplished the following:

- Extended its focus beyond health care delivery to include health policy and economics, as these three areas of health care have become interdependent, especially in limited-resource environments
- Procured and donated more than $250,000 in operating equipment and supplies to Mukurweini District Hospital and the Moi Teaching and Referral Hospital in Eldoret, Kenya, with the assistance of visiting teams from Vanderbilt University, Nashville, TN, and Johns Hopkins
- Organized lectures by the following distinguished surgeons: ACS President-Elect Andrew L. Warshaw, MD, FACS, FRCSEd(Hon), former surgeon-in-chief and chairman, department of surgery, Massachusetts General Hospital, and the W. Gerald Austen Professor of Surgery at Harvard Medical School, Boston; Michael Mulholland, MD, FACS, the Frederick A. Coller Distinguished Professor of Surgery and Chair, department of surgery, University of Michigan, Ann Arbor; and Russell G. Robertson, MD, chair, Council on Graduate Medical Education and the special advisor to Congress and the HHS with regard to physician supply and distribution
- Expanded its board of directors, appointed a full-time chief executive officer, and sought to expand delivery of care to the entire region over the next five years

T. Peter Kingham, MD, FACS
2010 Resident Volunteer Award

T. Peter Kingham, MD, FACS, a general surgeon at Memorial Sloan Kettering Cancer Center (MSKCC) in New York, NY, received the Surgical Volunteerism Award in 2010 for outreach during residency for his work as a co-founder and president of Surgeons OverSeas (SOS), an organization that improves surgical care in developing countries, most notably Sierra Leone. Since receiving the award, Dr. Kingham has formed a colorectal cancer consortium called the African Colorectal Cancer Group (ARCO) with his Nigerian colleague and SOS member, Isaac Alatise, MD. The consortium comprises MSKCC in New York, NY, and Obafemi Awolowo University Teaching Hospital, Federal Medical Centre Owo, Lautech Teaching Hospital,
and University of Ilorin Teaching Hospital in Nigeria. The consortium is sponsoring two prospective studies—one to create a database and biobank, and one related to colonoscopy—with the goal of improving the care of patients with colorectal cancer. Dr. Kingham said they hope this infrastructure can be applied to patients with other types of cancer in the future.

In addition to these efforts, Dr. Kingham has accomplished the following:

- Completed his surgical oncology fellowship at MSKCC and joined the faculty as a member of the hepatopancreatobiliary surgery service
- Continued to serve as president of SOS
- Continued to work with SOS co-founder Adam Kushner, MD, MPH, FACS, to document the burden of surgical disease in low- and middle-income countries, and published this research in *The Lancet*

Russell E. White, MD, MPH, FACS, FCS (EASC) 2012 Surgical Humanitarian Award

Russian E. White, MD, MPH, FACS, FCS (EASC), a general surgeon at Tenwek Hospital in Bomet, Kenya, received the Surgical Humanitarian Award in 2012 for his efforts to improve surgical care in Bomet. Dr. White currently directs the surgical residency training program at Tenwek Hospital, where the program has expanded to include a full residency in orthopaedic surgery. Dr. White is proud to say that his residents are scoring among the highest in the region on their written and oral examinations.

He serves as the country director for the College of Surgeons of East, Central, and Southern Africa, which is the certifying body for 11 countries in the region. He is also the educational coordinator for all the training programs in general surgery in Kenya. This year, Dr. White will coordinate the writing of the certifying exam for all the general surgery candidates, and will also direct all the oral and clinical exams for those health care professionals completing their training.

In addition to these efforts, Dr. White is involved in the following:

- Contributing time and expertise to research programs for all of the hospital’s residents
- Working on several ongoing clinical trials involving epidemiology, diagnosis, and treatment of esophageal cancer, which is the most common malignancy in Kenya
- Expanding the cardiac surgery program at Tenwek Hospital, which is the only center outside the capital that offers cardiac surgical services
- Looking into beginning a fellowship training program in cardiothoracic surgery, which would be the only program of its type in the region

Earlier this year, the Young Fellows Association (YFA) of the American College of Surgeons (ACS) announced its first essay contest. The YFA was inspired to present the essay contest and to have as its theme “The Promise of a Profession” based on the comments that Carlos A. Pellegrini, MD, FACS, FRCSI(Hon), made during his Presidential Address at the 2013 Clinical Congress in Washington, DC, and to address the challenges we, as young surgeons, face.

Today’s challenges
It is often said that the only constant in life is change. Young Fellows must deal with shifting practice expectations, including the ongoing shift from private practice to hospital and health system employment, a large training debt burden combined with declining reimbursement, and the Affordable Care Act’s expansion of access to health care services, along with new standards of care. Many surgeons wonder how our profession will survive all of this change.

In addition to these challenges, the training model for surgery has changed, largely due to the 80-hour workweek. Overall, this shift offers residents a more balanced work and private life, but it has also raised questions about whether new graduates are adequately prepared to face the realities of practice. Has surgical expertise suffered because of the 80-hour workweek? Has reduced time in a hospital setting led to a “failure to launch,” as some new graduates struggle in their first job? And does the system in which they work similarly struggle with the best way to integrate the individual who has trained under this new paradigm, especially since most health care institutions and surgical practices have largely been passive in their support of new associates?

The contest
In his Presidential Address, Dr. Pellegrini gave an inspiring talk about what the College has stood for during its history, and he charged new Fellows to create their future amid so much change, using the College as a guiding compass. This year’s essay contest, sponsored by the YFA Communications Committee, is the response of the young surgeons to Dr. Pellegrini’s address. It is this group’s desire to answer back to his charge and give voice to the promise of a profession.

With this in mind, the YFA opened a competition for all Fellows “young at heart” to write a one-page essay about what inspires them and what they view as the promise of the profession. The committee evaluated the winning essay out of the six submitted using a numeric scale in several categories, including technical knowledge, language, and writing style. The essay with the highest score is the winner of this year’s contest, and we are excited to share this essay with the College membership at large. The message of this winning essay underscores the fact that although much of the profession is changing, our dedication to our patients and our commitment to our colleagues remains very much the same.

by Ellen Farrokhi, MD, MPH, FACS
Challenges to our surgical profession are numerous. These demands include the need to adjust practices to comply with the Affordable Care Act, increased legal and regulatory requirements, new financial stresses, modifications in training requirements, and documentation of patient encounters through electronic health records.

Waning morale
These challenges have taken a personal toll on many surgeons. A 2008 survey of American College of Surgeons (ACS) members reported 40 percent of us feel burned-out, and nearly one-third screened positive for depression (n=7,905). More recently, a 2013 Medscape survey of 24,000 physicians in 25 medical specialties indicated that less than half (47 percent) of general surgeons agreed with the statement, “Yes, I would choose the same specialty.” This figure was a decrease from 60 percent in 2011. With these beliefs, how can one convey the promise of this profession to the next generation, let alone to ourselves? Where does the promise of our profession ultimately lie?

To answer these questions, I recall the advice from my research mentor, Suyu Shu, PhD, while at the Cleveland Clinic, OH: “When things are difficult and unclear, go back to fundamental principles.” Heeding this advice brought my attention to the College’s guidelines for the training of general surgeons and surgical specialists (see figure, page 31). These guidelines list “character” as the first criterion of surgical trainee selection, stating, “Character embraces ethics, conscientiousness, judgment, industry, and all other elements which make up the background of a surgeon.” Most people would agree with this criterion, but there is a big gap between knowing about character and living it out. Eliminating this gap takes leadership.

Exhibiting leadership, character
Surgeons are seen as leaders. At the most basic level, patients identify us as the leader of the health care team focused on their surgical care. We are trained to efficiently gather information, analyze data, and make decisions. We are also wired to fix problems, which helps
us to develop innovative approaches to address health care issues. Many of us are actively involved in finding viable solutions to the challenges facing our profession through service on local, regional, and national positions and committees. Our elected ACS leadership is actively involved with the federal government on key issues currently under deliberation.

The promise of the profession takes more than being a leader; it takes being a leader with “evidence of high character.” Indeed, we have all witnessed, experienced, or exhibited examples of poor leadership—abusive and degrading comments, disrespectful interactions, refusal to cooperate with other physicians, and arrogant behavior. A report on disruptive behavior by physicians revealed 21 percent of respondents (n=828) could directly attribute an adverse clinical outcome to a lapse in character. These data show what we all intuitively know—that lapses in behavior can and will negatively affect patient care.

For those of us involved in training fellows, residents, and medical students, consider the impact of our behavior on the next generation. They have to see not only how we operate, but also that our interactions with colleagues and patients, as well as our approach to challenges, are grounded in the quality of our character. This behavior includes how we hold one another accountable for lapses in character, just as we hold each other accountable for decisions that affect clinical patient care. We must have the same passion in imparting character attributes as we do for imparting surgical wisdom to our trainees.

As surgeon leaders, we need to strive to be better. I was delighted to see Carlos A. Pellegrini, MD, FACS, FRCSI(Hon), deliver his ACS Presidential Address, The Surgeon of the Future: Anchoring Innovation and Science with Moral Values, at the 2013 Clinical Congress, in Washington, DC. Moral values and actions reflect one’s character.

Notably, the ACS holds an annual Surgeons As Leaders training course that includes character-building in its curriculum. At our institution, we have implemented a program called Leadership Lived Out that explicitly trains tomorrow’s leaders on a foundation of virtuous character traits.

Each of us has challenges that we must address. In some cases, these concerns are best addressed collectively, while other challenges can only be met on an individual basis. In all cases, each of us must face and overcome these impediments by ceaselessly striving to exude high character in all that we do. The first critical step is to examine the quality of our own character in the behavior we exhibit with our colleagues, the health care teams we lead, the trainees we mentor, and most importantly, the patients to whom we provide care. We must do so because the promise of our profession ultimately lies within each of us.
Adverse behaviors and their effect on credentialing and licensure

by Gerald J. Bechamps, MD, FACS, and Scott Kurtzman, MD, FACS

Editor’s note: The following is the fourth in a series of excerpts from Being Well and Staying Competent: Challenges for the Surgeon, a guidebook issued in 2013 by what is now the Physician Competency and Health Workgroup of the Board of Governors Quality Pillar. The complete document is posted in the General Surgery Community at http://bit.ly/1qD34QV. Log-in is required.

“These are some of the questions posed by our colleagues who have engaged in some form of adverse behavior, which led to the loss of their credentials and/or restriction of their medical license. Loss of credentials and licensure takes a toll on physicians and their patients. As professionals, we have made a significant investment in our education and careers, and it can be difficult to find another career that is as financially and professionally rewarding as surgery. For society, loss of licensed health care professionals can result in reduced access to the talents and care that surgeons provide. The goal of this article is to define the terms used among the licensing and regulatory bodies, as well as the credentialing committees, and outline steps for individuals to reinstate themselves as fully productive members of the medical community.

Definitions
Illness generally is defined as the presence of a disease, whereas impairment is a functional classification and implies that the person is affected by a disease that renders him or her unable to perform specific activities. Regulatory and credentialing bodies often use these terms synonymously; however, mental and physical illness, as well as substance abuse, can eventually lead to impair-
A large portion of a state medical board’s activity centers on measuring competency, particularly in the areas of illness and impairment, and restricting licenses and mandating treatment programs for those health care professionals who are demonstrating signs of impairment or illness.

Disruptive physician behavior, as defined by the American Medical Association, is a style of interaction with physicians, hospital personnel, patients, family members, or other individuals that interferes with patient care. More specifically, the physician’s behavior intimidates and demeans others, potentially resulting in a negative impact on patient care. It is not a diagnosis, but could reflect underlying personality disorders, substance-related disorders, or psychiatric illness.*

Another area of potential impairment for physicians is addiction. Addiction is a compulsive activity or a psychological dependence on a certain behavior, which can eventually consume the attention of the individual to the exclusion of the other aspects of an individual’s life and, thereby, create impairment. Addiction may include substance abuse disorder, as defined by the American Psychiatric Association’s Diagnostic and Statistical Manual of Disorders, Fourth Edition, or addictive illness.

Related bodies
The Federation of State Medical Boards (FSMB) is a national body that leads the licensing community by promoting excellence in medical practice, licensure, and regulation.† The FSMB also functions as a resource and voice on behalf of the state medical boards in their protection of the public’s well-being. Another organization involved in supporting physician behavior is the Federation of State Physician Health Programs, which, as its name suggests, is an association of physician health programs (PHP) with knowledge and expertise specifically related to matters of physician health. These programs do not diagnose and treat physicians, but rather coordinate and monitor intervention, evaluation, and the treatment and the continuing care of an impaired physician, as well as those with potentially impairing illness. The PHPs have a primary commitment to uphold the mission of their state medical and osteopathic boards in order to protect the public.

The state medical board’s primary goal is to protect the public through the issuance of professional licenses, as well as the use of disciplinary action for those health care professionals who violate the state medical practice act. There are approximately 70 state medical boards, including 13 osteopathic boards; several states have dual boards. Unfortunately, many physicians finish their training with specialty certificates only to realize that it is not possible to practice medicine without meeting a certain standard in the state where he or she practices.

The issuance of a license attests to meeting a minimal standard of education and training. The United States Medical Licensing Examination (USMLE) is the product of a collaborative effort between the National Board of Medical Examiners, the FSMB, and the individual state licensing boards to develop uniform standards across the U.S. and Canada for the issuance of an initial license. In addition to the examination, other data are taken into consideration before the license is granted. For example, each state has its own rules and regulations regarding medical practice. The overall purpose of these guidelines is to protect the public through licensure, discipline, and assurance of a minimal level of education to issue a license. Many states now require additional education beyond medical school before a license is issued.

A large portion of a state medical board’s activity centers on measuring competency, particularly in the areas of illness and impairment, and restricting licenses and mandating treatment programs for those health care professionals who are demonstrating signs of impairment or illness. This is frequently done through the PHPs that work in conjunction with the state medical board and the state medical societies; however, PHPs should be insulated as much as possible from any political pressures and conflicting interests with the professional organizations.


Hospital credentialing

Credentialing is usually done at the local hospital or health care facility where the physician seeks to practice. The FSMB has developed a centralized credentialing bank that stores an individual’s college, medical degree, initial licensure, USMLE scores, and basic demographic information. This database helps to facilitate new licensure applications as physicians move from state to state and into different positions and, at the same time, protects the public from exposure to physicians who are under investigation in another jurisdiction. The local hospitals and health care facilities issue credentials depending on the individual’s training and upon the needs and standards they have established. An unrestricted license is usually mandatory; however, for individuals who have had their licenses restricted, each individual credentialing body has to establish the rules and regulations under which their practitioner is going to operate in the facility. It is imperative that each individual, depending on the jurisdiction in which he or she practices, be familiar with the state medical practice act and the unique rules and policies regarding that legislation.

Next steps

Although most physicians want to help their colleague reinstate his or her license, there has to be an appropriate balance between the goals of protecting the public and the safety of their health care versus the recovery of the ill physician. From a practical standpoint, if a health care professional is subject to a formal complaint, either with their local credentialing body or the state board, it is important that they undergo self-examination of their illness or addictive behavior. Initially, these individuals should obtain the assistance of their treating physician, as well as colleagues who may assist them in their recovery. However, if a formal hearing, locally or statewide, is initiated, then it is imperative that these physicians obtain legal counsel from a lawyer who is familiar with administrative health laws, as the rules of evidence in these hearings are different than in a criminal court proceeding.

It is necessary that individuals who are facing disciplinary action act with complete transparency before the hospital administrative body or the state regulatory agency in the hearing. Documentation of efforts to correct the illness or the impairment in a forthright manner is essential to a favorable decision by these authorities.

In many cases, if a patient has not been adversely affected by the individual’s behavior, then the PHP can work in conjunction with the state regulatory agency in terms of monitoring appropriate intervention, evaluating the condition, and recommending treatment and the ongoing care for the impaired physician. If anger or disruptive behavior is an issue, programs are available to assist individuals in managing these problems. Ongoing monitoring and continuing reports to the appropriate authority will be mandatory. If a medical license is encumbered, specific restrictive conditions need to be fulfilled in order to achieve full reinstatement of an unencumbered license. Again, an experienced health care lawyer should be secured to assist in these proceedings.

Even when treatment and rehabilitation are successful, the road to recovery can be difficult. Recovering substance abusers often face discrimination, but they should be given the opportunity to prove themselves through careful monitoring. Most state regulatory agencies will restore a license with conditions outlined in a public document, which may be used as guidelines for the local credentialing body. For those health care professionals with substance abuse problems, either alcohol- or drug-related, the typical period of observation is five years without recidivism.

This journey can be long and arduous, but with determination, discipline, and self-awareness, complete rehabilitation is achievable. In some instances, the road to full rehabilitation may be particularly challenging, and the individual may have to establish a new, modified professional routine. The Federation of State Physician Health Programs and the American Society of Addiction Medicine are both excellent resources for accomplishing that goal.
The Patient-Centered Outcomes Research Institute

The Patient-Centered Outcomes Research Institute (PCORI) is a not-for-profit organization established in the Affordable Care Act (ACA). It was created to help patients, clinicians, purchasers, and policymakers make more informed health care decisions "by advancing the quality and relevance of evidence" on how to prevent, diagnose, treat, monitor, and manage diseases, disorders, and other conditions. PCORI’s objective is to better ensure that patients, health care professionals, and other stakeholders have the evidence they need to make informed decisions when comparing treatment options through research guided by patients, caregivers, and the broader health care community.

This column discusses PCORI’s focus on patient-centered care, comparative effectiveness research (CER), research funding, and innovative projects. It also provides information on how surgeons can get involved.

How will PCORI meet the ACA mandate?
To meet the ACA mandate of enhancing the quality and relevance of patient-centered outcomes research, PCORI has adopted the following strategic goals:

- Increase the quality, quantity, and timeliness of usable, trustworthy information to support health care decisions
- Advance the implementation and use of research evidence
- Influence research funded by others so it is more patient-centered

To meet these goals, PCORI specifically focuses on clinical comparative research to investigate which currently available health care products and treatments work best for a given patient, caregiver, or other stakeholder. To achieve this aim, PCORI works from the premise that research might be enhanced if investigators routinely interact with patients to develop research questions. PCORI-funded research must demonstrate that it answers questions and addresses gaps identified by stakeholders to determine the solutions that work best for them. To gain the information needed to address a broad range of health care decisions, PCORI funds research based on five stakeholder-identified national priorities (see table, page 36).

In what innovative ways is PCORI advancing national research on PCOR?
In March, PCORI launched the National Patient-Centered Clinical Research Network (PCORnet), a national, interoperable multicenter research network specifically designed to support observational and randomized PCOR studies. PCORnet is a health data initiative which will work to conduct clinical research within patient communities and health care systems across a wide geographic area.

PCORI has awarded more than $93 million to 11 Clinical Data Research Networks (CDRNs) and 18 Patient-Powered Research Networks (PPRNs), which fall under the PCORnet umbrella. The purpose of CDRNs and PPRNs is to stimulate patient-driven research. The figure on page 37 illustrates how many sites affiliated with one or more of PCORnet’s 29 partner networks are expected to be established in each state. CDRNs are health system-based clinical data networks.
covering large populations that collect information in electronic health records (EHRs) in the course of routine patient care. The CDRNs are charged with building a large nationwide patient cohort with longitudinal electronic clinical data, developing policy for the standardization of data, and focusing on data security to improve patients’ ability to participate in multi-network, randomized clinical trials and observational studies.7

PPRNs are operated and governed by groups of patients, caregivers, or families connected by a shared health condition and who are interested in participating in CER. PPRNs are required to collect data on 80 percent of the population they represent.7 Half of existing PPRNs represent patients with rare diseases and are therefore critical for advancing research on these conditions. PPRNs organized around a specific disease will represent a group of motivated individuals ready to participate indefinitely in studies related to that disease. Typically, research grants have supported collaboration across a consortium of academic medical centers to study a rare disease, but the researchers and study group have often dispersed when the specific project is completed. PPRNs will not disperse, and the PPRN rare disease cohort will remain available to participate in future studies.

The initial phase of development for the CDRNs and PPRNs is 18 months, after which it is anticipated that PCORnet will have available information on several million diverse patients. This will greatly increase the statistical power of patient-centered CER due to larger samples. PCORnet works to advance the speed and efficiency of research by building a health care community that will produce meaningful information for end users. PCORnet has the potential to seamlessly include health research as a part of routine patient visits without interrupting care, thereby creating a national resource for health research.

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**How does PCORI research involve patients and other stakeholders in the application and review process?**

The specific focus on providing useful and practical comparative data for patients and caregivers is what distinguishes PCOR.
WHAT SURGEONS SHOULD KNOW ABOUT...

PCORI’s funding criteria specifically address patient-centeredness, engagement, and likelihood of changing practice. To receive funding, applicants must involve patients in clinical research design and decision-making processes to ensure that research questions are relevant to patients and other stakeholders.

Examples of questions that PCOR might address include:

• “Given my personal characteristics, conditions, and preferences, what should I expect will happen to me?”

• “What are my options, and what are the potential benefits and harms of those options?”

• “What can I do to improve the outcomes that are most important to me?”

• “How can clinicians and the care delivery systems they work in help me make the best decisions about my health and health care?”

Another way that PCOR engages patients and stakeholders is through the research application and review process. PCORI is the first large funding agency in the U.S. to require non-scientist reviewers to be involved in the review of all applications for its funding. The purpose of their involvement is to improve the relevance of PCORI-funded research for the stakeholders who take action based on the findings. Each funding application submitted to PCORI funding is reviewed by four merit reviewers—two clinical scientists, one patient or patient advocate, and one health care stakeholder, such as a clinician, purchaser, or representative from the health care industry. Through this process, end users have the ability to provide

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input on which research proposals PCORI should fund. PCORI has developed resources to help stakeholders communicate and work with patients, because those researchers seeking funding for PCOR have identified patient engagement as one of their biggest challenges. A webinar that provides examples of meaningful engagement can be found at http://www.pcori.org/events/2013/promising-practices-meaningful-engagement-conduct-research.9

How can surgeons get involved in PCORI?
Surgeons can get involved in PCORI in several ways. PCORI has approved $549 million to more than 300 research projects and initiatives since 2012, and as much as $1.5 billion will be committed to research projects in the upcoming three years—most of which will focus on targeted funding announcements and large pragmatic studies.3 A few engagement opportunities include:

• Eugene Washington PCORI Engagement Awards: These awards provide funding for smaller projects to develop knowledge concerning how consumers of health care information view and use PCOR, to build capacity for community engagement in PCOR, and to support channels for the dissemination and implementation of PCOR. Applications for funding are reviewed on an ongoing basis. For more information, visit http://www.pcori.org/funding-opportunities/eugene-washington-pcori-engagement-awards/.

• Large pragmatic studies: In 2014, PCORI launched a new initiative to fund large pragmatic clinical trials, large simple trials, or large-scale observational studies. This initiative provides an opportunity for clinicians to partner with diverse stakeholders, including patients, purchasers and/or payors, and professional organizations. These studies will involve broadly represented patient populations to ensure a large enough sample to evaluate differences in treatment effectiveness in patient subgroups. The studies aim to address prevention, diagnosis, treatment, or management of a disease and/or symptom improvement in health care system performance, and elimination of disparities in health care, and must be conducted in a typical clinical care and community setting.10

• Other PCORI funding opportunities: PCORI also issues regular funding announcements under its five broad national priorities for research and occasional calls for proposals on specific, high-impact topics. All funding opportunities are listed in PCORI’s funding center at http://www.pcori.org/apply.

• PCORI funding reviews: PCORI seeks guidance from clinicians and other stakeholders on the evaluation of proposals for its funding and to formulate research questions. Clinicians are critical stakeholders in the PCORI merit review process. To learn about the experience of past reviewers, visit http://www.pcori.org/content/get-involved.

• PCORnet: Once PCORnet is operational in late 2015, surgeons involved in research may be able to link external data to PCORnet to supplement their current study population. Linking clinical data registries
PCORI has approved $549 million to more than 300 research projects and initiatives since 2012, and as much as $1.5 billion will be committed to research projects in the upcoming three years—most of which will focus on targeted funding announcements and large pragmatic studies.

to PCORnet may be especially effective in creating a large, diverse study cohort. Surgeons may also have the opportunity to help leverage EHRs to help recruit eligible patients, monitor patient safety and study conduct, and collect clinical outcomes.

Other areas of engagement include opportunities to provide input on study design for integration with physician clinic or office operations, disseminate study findings, or contribute to the evaluation of PCORI-funded projects.

For additional questions and concerns regarding PCORI, contact the American College of Surgeons Division of Advocacy and Health Policy at ahp@facs.org or 202-337-2701.

REFERENCES

In the fall of 2013, the American College of Surgeons (ACS) listserv for rural surgery began receiving inquiries from surgeons at critical access hospitals (CAHs), who were getting requests from their administrators to sign certification that inpatients would reasonably be discharged within four days. Thus was the introduction of most rural surgeons, and the physicians and staff in the ACS Division of Advocacy and Health Policy (DAHP), to a minor clause in a long-standing federal law known as the 96-hour rule.

**Background**

The federal government created the CAH system as part of the Balanced Budget Act (BBA) of 1997 to ensure the financial viability of hospitals in remote rural areas, and thereby improve access to care for patients in these areas of the nation. In contrast to other hospitals, which are paid a set fee for patient hospital admissions under a diagnosis-related group (DRG) schedule, Medicare pays CAHs 101 percent of the actual hospital costs of caring for these patients. However, CAHs must comply with specific rules to participate in the program.

In the 1997 BBA, Congress defined both conditions of participation and conditions of payment for CAHs, requiring them to “provide acute inpatient beds...for a period not to exceed 96 hours.” In the 1999 Balanced Budget Refinement Act (BBRA), Congress changed the conditions of participation to a period that does not exceed, as determined on an annual average basis, 96 hours per patient.* This language change allowed surgeons in CAHs to care for patients who might require inpatient care exceeding 96 hours, as long as the average care for patients treated at these institutions on an annual basis remained at 96 hours or less. However, the conditions of payment were never updated to reflect the new language. The discrepancy was not noted in Washington, DC, until 2013, when new mandates regarding the two-midnight rule for inpatient admission were to take effect.

Administrators at the Centers for Medicare & Medicaid Services (CMS) began to notify rural CAHs that, in addition to the requirements for the two-midnight rule for hospital admissions, the conditions of payment in the BBA of 1997 would apply, which meant that CMS would not pay CAHs for inpatient stays exceeding 96 hours. According to posts on the rural surgery listserv, administrators at a handful of small hospitals began confronting surgeons about their compliance with the new requirements and asked...
In the 1997 BBA, Congress defined both conditions of participation and conditions of payment for CAHs, requiring them to “provide acute inpatient beds...for a period not to exceed 96 hours.”

the surgeons to sign attestations stating that their patients would be reasonably discharged within 96 hours. This new regulation would of course greatly restrict the patients who could receive health care services at a CAH.

A plan emerges
In early discussions, ACRS members and the DAHP staff, agreed that a multifaceted approach involving ACS-SurgeonsVoice was needed to mitigate the damage caused by the 96-hour rule, as even the best-laid plans in Washington often fall victim to politics, inaction, or unforeseeable events. The proposal presented at the December 2013 ACS Health Policy and Advocacy Group meeting featured a three-pronged strategy:

• Work with CMS to explore administrative options to offer relief from the rule
• Develop a legislative solution to repeal the 96-hour rule
• Inform surgeons and prepare them for the impact of the rule

ACS DAHP staff, along with their counterparts at the American Medical Association, AHA, and NRHA, began discussions with CMS staff to attempt to find solutions to the conflicting rules. In these discussions, CMS staff explained that they had limited ability to act, and due to the fact that the 96-hour rule was established under a federal law, only Congress could correct the unintended consequences of this legislation.

Nonetheless, the ACS DAHP staff realized that there were some means of mitigation. Because CMS had previously overlooked the mandate, prior violations would not be pursued. CMS also revealed that enforcement would be through audits of claims paid and Recovery Audit Contractor (RAC) recovery. Although CMS did not have the authority to simply “ignore” the rule, they did have some leeway in their approach to enforcement. DAHP’s involvement probably played a role in ensuring that no hospitals would be forced to repay CMS for these patients over the first six months of the 96-hour rules issued in 2013.

The third part of the strategy to resolve questions related to the 96-hour rule was legislative in nature, and led by members...
ACS-SurgeonsVoice plays critical role

by Tyler G. Hughes, MD, FACS

Editor’s note: The following is an invited commentary from Tyler G. Hughes, MD, FACS, ACS Governor and Chair of the Advisory Council for Rural Surgery.

Dr. Savarise’s column clearly shows the value of the American College of Surgeons grassroots advocacy program (ACS-SurgeonsVoice), and emphasizes how hard the members of the ACS DAHP and HPAG are willing to work on an issue that is of critical importance to rural surgeons and CAHs.

Everywhere I go, I hear questions regarding the effectiveness of the College. There’s no question that we often fight uphill battles on Capitol Hill. The people who lobby against us are well-funded and are motivated by forces far different from those of the average surgeon. The 96-hour rule is a great example of the ACS leadership listening to a problem, understanding its significance, allocating resources to the issue, and quickly springing into action to get a bill introduced. The value of individual surgeons contacting their members of Congress, the effect of the SurgeonsVoice action alerts, and the effect of multiple surgeons discussing this issue with their members of Congress at the ACS Leadership & Advocacy Summit in April also cannot be underestimated. The results on this issue, as outlined in Dr. Savarise’s article, clearly show that the College’s advocacy efforts can be very effective.

The 96-hour rule may seem like a small matter, but it is not in principle or effect. If surgeons can get a win on this issue, it’s one more stone in building a foundation for a better system for patients with surgeons’ input. Be politically active in whatever way you can, and meet with your members of Congress when they are home in the coming months.◆

Gathering support

The College used several tools to successfully gather support for the bill. First, rural surgeons were mobilized on the listserv to contact their representatives and senators.
A second wave of advocacy was initiated via the ACS-Surgeons Voice action alerts, recruiting more surgeons to contact their legislators. At the ACS Leadership & Advocacy Summit in April, the 96-hour rule was designated an item for discussion for surgeons who were participating in Capitol Hill visits.

Around the time that surgeons were mobilizing to overturn the 96-hour rule, the ACS was involved in a larger attempt to repeal the sustainable growth rate (SGR) formula used to calculate Medicare physician payments. The political and economic climate of 2014 brought the medical community closer than ever to fully repealing the SGR, with bills making it through committees in both the House and Senate. Unfortunately, just before the Leadership & Advocacy Summit, Congress scratched the permanent SGR fix and rapidly adopted another temporary patch. This legislation contained some important provisions, however. One suspended implementation of the two-midnight rule—the regulation that brought the 96-hour rule to light. By suspending this provision, Congress essentially halted further administrative pursuit of the 96-hour rule, leaving CMS in limbo but taking the pressure off the CAHs.

These legislative efforts, especially grassroots lobbying by individuals, effectively generated support for the Critical Access Hospital Relief Act. At the end of July, the bill had 81 cosponsors in the House and 29 in the Senate. At press time, however, the legislation seemed to be languishing. Perhaps with the temporary patch for the SGR, attention is elsewhere, or, perhaps, the impending mid-term elections are preventing movement on some pieces of legislation. For whatever reason, H.R. 3991/S.B. 2037 had not been scored by the Congressional Budget Office, a necessary step for the passage of any bill.

Outlook
To ensure that Congress returns attention to the legislation, DAHP Medical Director of Advocacy, Patrick V. Bailey, MD, FACS, has brought up the legislation in meetings with the Congressional Medical Caucus (a group of legislators with medical backgrounds) and other congressional leaders.

Dr. Bailey predicts that for the bill to succeed, it will need to be attached to a larger piece of legislation, such as an appropriations bill. However, he doesn’t foresee Congress acting on this issue until later this fall.

So, at press time, the 96-hour rule remained dormant, but still hung over the heads of surgeons in rural practices who use CAHs. The best source of relief will almost certainly emanate from new legislation. Knowing how important this issue is to rural surgeons and CAHs, the ACS DAHP, ACRS, and College leadership will continue their efforts to achieve passage of this legislation. ♦

Much of the early advocacy effort occurred at the grassroots level, with individual rural surgeons contacting members of Congress with whom they already had established relationships.
Patient quality of life (QOL) is a vitally important clinical outcome measure in surgical practice. In this article, the authors describe efforts to assess patient concerns and interventions to address deficits in QOL. Surgical teams are interested in learning how to measure QOL interventions effectively and to assist their patients in preserving or improving their QOL in the perioperative time.

**Drawbacks of rehabilitation programs**

To improve perioperative QOL and functional recovery, patients often are asked to participate in rehabilitation programs, many of which involve physical or psychosocial interventions. The rationale for employing physical exercise programs is based on reports that exercise interventions can ameliorate deficits in QOL and fatigue, including cancer-related fatigue. It follows that positive changes in fitness could lead to a reduction of cancer-related fatigue and overall improved QOL.

Traditional rehabilitation programs, such as aerobic exercise and smoking cessation programs, address issues that affect patient outcomes and are usually prescribed by a physician. Both in the preoperative setting and after a significant health event, such as a heart attack or major abdominal surgery, patients may have difficulty adhering to such programs.

For example, one patient reported that although she increased her physical fitness significantly during rehabilitation, she had “no QOL” because the frequency and duration of the exercise program had entirely disrupted her social life. The patient went so far as to say she would have preferred that she had not survived, indicating that neither her emotional nor social needs had been met. Few patient-provider encounters provide enough time to explore these needs. There is increased attention to quality measures, such as pay-for-performance, that improve narrowly-defined patient outcomes, which results in conflicting goals between patients and providers and increases stressors on patients, providers, and other stakeholders.

**PROQOL**

To address a similar problem associated with a different disease, chronic diabetes, the Beacon Patient-Reported Outcomes Quality of Life (PROQOL) Tool was launched by the Southeast Minnesota Beacon Program, Rochester, with funding from the Beacon program communities health information technology grant/award. PROQOL was developed with input from patient and health care providers and resulted in practical lessons learned for organizations interested in integrating the patient’s perspective into care management.

In this system, patient-reported outcomes are systematically measured and made available electronically to all health care providers, independent of location. Patients are able to report concerns related to less commonly discussed issues that may affect health management, such as social factors and personal relationships. The health care team develops a repository of “suggested actions” to respond to a broad set of issues that affect the patient’s health management within and without the formal health care system. Partnering with patients, caregivers, and other stakeholders, the original PROQOL tool used in the Beacon trial for diabetes can be modified to address issues common to other patients.

The patients’ single biggest concern will trigger a list of suggested actions from the repository. The patient and provider then can select interventions that are likely to suite the patient’s needs (see figures, page 45). Health care provider assessment may yield additional recommendations.
based on known modifiable risk factors for decreased QOL (such as lowered functional capacity/exercise and anemia) and postoperative complications, including immune-enhancing nutrition and smoking cessation.

Different patients will have different concerns, such as physical or emotional health or work/financial concerns. Their specific concerns will connect them to the corresponding resources in the repository. For example, if a patient identifies cost of treatment as their biggest concern, suggested actions include a review of medications by the physician for more economical options, referral to the institutional financial resources, alerting the public health nurse to initiate case management, and identifying government programs for financial aid, community supportive resources such as the American Cancer Society resources, and Internet resources the patient can access independently. In this manner, the entire spectrum of stakeholders, both clinical and non-clinical, health care institutions, and community are mobilized to address the patient’s biggest concern.

As another example, if fatigue is identified as the main concern, the patient would be guided toward exercise modification, relaxation techniques, and potential screening for depression.

The PROQOL system hence identifies and addresses otherwise uncovered clinical problems in roughly 25 percent more patients than in standard care, which increases patient satisfaction with care, reduces complications, and improves QOL for both the patients and their caregivers.

REFERENCES

As robotic surgery continues to become increasingly popular for use in certain types of operations, surgeons need to be aware of what steps they can take to reduce the risks associated with these procedures. The Joint Commission urged surgeons and health care organizations to focus additional attention on the unique risks of robotic procedures in the June 2014 issue of its Quick Safety newsletter.*

The additional caution measures are a result of a general increase annually in the number of robotic surgery-related reports to The Joint Commission’s Sentinel Event Database over the past seven years. From 2006 to 2013, the database received 34 reports of sentinel events related to robotic surgery that affected 36 patients.* (A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof.)

Of the 34 reports, 27 were related to unintended retention of foreign objects, and seven to operative or postoperative complications. The complications were usually due to hemorrhage caused by laceration. Other complications included injury to surrounding tissue and serious injury, including blindness, related to prolonged surgery. Of the seven operative or postoperative complication reports, two resulted in death from excessive blood loss and one was related to a delay in treatment.*

The reporting of most sentinel events to The Joint Commission is voluntary and represents only a small proportion of actual events. These data are not an epidemiologic data set and no conclusions should be drawn about the actual relative frequency of events or trends in events over time. Therefore, it is questionable whether the increase in robotic surgery-related reports stems from the more frequent occurrence of sentinel events or simply from more reporting.

The reports in the Sentinel Event Database are consistent

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Although current robotic systems are designed to minimize potential patient harm with features such as redundant safety mechanisms to minimize human error, fault tolerance, just-in-time maintenance, and system alerting, all mechanic and electronic devices are subject to failure.

With current literature for the most serious events involving robotic surgery. These events are generally categorized as directly related to the use of a robotic system and the general risks of the operative procedure. Surgeons should consider the unique risks of robotic surgery within both types of events.

For example, surgeons may be located at some distance from patients during robotic surgery, and precise control of the robot can depend on the quality of the data connection between the surgeon's console and the operating room robot. Although current robotic systems are designed to minimize potential patient harm with features such as redundant safety mechanisms to minimize human error, fault tolerance, just-in-time maintenance, and system alerting, all mechanic and electronic devices are subject to failure.

Another risk is associated with training and credentialing. Robotic surgery is a relatively new technology and requires advanced operator skills typically not taught during residency. Surgeons should be adequately trained in the use of surgical robots. According to an article in the April 2011 issue of the *Journal of Urology*, “credentialing should involve the demonstration of proficiency and safety in executing basic robotic skills and procedural tasks.”

### Safety actions to consider

Surgeons and health care institutions that use surgical robots should consider the following safety actions:

- Develop and follow credentialing guidelines. A period of focused professional practice evaluation for any newly granted privilege needs to be implemented. Once a confidence level is achieved with the practitioner’s practice related to robotic surgery, a transition to ongoing professional practice evaluation should begin.

- Provide patient assessments to ensure the planned robotic procedure is appropriate for the individual patient.

- Improve operating room team communication. During robotic surgery, the team must communicate in different ways because the surgeon is typically positioned at a console away from the operating table, and the other team members cannot see what the surgeon sees.

- Standardize processes in the operating room, including the count process, by taking into account sponges, needles, and other supplies, as well as checking tools and tool tips to ensure they are secure and in working order.

Should a robotic surgery become a sentinel event, The Joint Commission encourages its accredited health care organizations to report the case in an effort to improve patient safety and quality of care. For more information, go to [www.jointcommission.org](http://www.jointcommission.org).

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More than one-third (37 percent) of the injured patients in the National Trauma Data Bank® (NTDB®) 2013 Annual Report tested positive for alcohol. Some of these intoxicated patients may have chronic drinking problems and alcohol dependence. As the length of the hospital stay to treat their injuries increases, the time of abstinence from alcohol also rises, which may pose its own set of problems.

Dealing with DTs
In alcohol-dependent individuals, signs and symptoms of alcohol withdrawal syndrome (AWS) may develop within 24 to 48 hours after their last drink. AWS is common and most often is mild; however, the abrupt cessation in a patient who is alcohol-dependent may lead to delirium tremens (DTs)—a state of severe dysautonomia and encephalopathy—as well as withdrawal-related seizures, either of which may be fatal.*

The severity of baseline symptoms of AWS can be measured using the revised Clinical Institute Withdrawal Assessment for Alcohol (CIWA-Ar). This scale includes 10 items that score the severity of symptoms, including

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Withdrawal and injury
To examine the occurrence of injuries in which alcohol withdrawal was involved, the author searched the admissions records in the NTDB dataset for 2013 using the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnoses codes. Specifically searched were records containing diagnosis code 291.81, Alcohol withdrawal (processes and symptomatic effects resulting from abstinence from alcohol). A total of 550 records containing a diagnosis of alcohol withdrawal were found; 529 of these records contained a discharge status, of which 349 patients were discharged to home, 92 to acute care/rehab, and 83 to skilled nursing facilities; five died. These patients were 81 percent male, on average 51.9 years of age, had an average hospital length of stay of 12.4 days, an intensive care unit length of stay of 7.3 days, an average injury severity score of 11.3, and were on the ventilator for an average of 7.3 days, an average injury severity score of 11.3, and were on the ventilator for an average of 7.3 days (see Figure 1, page 49). The top three incident locations of initial injury were home (45 percent), street (40 percent), and public building (10 percent). (See Figure 2, page 49.)

In this group of AWS patients, injury occurred more often at home than in the street where one would typically find the homeless population. Although the mortality was low for AWS patients, these patients had a longer average hospital length of stay in comparison with other groups of injured patients as reported in previous issues of the Bulletin, and one-third had discharge dispositions that
included further hospitalization or long-term care.

**AWS does not discriminate**
Alcohol dependence shows no distinction between race, age group, ethnicity, or social class. One needs to be mindful and identify injured patients who may have alcohol dependence issues and adequately treat AWS to mitigate the potential complications, including unanticipated withdrawal.

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

**Acknowledgment**
Statistical support for this article has been provided by Chrystal Caden-Price, Data Analyst, and Alice Rollins, NTDB Coordinator.
For his contributions to the American College of Surgeons (ACS), trauma care, and the field of surgery, J. Wayne Meredith, MD, FACS, has been selected to receive this year’s Distinguished Service Award (DSA). A Fellow of the ACS since 1990, Dr. Meredith is the Richard T. Myers Professor and Chair, department of surgery, Wake Forest School of Medicine; surgeon-in-chief, Wake Forest Baptist Health; and medical director, Childress Institute of Pediatric Trauma, Wake Forest University Baptist Medical Center, Winston-Salem, NC. The DSA is the highest honor bestowed by the ACS and will be presented Sunday, October 26, during the Convocation ceremonies at the 2014 Clinical Congress in San Francisco, CA.

The Board of Regents of the ACS is presenting the DSA to Dr. Meredith in appreciation of “his continuous and devoted service as a Fellow of the American College of Surgeons” and “in recognition of his distinctive scientific contributions in cardiovascular physiology during resuscitation, trauma registries, and trauma systems,” the award citation states.

**Leadership in ACS trauma programs**
In his more than 20 years as a Fellow, Dr. Meredith has devoted much of his energy to ACS trauma-related activities. He served as the Medical Director of Trauma Programs (2006–2010) and Past-Chair of the Committee on Trauma (COT) (2002–2006). He has chaired the COT’s National Trauma Data Bank® Ad Hoc Committee (1997–2002) and the Trauma Registry Subcommittee (1994–2002) and continues to serve on the Verification, Review, and Consultation Committee (1996–present). In addition, he has been a liaison member of the Program Committee (2002–2006), a member of the national faculty for Advanced Trauma Life Support® (2002–present), and the ACS COT representative to the American Board of Surgery Trauma, Burns, and Critical Care Advisory Council (2005–2006).

Dr. Meredith also has played a significant role in state-level ACS activities since joining the North Carolina Chapter of the ACS in 1991. He has served as a member of the chapter’s Board of Directors (1994–present), a member (1991–present) and Chair (1991–1997) of the North Carolina COT, and Chapter President (2005).

**Commitment to surgical education**
He joined the faculty of Wake Forest University Health Sciences in 1987. In his years of service at Wake Forest University School of Medicine, Dr. Meredith has taken on many roles. He was director of surgical sciences through June 2014 and appointed surgeon-in-chief of Wake Forest Baptist Health Medical Center in July of this year. In addition to serving as the Richard T. Myers Professor and Chair, he is the residency program director, department of surgery, Wake Forest School of Medicine. Along with serving as medical director, Childress Institute of Pediatric Trauma, department of surgery, Dr. Meredith also holds a cross-appointment at the Institute for Regenerative Medicine, as well as a joint appointment as professor of pediatrics in the department of pediatrics. He is a member of Wake Forest’s graduate medical education committee (1999–present), the
The Board of Regents of the ACS is presenting the DSA to Dr. Meredith in appreciation of “his continuous and devoted service as a Fellow of the American College of Surgeons” and “in recognition of his distinctive scientific contributions in cardiovascular physiology during resuscitation, trauma registries, and trauma systems,” the award citation states.

risk and insurance management advisory council (2002–present), the faculty executive council (2002–present), the cancer center oversight committee (2004–present), the medical executive committee (2011–present), and the health system management council (2011–present). He is on the boards of the North Carolina Baptist Hospital and the Wake Forest Baptist Medical Center.

Other contributions to trauma surgery
In addition to his previously noted service in leadership roles in ACS Trauma Programs, Dr. Meredith has been active in the field in various capacities—both nationally and globally. Dr. Meredith has been named a visiting professor or named lecturer at more than 20 institutions around the world, from Johannesburg, South Africa, to Quito, Ecuador. He is author or coauthor of more than 170 scientific publications, more than 20 book chapters, and one textbook, Trauma: Contemporary Principles and Therapy. He also serves on the editorial boards of the American Journal of Surgery and the Journal of Trauma and Acute Care.

His research interests include thoracic trauma, the biomechanics of crash injury, injury severity measures, and trauma systems development. Over the course of his career, Dr. Meredith has been awarded 10 grants for various trauma studies. He currently serves as the principal investigator for a National Institute of Health grant for Integrative Training in Trauma and Regenerative Medicine, as well as a joint project with the Wake Forest School of Medicine and the National Highway Traffic Safety Administration that established the Crash Injury Research and Engineering Network Center of Wake Forest and Virginia Tech, Blacksburg.

Dr. Meredith has held leadership roles in many other professional organizations as well, including president of the Southeastern Surgical Congress, the Eastern Association for the Surgery on Trauma, the Southern Surgical Association, the American Association for the Surgery of Trauma, and the Halsted Society. In addition, he has served as director of the American Board of Surgery and the American Board of Thoracic Surgery.

Dr. Meredith graduated from Emory University, Atlanta, GA, with a bachelor of arts in physics. He earned his medical degree and completed his surgical training at the Bowman Gray School of Medicine, Winston-Salem, NC. He completed his trauma/critical care fellowship and was visiting assistant professor of surgery/trauma under the supervision of Donald D. Trunkey, MD, FACS, at Oregon Health Sciences University Hospital, Portland.◆
In memoriam:
Thomas R. Russell, MD, FACS, remembered for his enduring contributions to the ACS

by Carlos A. Pellegrini, MD, FACS, FRCSI(Hon), and Diane S. Schneidman

Tom was the right person for the job. As a Regent and in professional circles, he had a reputation as a bright, kind, high-energy individual, who was willing to weigh all sides of an issue.

Childhood and education
Dr. Russell was the son of Floyd and Marianna Russell. A native of San Francisco, he attended Town School for Boys and then The Thacher School—a highly selective high school in Ojai, CA. One of the unique characteristics of The Thacher School is that it augments a challenging academic program with lessons learned from the care of horses and camping. Like his classmates, Tom would start every day by caring for his horse before breakfast and going to class. This experience had a profound effect on him, and he remained dedicated to Thacher and its principles—honor, fairness, kindness, and truth—throughout his life.

At age 15 he spent his summer as a wrangler at the Tumbling McD Dude Ranch in Philo. He returned the next year as chief wrangler, a position he filled every summer until his second year of medical school. He claimed that he developed his remarkable talent for remembering people’s names and life stories while taking care of 40 dudes a week at the ranch. As a youth, Dr. Russell was also an excellent tennis player. In fact, at one time, the local pro had his mother convinced that with a few more lessons, he could go to Wimbledon. He kept up his game throughout his life, with surgical chiefs and admirals seeking him out as a partner. Ultimately, however, Dr. Russell chose more scholarly pursuits. He earned a bachelor of arts degree in zoology from the University of California, Berkeley, in 1962 and his
medical degree from Creighton University Medical School, Omaha, NE, in 1966. It was during medical school that Tom adopted the motto he would follow well into his years as ACS Executive Director: “Take the stairs, be nice to the janitor, and the patient comes first.”

Military service, training, and practice
He did a rotating internship at San Francisco General Hospital from 1966 to 1967 and began his general surgery residency at the University of California, San Francisco (UCSF), in 1967. His residency training was interrupted by service in the Vietnam War from 1968 to 1970, during which he was a Lieutenant Commander and U.S. Navy flight surgeon aboard the U.S.S. Ticonderoga and the U.S.S. Forrestal.

Dr. Russell resumed his surgical training at UCSF in 1971 and completed it in 1975. During those same years, he undertook a research project on gastrointestinal hormones physiology at the Veterans Hospital-Fort Miley in San Francisco and a fellowship under world-renowned pancreatic surgeon Maurice Mercadier, MD, at the L’Hopital de la Pitie, part of the Hopitaux de Paris, France.

In 1975, Dr. Russell joined the practice of Donald M. Gallagher, MD, FACS, and Peter Volpe, MD, FACS, initially taking a preceptorship in colon and rectal surgery and then practicing in this specialty in San Francisco for nearly 25 years. By 1980, Presbyterian Hospital—formerly the Sanford Hospital and now the California Pacific Medical Center—recognized him for his patient care philosophy, his teaching of residents, and his ability to lead, naming him chair of its department of surgery, a position he held until he moved to Chicago, IL, in 2000. His wife of 35 years, Nona Chiampi Russell, MD, a pathologist, also practiced at this institution.

Tom was affiliated with several other hospitals in the San Francisco area and trained, mentored, and inspired countless residents and medical students as a clinical professor of surgery at UCSF. Students and residents always commented on Tom’s unique ability to remember their names and the names of their loved ones, as well as his willingness to always make time to listen to them—to understand their aspirations and to help them move forward in their careers.

Right man for the job
Tom became a Fellow of the ACS in 1979. He was elected to the Board of Governors in 1990 and served in that role until 1993, when he was elected to the Board of Regents. He served two consecutive three-year terms as a Regent, during which time he was a member (1994–1995) and Chair (1998–1999) of the Nominating Committee, a member of the Member Services Liaison Committee (1993–1999), and a member of the Advisory Council for Colon and Rectal Surgery (1993–2000). The two years leading up to Dr. Russell assuming the role of ACS Executive Director were difficult for our College, and staff morale was low.
Furthermore, the Institute of Medicine was poised to release its groundbreaking report *To Err Is Human: Building a Safer Health System*, which brought to the nation’s attention the number of complications and deaths resulting from medical and surgical error.

Given these internal and external stressors, the College was in need of thoughtful and compassionate leadership. Tom was the right person for the job. Among the Regents and in professional circles, he had a reputation as a bright, kind, high-energy individual who was willing to weigh all sides of an issue. As C. James Carrico, MD, FACS, then Chair of the Board of Regents said, “One of Tom’s greatest strengths is his level-headed approach to problem solving. He listens to all parties objectively and is able to come to a reasonable solution and to reach consensus with all parties concerned.”

Dr. Russell would go on to lead the College through 10 years of considerable growth and necessary change. Soon after assuming the position of Executive Director, he initiated a strategic planning process to do away with outmoded policies and program structures. He reorganized the College into four divisions: Education, Research and Optimal Patient Care, Advocacy and Health Policy, and Member Services. The College also developed a mission statement to guide the work of staff and volunteers alike: “The American College of Surgeons is dedicated to improving the care of the surgical patient and to safeguarding standards of care in an optimal and ethical practice environment.”

**Emphasis on quality and education**

Perhaps one of Dr. Russell’s most significant accomplishments as ACS Executive Director was bringing the Veterans Affairs (VA) National Surgical Quality Improvement Program, which had been credited with substantial improvement in the quality of care provided to veterans, into the private sector under the College’s aegis as ACS NSQIP®. He worked with ACS Past-President R. Scott Jones, MD, FACS, and Shukri Khuri, MD, FACS, the surgeon who had launched the program at the VA, to make this happen. With the VA’s blessing and funding from the Agency for Healthcare Research and Quality (AHRQ) and the ACS Finance Committee, ACS NSQIP launched in 2004.†

The more than 550 hospitals that have since participated in ACS NSQIP, now under the direction of Clifford Y. Ko, MD, MS, MSHS, FACS, have used the program’s risk-adjusted, evidence-based outcomes data to significantly reduce complications, limit error, and save countless lives and millions of dollars. Dr. Russell was the driving force behind the ACS Clinical Scholars in Residence Program, through

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which surgical residents are able to contribute on-site to the College’s quality improvement programs.

In addition, Dr. Russell guided the expansion of the College’s educational programming. In 2001, he tapped Ajit K. Sachdeva, MD, FACS, to serve as Director of the ACS Division of Education. “Sach” quickly began redesigning the Clinical Congress and other ACS educational programs with the goal of assisting surgeons in their efforts to meet new and evolving maintenance of certification requirements. Moreover, the College began offering more hands-on Postgraduate Courses and simulated training programs at ACS Accredited Education Institutes to help surgeons become more adept in the use of advanced technology.

Under Tom’s direction, the College established the ACS Foundation in 2005 to better support its scholarship programs. This move resulted in significant expansion of the educational opportunities that the College provides to residents and surgeon researchers. He was installed as Chair of the Foundation’s Board of Directors in October 2009—a position he held until February 2013.

Advocacy and visibility
The early 2000s were politically charged years for health care, culminating in the passage of the Affordable Care Act in March 2010. Of particular concern to surgeons were the ongoing threats to reimbursement stemming from the use of the sustainable growth rate formula to calculate Medicare payment. This payment cut and other legislative measures had the potential to seriously jeopardize access of patients to surgery. Dr. Russell encouraged the College to take a proactive stance.

To improve the College’s visibility and influence in Washington, the Board of Governors’ Committee on Socioeconomic Issues, chaired by Andrew L. Warshaw, MD, FACS, FRCSEd(Hon), suggested that the College establish a political action committee (PAC). Because of its tax-exempt status as an educational group, the College itself could not create its own PAC. Dr. Russell and the Regents moved forward with the development of the American College of Surgeons Professional Association (ACSPA), which would have the ability to develop a PAC. The ACSPA-SurgeonsPAC was established in 2002 and contributes to the election campaigns of candidates who are supportive of the surgical community’s political agenda.

In addition, Dr. Russell and Cynthia A. Brown, then Director of the ACS Division of Advocacy and Health Policy, led an effort to expand the Washington Office’s lobbying and health policy staff. To accommodate this growth, the Washington Office needed to relocate to a larger facility—preferably one closer to Capitol Hill than its Georgetown location. The Regents’ approved a plan developed by ACS Chief Financial Officer Gay L. Vincent to construct a 10-story building at 20 F Street, NW, which is in walking distance to Capitol Hill. The building officially opened its doors in 2010.
Perhaps Tom’s greatest legacy as Executive Director, however, will be his ability to connect with all surgeons and ACS staff.

To further improve the College’s visibility, the ACS established a Public Profile and Communications Committee, chaired by ACS Regent Jack McAninch, MD, FACS, and hired the public relations firm Weber Shandwick to broaden the College’s reach to media outlets. In addition, a fifth division of the College, Integrated Communications, was created under Linn Meyer to further raise the College’s public profile.

Inclusiveness
Perhaps Tom’s greatest legacy as Executive Director, however, will be his ability to connect with all surgeons and ACS staff. Dr. Russell traveled extensively as Executive Director, participating in entire chapter meetings so as to gain insights into the experiences and views of the broad ACS membership. Furthermore, he opened up ACS membership to anesthesiologists, nurses, and other members of the operating room team, so that they could all share common educational experiences at the Clinical Congress and other College-sponsored programs.

He reached out to the leadership of the American Society of General Surgeons (ASGS), which had a somewhat antagonistic relationship with the College, and under his leadership, ASGS was given specialty society representation on the ACS Board of Governors.‡ To make the College’s resources more widely available to some of the smaller surgical specialty societies, the ACS also began providing association management services to these groups.

Other initiatives that Dr. Russell led include the following: the establishment of Operation Giving Back at the suggestion of Dr. Warshaw and the Governors.

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Committee on Socioeconomic Issues; improvements in ACS Trauma Programs through the recruitment of our current Executive Director, David B. Hoyt, MD, FACS, as Medical Director; the refurbishment of the Murphy Memorial Auditorium Building in Chicago, IL; and restoration of the College’s Archival materials.

Tom was a highly respected and well-liked leader, not only among the ACS members, but among the organization’s staff as well. Many staff members have fond memories of him making his morning “rounds,” stopping by their desks to see how they were doing. Tom had an open-door policy and was always willing to listen to employees’ concerns about the workplace or to offer counsel to individuals with ailing family members. As a testament to his positive effect on staff morale, employee turnover dropped to 5 percent from 27 percent.‡

His spirit lives on

He was a devoted and loving family man and is survived by his wife, Nona; his daughters, Katie Russell, who is currently a chief surgery resident at the University of Utah, Salt Lake City, and soon to be a pediatric surgery fellow at Children’s Hospital of Philadelphia, PA, and Jackie Russell, a student in veterinary medicine at the University of California, Davis; his sister, Susie Tompkins Buell; two nieces, Quincey and Summer; and numerous grand-nephews and nieces. Always a cowboy at heart, Tom returned with his family to their ranch in Philo as often as their busy schedules would allow.

Dr. Russell remained fiercely loyal to the armed services throughout his life. Indeed, despite the fact that he could have undergone treatment wherever he wanted, he went to the Ft. Miley VA Hospital for much of his medical care.

He was a man of enormous integrity and generosity, and with his gentle humor and enduring optimism, he had a gift for bringing out the best in people. His imprint will permanently remain on the College and the many lives he touched.

The College will honor Dr. Russell with the presentation of its Lifetime Achievement Award at the Clinical Congress this month in San Francisco. Any donations in Tom’s memory should be made to The Thacher School in Ojai; the San Francisco Achievers, a public high school mentoring and scholarship program; or the Thomas R. Russell, MD, FACS, Scholarship Fund at the ACS. ◆
Sen. Jack Reed (D-RI) participated in a tour of the trauma division and burn center at Rhode Island Hospital, Providence on August 29, and joined a press conference there with William Cioffi, Jr., MD, FACS, J. Murray Beardsley Professor and chairman, Alpert Medical School of Brown University, Providence, at which they discussed recently enacted trauma legislation and additional trauma bills pending before Congress. Other physicians, first responders, and burn care experts also participated in the tour and media event. Topping the agenda was the Improving Trauma Care Act, P.L. 113-152, which Senator Reed wrote and which the American College of Surgeons (ACS) strongly supported. President Barack Obama signed the law on August 12, 2014.

The Improving Trauma Care Act appropriately reflects the relationship between burns and other traumatic injuries and makes burn centers eligible for participation in federal trauma care programs. "Excluding burn injuries from ‘trauma’ not only obscured the close interrelationship between trauma and burn care, but it also excluded burn centers from participating in federal trauma care and research programs," said Dr. Cioffi, ACS Treasurer and president of the American Association for the Surgery of Trauma. "Mass casualties from the Rhode Island nightclub fire in 2003 demonstrated why we need to strengthen the burn care infrastructure in this country and ensure that burn and trauma care are closely integrated. Now with Senator Reed’s Improving Trauma Care Act, we will be able to create a more efficient and responsive emergency medical care system."

Although this new trauma law is considered a breakthrough for the nation’s trauma and burn community, two important grant programs, the Trauma Care Systems Planning Grants and the Regionalization of Emergency Care Systems Pilot Projects, have not received federal funding since 2005, which threatens emergency care in communities across the country. The first program supports state and rural development of trauma systems and the second funds pilot projects to create innovative models of regionalized emergency care. The law would also direct states to update their model trauma care plan. At press time, Senator Reed was working on legislation to fund these programs.

"Trauma care is not only critical to providing timely access to lifesaving interventions, it is the cornerstone of our health care system—central to both our national security and disaster preparedness," said Senator Reed. "Efforts to reauthorize funding for the Trauma Systems and Regionalization of Emergency Care Reauthorization Act are gaining increased commitment from elected officials. We must get this bill signed into law before the programs lapse at the end of September to strengthen and improve trauma and emergency care in the U.S."

The House of Representatives recently passed H.R. 4080, the Trauma Systems and Regionalization of Emergency Care Reauthorization Act, which would restore funding to these two important programs. Senator Reed is working to get its counterpart, S.2405, passed in the Senate.

Senator Reed’s efforts are strongly supported by the ACS, Dr. Cioffi said. "It is critical that we continue to build and refresh our trauma system and make sure that the patients, given their type of illness or injury, are always sent to appropriate, optimal facilities.”
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In November, Proposition 46 on the California statewide ballot will seek to weaken the state’s landmark Medical Injury Compensation Reform Act (MICRA) by raising the cap on noneconomic damages four-fold to $1.1 million from $250,000. The leadership of the Northern California, Southern California, and San Diego Chapters of the American College of Surgeons (ACS) have joined in a statewide effort to empower surgeons to advocate with their patients, colleagues, and other health care professionals for the preservation of MICRA to ensure patient access to quality care. A parallel intent is to educate members of the California legislature about the need to maintain this type of meaningful medical liability reform. MICRA has been the gold standard for medical liability reform since its enactment, and surgeons in other states with tort reform laws may use this vote as a barometer of what could happen to their own liability legislation. Originally signed into law by Gov. Jerry Brown (D) in 1976, MICRA was enacted as a means of preserving patient access to care and deterring frivolous lawsuits against health care professionals and hospitals. The $250,000 cap on noneconomic damages ensures that legitimate claims move forward and discourages trial lawyers from filing non-meritorious lawsuits. MICRA allows patients to receive unlimited compensation for economic damages for past and future medical costs, past and future lost wages, and punitive damages. Over nearly four decades, MICRA has helped to contain health care costs, improve patient access to care, and stabilize medical liability premiums so that rates are much lower than in other populous states without similar reforms, such as New York and Florida.

Potential effects of Proposition 46
The need to preserve MICRA is essential in California, as millions of new patients have health insurance coverage through Covered California, the state’s health insurance exchange. A report from the Legislative Analyst’s Office (the California legislature’s nonpartisan fiscal and policy advisor) states that if Proposition 46 passes, the costs for California taxpayers will increase by hundreds of millions of dollars annually. A full report is available at http://www.lao.ca.gov/ballot/2014/prop-46-110414.pdf.

The campaign on behalf of Proposition 46 is misleading, as the initiative appears to focus on patient safety and prescription drug abuse, but hidden within is the quadrupling of the MICRA cap. California surgeons have many opportunities from now until the November 4 election to become educated and engaged in the “No on 46” efforts. Examples include the following:

• Visit the official “No on 46” Web page at http://www.noon46.com/ for valuable information on the campaign, as well as materials that may be useful for engagement. While there, consider signing up as a supporter of the campaign.

• Send a letter to the editor of your local newspaper. Editors in small towns and cities are...
MICRA has been the gold standard for medical liability reform since its enactment, and surgeons in other states with tort reform laws may use this vote as a barometer of what could happen to their own liability legislation.

always looking for items to publish. Talking points are available at the “No on 46” Web page, or surgeons may contact Justin Rosen, ACS State Affairs Associate, for assistance at state_affairs@facs.org.

• Where appropriate, use “No on 46” campaign materials in patient waiting rooms. Be sure to find out beforehand what institutional policies may exist restricting or banning such activity.

• Social media can be a useful tool. Post or re-post related items on your Facebook page or Twitter account.

• Take action when requests are sent from the California ACS Chapters.

• Vote “No on 46” on November 4.

The campaign to defeat Proposition 46 is a major undertaking, and tens of millions of dollars will be spent in support of and in opposition to this ballot initiative. The ACS, the California Chapters of the College, and many prominent medical, civic, government, and labor organizations have united to preserve patient access to quality care. California surgeons can play a major role in the campaign by making their voices heard, and their votes counted.

MOC review course offered at Clinical Congress

The American College of Surgeons (ACS) 2014 Clinical Congress will feature a Didactic Course titled Maintenance of Certification (MOC) Review: Essentials for Surgical Specialties, on Monday, October 27, 12:30–4:45 pm, in Moscone West, Room 1010. This course will address fundamentals common across the surgical specialties, such as emergency airway management; deep vein thrombosis prophylaxis; postoperative management, including myocardial infarction recognition; pain management; and patient safety.

Course Chair Robert R. Lorenz, MD, FACS, and Co-Chair Robert Bahnson, MD, FACS, have developed a course that is designed to help prepare participants for recertification examinations and support lifelong learning and practice improvement. Dr. Lorenz is an otolaryngologist and attending surgeon, Cleveland Clinic, OH. Dr. Bahnson is a urological surgeon at the Arthur G. James Cancer Hospital and Solove Research Institute and Ohio State University Medical Center, Columbus, and Chair of the American College of Surgeons Professional Association’s political action committee (ACSPA-SurgeonsPAC).

Sponsored by the ACS Division of Education and approved by the Program Committee, the MOC course will include continuing medical education credit that may be used for self-assessment purposes. The College has arranged a special fee structure for this program, charging nonmembers the same enrollment fee as ACS Fellows. The reduced fee applies to this course only and not to the Clinical Congress registration fee. To register for the course, go to the Clinical Congress 2014 Web page at http://www2.facs.org/clincon2014/index.html.

For details on this course, contact Dr. Lorenz at lorenzr@ccf.org or Dr. Bahnson at Robert.Bahnson@osumc.edu. For more information on the scientific sessions at the ACS 2014 Clinical Congress and to register, go to http://www2.facs.org/clincon2014/scientific/postgraduate.html.
New CME information for 2014
Clinical Congress attendees

Clinical Congress 2014 will feature many opportunities for attendees to earn continuing medical education (CME) and Self-Assessment credits for American Board of Surgery (ABS) Maintenance of Certification (MOC) Part 2. Attendees should be aware of changes in the requirements for fulfilling new MOC Part 2 requirements and of the new processes for claiming CME and Self-Assessment credits. The College will be implementing some changes in how surgeons can claim their educational credits to help make this process smoother and ensure that attendees can meet the new deadline of December 1, 2014.

The ABS recently changed the requirements for Part 2 of its MOC program. Of the 90 CME credits required every three years, 60 credits must be Self-Assessment credits. Self-Assessment activities are required to assess understanding of the material presented in the CME program. A minimum score of 75 percent correct or higher must be achieved, with unlimited attempts. Table 1 on this page indicates the types of sessions that offer CME and Self-Assessment credits.

### Claiming credits
Table 2 outlines how attendees can earn CME and Self-Assessment credits. In order to earn and claim educational credit, physicians must go to www.cme.facs.org. Your name badge with the REG ID number or your ACS ID number will be needed. The individual session evaluations and the posttests required for Self-Assessment credit must be completed online. After completing your last activity at the Clinical Congress, the Global Evaluation must be completed online at www.cme.facs.org.

Session evaluations and the global evaluation may be completed using kiosks.

#### TABLE 1. SESSIONS OFFERING CME, SELF-ASSESSMENT CREDITS

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<thead>
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<th>Session type</th>
<th>Offers CME</th>
<th>Offers Self-Assessment</th>
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<td>Named Lectures</td>
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<td></td>
</tr>
<tr>
<td>Panel Sessions</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Scientific Papers</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Surgical Forum Sessions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Video-Based Education Sessions</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Meet-the-Expert Luncheons</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Poster Presentation of Exceptional Merit</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Postgraduate Didactic Courses</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Postgraduate Skills Courses</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Town Hall Meetings</td>
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#### TABLE 2. PROCESS FOR EARNING AND CLAIMING CME AND SELF-ASSESSMENT CREDIT

<table>
<thead>
<tr>
<th>Process</th>
<th>To claim CME</th>
<th>To earn Self-Assessment</th>
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<tbody>
<tr>
<td>Attend session</td>
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<td>X</td>
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<td>Complete each session evaluation online at <a href="http://www.cme.facs.org">www.cme.facs.org</a>. Use a kiosk in the Moscone Center or access off-site at your convenience</td>
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<td>Once the online Global Evaluation is completed, your certificate will be available online*</td>
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*Except certain Postgraduate Courses.
CME certificates are available online following completion of the session evaluations and the global evaluation.

located throughout the Moscone Center. ACS staff will be available on-site to assist. Completion of a Global Evaluation is required to claim CME Credit and earn Self-Assessment Credit, as well as generate a CME certificate. The Global Evaluation should be completed after you have attended your last activity at the Clinical Congress and must be completed by December 1, 2014.

CME certificates are available online following completion of the session evaluations and the global evaluation. Attendees will be able to go to www.cme.facs.org at their convenience and log in using the REG ID number or ACS ID number on their name badge. Surgeons will be able to print the Clinical Congress 2014 certificate off-site, as well as transcripts of all sessions attended. A number of Postgraduate Courses have additional requirements that need verification following the conclusion of Clinical Congress. Allow up to four to six weeks for notification to claim certificates for these courses. Certificates of Attendance are available online.

For additional information on how to claim CME credit or earn Self-Assessment credit, read the instructions on the CME Claiming site, www.cme.facs.org, call the My CME office after Clinical Congress at 866-918-4799 or 312-202-5430, or e-mail the College at mycme@facs.org. Fellows and Associate Fellows can access their CME Certificates online at www.facs.org after logging in using their ACS Member ID and going to My CME. ♦

Register now for 2014 Outcomes Research Course, December 4–6, in Chicago, IL

The American College of Surgeons (ACS) Outcomes Research Course will take place December 4–6 at ACS headquarters in Chicago, IL. The three-day course, led by Course Chair David R. Flum, MD, MPH, FACS, is designed for clinical and health services researchers with varying degrees of experience in the field. Participants will be able to select modules appropriate to their skill level and interest. Participants new to the field will be able to focus on didactics and skills-based labs in managing, analyzing, and interpreting large datasets. Meanwhile, participants with more established research agendas will be able to present their research to experts for critique and advice. Participants will also be exposed to scientific and practical aspects of ongoing surgical outcomes research of leaders in the field.

Course registration is limited to 70 participants, and preference is given to ACS members. Note that this course is offered only every other year. For additional information, visit the course website at https://www.facs.org/quality-programs, or contact Carla Manosalvas at OutcomesResearchCourse@facs.org. ♦

**COURSE FACULTY**

<table>
<thead>
<tr>
<th>Dr. Flum, Course Chair</th>
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<tr>
<td>Rafael Alfonso-Cristancho, MD, MSc, PhD</td>
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<td>Nancy N. Baxter, MD, FACS</td>
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<td>Karl Y. Bilimoria, MD, MS, FACS</td>
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<td>Jeannette W. Chung, PhD</td>
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<td>Justin B. Dimick, MD, MPH, FACS</td>
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<td>Samuel R. G. Finlayson, MD, MPH, FACS</td>
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<td>Caprice C. Greenberg, MD, MPH, FACS</td>
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<td>Arden M. Morris, MD, FACS</td>
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<td>Gretchen M. Schwarze, MD, FACS</td>
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<td>Dorry L. Segev, MD, FACS</td>
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<td>David R. Urbach, MD, FACS</td>
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AMERICAN COLLEGE OF SURGEONS PROFESSIONAL ASSOCIATION (ACSPA)

As of June 2014, the ACSPA-Surgeons PAC (political action committee) has raised $226,000 in both personal and corporate funding from 650 members of the College and staff, with a $348 average contribution. Of this amount, $206,628 were personal dollars, and $19,335 were corporate dollars.

The ACSPA-Surgeons PAC hosted a reception at the 2014 American College of Surgeons (ACS) Committee on Trauma (COT) Annual Meeting in March 2014; at this meeting, 48 percent of COT members contributed to the PAC. The COT continues to exemplify excellence as a leading force in advocacy and health policy efforts.

The PAC also hosted events at the 2014 Advocacy Summit. The Political Luncheon, held Monday afternoon of the conference, featured Cook Political Report election handicapping expert David Wasserman, who gave attendees an insider’s look at Washington, DC, politics and a preview of the upcoming 2014 elections. Later that evening, the PAC hosted a fundraiser at the International Spy Museum. A retired CIA spy was present to address attendees and participants were able to tour the facility. The event raised $55,000 for the Surgeons PAC.

Held in conjunction with the 2014 Residents as Teachers and Leaders Course in Chicago, IL, a “Pizza and Politics” dinner reception was hosted by the PAC. Brian Gavitt, MD, resident representative to the Surgeons PAC Board of Directors, and staff led a discussion on the importance of surgical advocacy and an update on current political affairs. This event was held to increase resident involvement in the PAC.

Upcoming Surgeons PAC projects include an independent expenditure for a communication “expressly advocating the election or defeat of a clearly identified candidate that is not made in cooperation, consultation, or concert with, or at the request or suggestion of, a candidate, a candidate’s authorized committee, or their agents, or a political party or its agents.”

AMERICAN COLLEGE OF SURGEONS (ACS)

The ACS Strategic Model has been reviewed, noting the priorities for the year. The ACS leadership holds an annual review against the College’s overall priorities in an effort to refocus the planned actions and events of the upcoming year. Overall, 100 projects have been completed. ACS staff will focus on six programmatic areas throughout 2014, including the quality database integration project, the standardization of verification and accreditation programs, and four different project areas in education. Many of these projects are dependent upon evaluation of new technology infrastructure.

Other information technology initiatives included the following:

• The College has updated its Web presence to support access on mobile devices, with the new ACS website consisting of mobile-friendly Web pages. The ACS Communities site and new website went live in August.

• Priorities for the year include:
  – Accreditation management (electronic workflow and financial management)
  – Data quality registries (business intelligence software platform for reporting)
  – Education (learning management system, MyCME/MyUniversity, medical/resident student tracking, CME, and accreditation)

Other recent ACS activities that affect the organization as a whole are as follows:

• The Ernest Amory Codman, MD, FACS, memorial headstone was placed at the Mount Auburn Cemetery, Boston, MA, on July 22.

• The ACS offered support for the Global Health Initiative for
Surgery, which the World Health Organization recently approved.

- A medical director for Operation Giving Back is in the process of being recruited.

- The College has been measuring employee engagement as it relates to the organization’s bottom line. A customized report was given to division directors to review, which was followed by a meeting with employees to create an action plan for division improvement.

**Finance**

The College has committed to funding two new educational programs:

- The Thomas R. Russell, MD, FACS, Faculty Research Fellowship award has been approved at the level of $40,000 for two years ($80,000 in total).

- An ACS/American Society for Surgery of the Hand Career Development Award for a hand surgeon will be offered by the ACS Scholarship Fund. There is a commitment of $200,000 (ACS portion $40,000/year for five years), which will be provided by the ACS Scholarship Fund.

Other ACS Finance initiatives included the following:

- The ACS will give $10,000 to the Institute of Medicine for a military medicine study.

- Approval of a National Institutes of Health (NIH)/ACS Workshop has been given, provided there is a proposal submitted to NIH in support of this effort. College support would be $40,000.

- In addition, the ACS and ACS Foundation budgets were presented for the Regents’ approval, which was granted.

**Division of Advocacy and Health Policy**

Two Fellows have accepted leadership positions in the Division of Advocacy and Health Policy. The new division staff leadership team consists of: Christian Shalgian, Division Director; Frank G. Opelka, MD, FACS, Medical Director for Quality and Health Policy; and Patrick V. Bailey, MD, FACS, Medical Director for Advocacy.

The key advocacy issues for the ACS are Medicare physician payment, medical liability reform, workforce/graduate medical education, quality, trauma, and cancer. The ACS is the only physician group to testify before all three congressional committees with jurisdiction over the Medicare program.

Dr. Opelka spoke about the dramatic shift from spending controls to value-based purchasing. Policymakers and surgeons must redefine an economic model through surgeon reeducation using process reengineering, payment policy, data and quality measurement, and technology.

The national landscape of health policy will be dominated by government focus on key Affordable Care Act principles, which are:

- Coverage
- Insurance reform
- Performance measurement
- Payment reform

The College’s advocacy priorities are as follows:

- Inspiring quality
- Repealing and replacing the sustainable growth rate
- Relative Value Scale Update Committee
- Professional liability, regulatory burdens, and the workforce
- State activity

The ACS is using a collaborative approach to address health policy issues. The College seeks to support all surgical disciplines in the current and emerging economic models and to join multi-stakeholder activities within the U.S. Department of Health and Human Services, the Agency for Healthcare Research and Quality, the Centers for Disease Control and Prevention, and the Centers for Medicare & Medicaid Services to provide...
a College voice for surgical care in every policy forum. Furthermore, the College supports policies that position ACS clinical data sources to extend our programs into preferred payor models suited for economic models emerging from national strategies.

Dr. Bailey will direct much of his energy into rallying the membership to issues of importance through SurgeonsVoice, Action Alerts, state chapters, and other ACS health policy committees, stressing the importance of the SurgeonsPAC. He believes it is particularly important to encourage ACS members to begin the process of establishing relationships with individual legislators, their staff, and agency staff.

Strategies for specific programs are as follows:

• Trauma programs, grants and pilot projects
  – Advocate for reauthorization and funding
  – 2014 expirations: two programs totaling $24 million/year
  – 2015 expirations: two programs totaling $200 million/year
  – Engage the COT SurgeonsVoice, and state chapters

• Enlist bipartisan champions in the House and Senate

• The Critical Access Hospital (CAH) Relief Act—96-Hour Rule
  – The 96-Hour Rule will remove restrictions as a condition of payment on individual physicians, but it will remain a condition of participating for annual average length of stay for CAHs.

Furthermore, a Postgraduate Course on advocacy is in the concept stage and will be held at a future Clinical Congress.

**Division of Education**

The overarching mission of the Division of Education is to promote excellence and expertise in surgery through innovative education, training, verification, validation, and accreditation. Through the Division of Education, the ACS seeks to serve as the premier national and international surgical education resource through the design, implementation, and evaluation of leading-edge programs and establishing new benchmarks. Professional development is evolving to emphasize mastery and expertise, with an increasing focus on specific needs of individual learners. This evolution will be addressed through a variety of strategies, including high-fidelity experiences, robust assessments, and comprehensive faculty development and support.

The following are important emergent areas of focus for the Division of Education:

• Leadership in transforming residency training in surgery

• Leadership in addressing recognition and mitigation of impact of fatigue

• Leadership in advancing simulation-based surgical education and training

• Special focus on early career transitions

Examples of initiatives in this area are as follows:

• Special courses on new procedures and technologies will be offered both regionally and at the Clinical Congress.

• The Committee to Enhance Peak Performance in Surgery through Recognition and Mitigation of the Impact of Fatigue has developed a Statement on Peak Performance and Management of Fatigue (subsequently published in the August Bulletin).

• The Board approved the Patient Education Committee’s Statement on the Effects of Tobacco Use on Surgical Complications and the Utility of Smoking Cessation Counseling (also published in the August Bulletin).
Upon a request from the Committee on Perioperative Care, the B/R approved removal of the following position statements:

- Statement on the Use of Cell Phones in the Operating Room
- Statement on Blunt Suture Needles

The following statement should be updated:

- Statement on Surgical Technology Training and Certification

The Division of Education continues to focus on quality when developing and delivering their educational programs.

Division of Member Services

The Division of Member Services is responsible for credentialing of Fellows, the Archives, the Advisory Councils, the Board of Governors, Chapter Services, and other ACS activities. Some of the division’s recent activities follow:

- The ACS has recently hired a new archivist, Adam Carey, MA, MLIS, ABD, who is spearheading the ACS Surgical History Group’s activities.

- The formation of the Bolivia Chapter was approved by the Board of Regents in its June meeting. It will be the College’s 39th International Chapter, bringing the total number of Chapters to 105: 66 domestic (including two Canadian Chapters) and 39 international.

The Board of Regents (B/R) accepted resignations from 12 Fellows. Beginning with the June 2014 list of resignations, the Fellows were sent a special letter from the First and Second Vice-Presidents. This letter included the new membership benefits brochure and invites the Fellow to contact the Vice-Presidents if they wish to discuss any questions, concerns, or reasons for the resignation.

The B/R approved a change in status from “Active” to “Retired” for 97 Fellows as outlined in the report. The 97 Fellows of the College who indicated their desire to retire were provided with the requirements for retired status.

Division of Research and Optimal Patient Care

The Division of Research and Optimal Patient Care has purview over all the ACS Quality Programs. Following are updates on those programs:

- A total of 542 hospitals are now participating in the ACS National Surgical Quality Improvement Program (ACS NSQIP®), 487 of which are enrolled in Adult NSQIP.

- The Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program now has 743 accredited participating centers—a significant market share of all U.S.-based bariatric centers.

- The ACS has continued development of the Surgeon Specific Registry (SSR), formerly known as the ACS Case Log. Approximately 5,000 surgeons who have submitted at least 20 cases and more than 5 million records are listed in the registry.

- The ACS released a request for proposals to several information technology/business intelligence vendors to evaluate which services are available to streamline and to standardize current processes across DROPC programs and ACS registries.

- The Outcomes Research Course, sponsored by the Surgical Research Committee, will be chaired by David R. Flum, MD, MPH, FACS, on December 4–6, in Chicago, IL (see more complete program information on page 63). The course will be taught by 14 faculty members who are leaders in the field of outcomes research.

- Upon the recommendation of the Executive Committee and the Injury Prevention Committee of the COT, the following three injury prevention statements were approved:

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and subsequently published in the September Bulletin:

- Statement on Intimate Partner Violence
- Statement on Bicycle Safety and the Promotion of Bicycle Helmet Use
- Statement on Older Adult Falls and Falls Prevention

**Journal of the American College of Surgeons**

The *Journal of the ACS (JACS)* remains a valuable resource for surgeons and continues to expand. The journal currently has 13 deputy editors, 11 senior editors, 69 editors, and seven international correspondents. *JACS* is adding a CME Editor and an Associate Statistician in the near future. More ad hoc reviewers are being sought than ever before, and in 2013, 846 surgeons evaluated manuscripts; there was also an increase in original scientific articles submitted over the past five years.

The journal is scholarly and peer-reviewed and many of the articles require a statistical analysis. It is the official journal for the Southern Surgical Association, the Western Surgical Association, and the New England Surgical Society.

Developments at *JACS* include the following:

- Social media efforts have continued to increase with the recent addition of a full-time social media editor.
- In 2013, surgeons were granted 82,771 credits through *JACS*; 3,579 different surgeons, claimed those credits, averaging 23.1 credits per person.
- The journal will be enhanced with the new ACS website and will display equally well on mobile devices.
- The *JACS* resource center, an online educational website, is expected to launch soon. It will contain article collections, videos and discussions.
- *JACS* distributes a Chinese edition, which has its own editorial board, to 30,000 surgeons.

**Ethics**

The Committee on Ethics proposed several new initiatives. The following ideas received the most support from the B/R:

- Author a book that will serve to define the framework of the new field of surgery ethics as it has evolved during the past 10 years
- Develop a variety of educational offerings in surgery ethics, including activities for those committed to advanced study, as well as for those seeking a working knowledge of the application of fundamental principles in surgical practice
- Expand the membership of the Committee on Ethics to allow better integration of ethics throughout the organization

**American College of Surgeons Foundation**

The current goal of the 1913 Legacy Campaign is to raise $5 million. Phone calls and e-mails are being made to campaign responders who have received personal solicitation letters.

The ACS Foundation Board of Directors unanimously voted to present the 2014 Distinguished Philanthropist Award to Dr. and Mrs. W. Gerald Austen, Boston, MA. The Award will be presented at the Foundation luncheon on October 27, 2014, in San Francisco, CA.
Austria-Hungary Chapter holds assembly at 55th Congress of the Austrian Society of Surgery

The annual assembly of the Austria-Hungary American College of Surgeons (ACS) Chapter took place at the 55th Congress of the Austrian Society of Surgery on June 27 at the Messe Congress in Graz, Austria. Hosting the event was Albert Tuchmann, MD, FACS, ACS Governor for Austria-Hungary, and Prof. Freyja Smolle-Jüttner, MD, President of the Austrian Society of Surgery. At the meeting, Prof. Fritz Stellwag-Carion, MD, FACS, President of the Austria-Hungary Chapter, delivered a lecture titled A Journey of a Group of American Surgeons through Germany and Austria in the Early 20th Century. Since its inception in 2009, the Austria-Hungary Chapter has added a total of 40 Fellows and Resident Members: 32 from Austria and eight from Hungary.

Tennessee Chapter meeting includes grassroots advocacy training for council

More than 100 Tennessee surgeons, residents, medical students, and affiliate chapter members gathered at Paris Landing State Park, Buchanan, TN, on the shores of Kentucky Lake for the 2014 Tennessee Chapter of the ACS (TNACS) annual meeting. This year’s special guests included ACS President Carlos Pellegrini, MD, FACS, FRCSI(Hon); Mrs. Kelly Pellegrini; David McAneny, MD, FACS, from the Massachusetts Chapter; and Donna Tieberg, ACS Chapter Services Manager. During his keynote address, Dr. Pellegrini offered a moving memorial tribute to Thomas R. Russell, MD, FACS, former Executive Director of ACS, and presented an update of College activities and programs. Dr. Pellegrini also spoke on the treatment of esophageal cancer and other complex diseases. Dr. McAneny, a Board of Governors liaison to the ACS Health Policy Advisory Council and a member of the Governors’ Health Policy and Advocacy Workgroup, led the TNACS Executive Council members through a planning process to incorporate ACS SurgeonsVoice, the College’s grassroots advocacy program at the chapter level.

The Tennessee Surgical Quality Collaborative held its quarterly meeting in conjunction with the TNACS Chapter meeting. Five surgeon champions described how the collaborative has contributed to the quality improvement activities at their hospital facilities.

The Tennessee Committee on Trauma and Cancer also met in conjunction with the chapter, bringing together surgeons and other health care professionals involved in both areas of treatment. Four resident paper competitions took place during the Tennessee annual meeting. First place in the Trauma Paper Competition was awarded to Leah Hendrick, MD, of the University of Tennessee Health Science Center (UTHSC), Memphis, and second place went to Rodrigo Interiano, MD, also of UTHSC. The first-place winner in the Cancer Paper Competition was Elena Paulus, MD, of UTHSC, and second place went to Dr. Interiano. The Basic Science Paper Competition first-place winner was Nathan Hinkle, MD, of UTHSC, and second-place winner was Lindsay Bools, MD, University of Tennessee Knoxville. For the Clinical Science Paper Competition, placing first was Brent Soder, MD, of the University of Tennessee College of Medicine Chattanooga. Second place went to Catherine Kling, MD, of Vanderbilt University Medical Center, Nashville. A venue will be announced for the 2015 OCT 2014 BULLETIN American College of Surgeons

by Donna Tieberg
TNACS Annual Meeting, which will take place in Knoxville in mid-summer 2015.

New Jersey Chapter travels to Italy for annual pilgrimage
The New Jersey Chapter of the ACS traveled to Sicily, Italy, for its annual pilgrimage. A highlight of the trip was an Educational Symposium, jointly sponsored by the New Jersey and Italy Chapters on May 12 at the University of Catania School of Medicine. Michael J. Spedick, MD, FACS, President-Elect of the New Jersey Chapter, worked closely with officers of the Italy Chapter to organize this year’s New Jersey Chapter pilgrimage.

Combined South Carolina/North Carolina Chapter meeting includes new scholarship program
The South Carolina and North Carolina Chapters of the ACS hosted a combined annual chapter meeting, July 18–20, at the Marriott Resort and Spa Grande Dunes in Myrtle Beach, SC. The meeting took place in conjunction with the South Carolina Vascular Society and Bariatric Society of the Carolinas. A guest speaker at the meeting was Patricia Numann, MD, FACS, Past-President of the ACS and a member of the Board of Directors of the ACS Foundation, who gave two presentations: What’s Happening in Surgery at the National Level? and Global Burden of Surgical Disease. Joseph Cofer, MD, FACS, Past-President of the Tennessee Chapter of the ACS, also delivered two presentations: ABS [American Board of Surgery]—Changing Case Requirements for Eligibility, and American Board of Surgery—Maintenance of Certification. Vice-Chair of the Resident and Associate Society of the ACS, Joseph Sakran, MD, MPH, assistant professor of surgery at the Medical University of South Carolina, spoke on The Resident Quality Curriculum—The Quality in-Training Initiative (QITI): The Next Generation.

New at the combined chapter meeting this year was the inclusion of both scholarship and
There were eight resident oral presentations at the South Carolina/North Carolina Chapter meeting. The winners were: first place, Samuel W. Ross, MD, MPH, Carolinas Medical Center, Charlotte, NC; and second place, Bindhu Oommen, MD, MPH, Carolinas Medical Center. There was a tie for third place with one award shared by Travis Benzing, MS, Ralph H. Johnson Department of Veterans Affairs Medical Center and Medical University of South Carolina, Charleston, and Swapnil Kachare, MD, East Carolina University Brody School of Medicine, Greenville, NC. The first-place resident presentation award winner received $1,000, the second-place winner received $600, and the third-place winners split $400. Plans are already under way for next year’s combined South Carolina/North Carolina Chapter annual meeting, July 17–19, 2015, at the Grove Park Inn Resort and Spa, Asheville, NC.

Georgia Society of the ACS holds diverse meeting on St. Simons Island

More than 70 Fellows, residents, medical students, and other attendees enjoyed the robust programming and social activities at the annual meeting of the Georgia Society of the American College of Surgeons (GSACS), which convened August 21–24 at the historic King and Prince Resort, St. Simons Island, GA. A total of 21 exhibitors also participated in the meeting.

Keynote speaker Patricia L. Turner, MD, FACS, Director, ACS Division of Member Services, opened the meeting with a state of the American College of Surgeons address and returned later in the conference to give a presentation and answer audience questions on Surgeons as Leaders. A second keynote speaker, John Hedstrom, JD, Deputy Director, ACS Division of Advocacy and Health Policy, provided an update on legislative activities, including the sustainable growth

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★ To see how your involvement can make a difference.

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Apply now for 2016 ANZ, Germany, Japan traveling fellowships

The International Relations Committee of the American College of Surgeons (ACS) has announced the availability of one traveling fellowship to each of the following countries in 2016: Australia and New Zealand (ANZ), Germany, and Japan. Applications for these awards are due November 15, 2014. Applicants may apply for more than one scholarship, but must supply separate essays for each location.

Purpose
The traveling fellowships are intended to encourage an international exchange of information concerning surgical science, practice, and education and to establish professional and academic collaborations and friendships.

These are exchange fellowships; for example, a U.S. or Canadian ACS Traveling Fellow will visit Japan for the annual meeting of the Japan Surgical Society, and a Traveling Fellow from Japan will visit the U.S. for the Clinical Congress.

Basic requirements
The traveling fellowships are available to Fellows of the ACS in most surgical specialties who meet the following requirements:

• Have a major interest and accomplishment in basic sciences related to surgery

• Hold a current full-time academic appointment in Canada or the U.S.

• Are under 45 years of age on the date their application is filed

• Are enthusiastic, personable, and possess good communication skills

Activities
The traveling fellows are required to spend a minimum of two to three weeks in the countries they visit. While in the country they are visiting, they are expected to engage in the following activities:

• Attend and participate in the annual scientific meeting of the host country:
  – Royal Australasian College of Surgeons, Brisbane, Australia (May 3–6, 2016)
  – Germany Society of Surgery, Berlin (April 26–29, 2016)
  – Japan Surgical Society, Osaka (April 14–16, 2016)

• Participate in the formal convocation ceremony of that annual meeting

• Attend and address the local ACS chapter meeting during that annual meeting

• Visit at least two medical centers in the country before or after the annual meeting to lecture and share clinical and scientific expertise with the local surgeons

The academic and geographic aspects of the itinerary will be finalized in consultation and mutual agreement between the Fellow and the President or designated representative of the local chapter of the ACS. The surgical centers to be visited depend to some extent on the special interests and expertise of Fellows and their previously established professional contacts with surgeons in their selected country.

Spouses are welcome to accompany successful applicants. There will be many opportunities for social interaction in addition to these professional activities.

Financial support
The College will provide a dollar amount yet to be determined at press time, which will cover the scholars’ expenses. The awardees must meet all travel, living, and registration expenses. Senior chapter representatives will consult with the Fellows about the centers to be visited, the local arrangements for each center, and other advice and recommendations about travel schedules. The Fellows are advised to make their own travel arrangements in North America to take advantage of reduced fares and travel packages for travel overseas.
The traveling fellows are required to spend a minimum of two to three weeks in the countries they visit.

The ACS International Relations Committee will select the three Traveling Fellows after review and evaluation of applications. Personal interviews may be requested prior to the final selection.

The closing date for receipt of completed applications for all three destinations is November 15, 2014. The successful applicants and alternates will be selected and notified by March 2015.

Send applications for this scholarship in the form of a single PDF to kearly@facs.org or via post to: International Liaison Section, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211.

2014 Claude H. Organ, Jr., MD, FACS, Traveling Fellow announced

Catherine J. Hunter, MD, a pediatric general surgeon from Chicago, IL, was recently selected to receive the Year 2014 Claude H. Organ, Jr., MD, FACS, Traveling Fellowship of the American College of Surgeons (ACS). Dr. Hunter, a 2014 ACS Initiate, is an attending surgeon and assistant professor of surgery, division of pediatric surgery, Ann & Robert H. Lurie Children’s Hospital, Chicago.

She plans to use her award to travel to key surgical conferences, including the ACS Clinical Congress 2014, the 2014 Association for Academic Surgery’s Fundamentals of Surgical Research and Career Development courses, the Academic Surgical Congress in 2015, and the 2015 meeting of the Federation of American Societies for Experimental Biology. One of her goals is to learn how women surgeons can become able mentors, and she anticipates getting critical feedback from experts in the field to help foster her mentoring skills. She also intends to hone her skills at building a research team, develop collaborative relationships with individuals outside of her institutions, and improve her grant-writing skills.

The Claude H. Organ, Jr., MD, FACS, Traveling Fellowship was established in memory of Dr. Organ, a Past-President of the College. The $5,000 award makes it possible for an outstanding young surgeon to attend an educational meeting or make an extended visit to an institution of his or her choice, tailored to his or her research interests.

The Organ Traveling Fellowship benefits young surgeons who are members of the Society of Black Academic Surgeons, Association of Women Surgeons, or Surgical Section of the National Medical Association. It is awarded annually.

The requirements for this award are posted at http://www.facs.org/memberservices/organ.html. Information regarding the 2015 Claude Organ Traveling Fellowship will be published soon.
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It was an honor to be awarded the 2013 Claude H. Organ, Jr., MD, FACS, Memorial Traveling Fellowship. Over the years, my interests in academic surgery have widened to focus on leadership and global health care. This award allowed me to marry both interests in a capstone experience that I will always remember.

For the last two years, I have been enrolled in the MBA for Executives: Leadership in Healthcare program at Yale University School of Management (SOM), New Haven, CT, and I was able to apply the Claude Organ Traveling Fellowship toward a two-week (April 12–27, 2014) visit to India to explore various aspects of the health care system there. Other students and alumni from the SOM program and I visited Mumbai, New Delhi, Hyderabad, and Bangalore and visited hospitals, pharmaceutical companies, research organizations, not-for-profits, professional societies, and ayurvedic facilities; we even met with the Ministry of Health. It was truly a spectacular opportunity.

Along the way, I realized a few key truths:
India may have a lot to learn from America, but we have a lot we can glean from India. Because health care spending is limited to just 1 percent of the national gross domestic product, India has had to innovate to find efficient ways to provide care to a large population.

- **Diversity exists everywhere.** India is a country of tremendous contrasts—where the extremes of wealth and poverty coexist. We may think of countries as homogeneous populations, but in fact, there is tremendous diversity—in language, culture, religions, and socioeconomic status.

- **Necessity is the mother of invention, and innovation can breed efficiency.** India may have a lot to learn from America, but we have a lot we can glean from India. Because health care spending is limited to just 1 percent of the national gross domestic product (GDP), India has had to innovate to find efficient ways to provide care to a large population. “Do more with less” seemed to be a prevailing principle there, and it was amazing to see how much could be done with their limited resources.

- **Be contrarian and persistent.** So many of the success stories we heard in India were those of people who had a contrarian view—an idea that was not mainstream, and yet, with persistence, they were able to capitalize on this ingenuity.

- **Focus on your core strengths.** Many Indian facilities—whether pharmaceutical, research, biotech, or patient care—have been streamlined to focus on their key strengths. Success then becomes less about competition, and more about cooperation, as synergies exist between firms and industries.

- **Purpose above all.** I was struck by the focus on “a higher purpose”—a sense of doing well by doing good—remembering that patients come first, and how this dictates business practices.

In an effort to share my experiences with @AmCollSurgeons followers, I tweeted my way throughout our trip. This article contains some of the highlights of my time in India.

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**Pharmaceuticals, other manufacturers**

We started our tour at Cipla Global Limited’s headquarters in Mumbai, one of the largest generic drug manufacturers in India—a key health care resource in the country, as they provide access to low-cost medications to many patients. While in Mumbai, we also met with the leadership of Johnson & Johnson India, which manufactures everything from devices to pharma to consumer products. We learned that while the return on capital is great in India, there is still much to be done from a corporate social responsibility and public policy perspective to address poverty and health inequities in the nation.

In addition, we visited Dr. Reddy’s Laboratories Limited, another generics manufacturer, focused more on international export of generic drugs and based in Hyderabad. At Hetero Drugs Limited, also in Hyderabad, we saw the lab and manufacturing facilities, as well as their headquarters. It was interesting to see how manufacturing processes for generics are streamlined, and new compounds made with intense scrutiny for quality assurance. Partnerships and alliances between pharmaceutical firms are critical to ensuring a strong industry.

**Foundations**

We heard about “big, best, and bold strategies” to address global health care issues based on fundamental human values at the Wockhardt Foundation in Mumbai. This Foundation works on grassroots projects to improve quality of life and sponsors a number of initiatives aimed at improving access to clean water, enhancing education, and delivering primary care services to patients. The outcomes of relatively simple interventions that address these issues were striking. We also visited the Jana Foundation in Bangalore and saw...
how microfinance programs can make a difference in terms of socioeconomic status, particularly for women.

**Hospitals**

Raj Badwe, MD, a breast cancer surgeon, leads Tata Memorial Hospital in Mumbai—the leading cancer hospital in the country. We saw huge demand for cancer services, but also were impressed by some of the efficiencies built into their system, from barcoding pharmaceutical prescriptions, to their homegrown electronic health records, to the amazing productivity of their pathology department. While in Mumbai, we had dinner with the representatives of the Indian Cancer Society, the Indian Cancer Oncology Network and V-Care Welfare Association, and learned about their system of cooperative group trials.

Public-private partnerships also increase access to care, as patients with a diagnosis of cancer are given free rail passes to get to hospitals for treatment. Family plays a critical role in decision making. Most health care expenses in India are paid out-of-pocket, and few people, other than some government employees, have health insurance coverage.

At Tata, we saw what a largely public hospital was like, and while
we appreciated that it was in a better position than most, given that it is funded under the Department of Atomic Energy rather than the Department of Health, it was still a far cry from the more corporate-appearing hospitals, like Kokilaben Dhirubhai Ambani Hospital and Medical Research Institute, which we also visited while in Mumbai.

In Hyderabad, we toured Yashoda Hospital, where we found talent that had trained in North America and the U.K. before coming back to India to provide care. Finally, we visited Narayana Hospital in Bangalore, where we met with Devi Shetty, MD, a world-renowned cardiac surgeon who has been called the “Henry Ford of Surgery” because of his innovative approach to doing more with less.

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### Ministry of Health and Family Welfare

We visited the capital city of New Delhi, where we met with leaders of India’s Ministry of Health and Family Welfare. They have ambitious goals—to increase access to primary health care to all citizens of India—but are functioning on a limited budget of approximately 1 percent GDP.

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### Ayurveda

While in New Delhi, we branched out of “Western” medicine, and visited an ayurvedic facility that has both inpatient and outpatient facilities. Although this holistic approach to patient care may be particularly useful for improving quality of life, it was clear that objective research was needed to quantify its impact.

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### Contract research organizations

As one of the fastest-growing biotech contract research organizations, we were impressed by the facilities at Sai Life in Hyderabad. This firm, like many in India, is focused on its core competency (biotechnology), rather than manufacturing, and has done well in this regard.

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### Outsourcing radiology

We visited Telerad Solutions in Bangalore, a company founded by two Yale physicians that now reads radiology images from all over the world and houses a local outpatient clinic, as well. Throughout the trip, we gained a broader understanding of health care needs and opportunities in India, as well as how we can learn from the efficiencies there to improve our own systems at home.

We built collaborations and friendships that will continue into the future. It was a remarkable journey, and I am thankful to the American College of Surgeons and the family of Dr. Organ for the privilege of the award that made this trip possible.

As a final note, a few weeks after my return from India, I was told that I would receive yet another honor—to be class marshal at our Yale commencement—a privilege given to the student who received a grade of “Distinction” in the most classes. My two weeks in India, along with my two years in the MBA program at Yale, have had an indelible impact on me. Both were amazing, transformative experiences, and for them, I will be eternally grateful.

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OCT 2014 BULLETIN American College of Surgeons
Calendar of events

OCTOBER

Italy Chapter
October 12–15
Rome, Italy
Contact: Giuseppe Nigri, giuseppe.nigri@uniroma1.it, www.facsitaly.com

ACS Clinical Congress
October 26–30
San Francisco, CA
www.facs.org

NOVEMBER

Argentina Chapter
November 3–6
Buenos Aires, Argentina
Contact: Congress Secretary, congreso@aac.org.ar, http://www.facs.org.ar/

Southwestern Pennsylvania Chapter
November 3
Pittsburgh, PA
Contact: Dianne Meister, dmeister@acms.org, www.acms.org/spec/ACS/index.html

Jacksonville Chapter
November 6
Jacksonville, FL
Contact: Patti Chapman, rotaryexecsec@aol.com

Connecticut Chapter
November 7
Farmingham, CT
Contact: Christopher Tasik, info@ctacs.org, www.ctacs.org

Keystone Chapter
November 7
Hershey, PA
Contact: Debbie Faesel, dfaesel@pamedsoc.org, http://www.keystonesurgeons.org/

San Diego Chapter
November 11
San Diego, CA
Contact: Jim Cox, surgeons@sdcacs.org, http://www.sdcacs.org/

Wisconsin Surgical Society
November 14–15
Kohler, WI
Contact: Terry Estness, wisurgical@att.net, http://www.wisurgicalsociety.com/

Arizona Chapter
November 15–16
Tucson, AZ
Contact: Joni Bowers, jonib@azmed.org, www.azacs.org

Colorado Chapter
November 17
Denver, CO
Contact: Carol Goddard, carol@goddardassociates.com, coloradoacs.org

South Korea Chapter
November 27–29
Seoul, South Korea
Contact: Sun-Whe Kim, sunkim@snu.ac.kr

DECEMBER

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

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

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

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

FUTURE CLINICAL CONGRESSES

2014
October 26–30
San Francisco, CA

2015
October 4–8
Chicago, IL

2016
October 16–20
Washington, DC

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