A new era begins for ACS online properties
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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.

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ew surgeons in the early 20th century could have predicted that outcomes measurement, public reporting, and patient-centered care would be hallmarks of the 21st century U.S. health care delivery system. One surgeon, however, did have this prescient vision: Ernest Amory Codman, MD, FACS, who first promoted these practices in his “end result idea.” Though much reviled at the time, this concept—which called for monitoring patient outcomes after discharge to determine which treatments worked and which didn’t and then sharing this information to improve patient care—now guides the quality improvement programs that the American College of Surgeons (ACS), other organizations, and government agencies have implemented.

To recognize the valiant contributions that Dr. Codman has made to American surgery and to patient care, the ACS and other groups that have benefited from his wisdom agreed to place a headstone at his previously unmarked interment site in Mount Auburn Cemetery, Cambridge, MA. Leaders of these organizations gathered at a dedication ceremony on July 22 to pay homage to the maverick surgeon from Boston.

Efforts to have a headstone placed at Dr. Codman’s gravesite were initiated soon after publication of a Bulletin article by ACS Past-President LaMar S. McGinnis, Jr., MD, FACS. In that article, Dr. McGinnis noted that when Dr. Codman died in 1940 of melanoma, he had limited financial means and asked his wife not to have a marker placed on her family’s burial lot, where his ashes were to be stored. Dr. McGinnis added, “I believe that The Joint Commission, the American Cancer Society, the American College of Surgeons, and the American Academy of Orthopaedic Surgeons should erect a headstone at the gravesite to properly acknowledge this visionary and our debt to him.”*

All of these organizations, as well as the West Virginia Chapter of the ACS; Massachusetts General Hospital (MGH), where Dr. Codman practiced for much of his career; the American Shoulder and Elbow Society; and the American Orthopaedic Association, contributed to the cause financially and/or sent representatives to the memorial service. (For a list of donors, go to http://www.facs.org/news/2014/codmanmemorialdonors.html.)

Celebration of an extraordinary life

At the dedication ceremony, Dr. McGinnis and other champions of Dr. Codman’s work described his life and enumerated “the improper Bostonian’s” legendary contributions to surgery and medicine. Other speakers included Andrew L. Warshaw, MD, FACS, ACS President-Elect, and, like Dr. Codman, a “Preparation H” surgeon, meaning he studied, trained, and taught at Harvard Medical School; William J. (Bill) Mallon, MD, FACS, author of the definitive biography on Dr. Codman; E. Philip S. Polack, MD, FACS, who led the charge in West Virginia to raise money for a headstone; Erin S. DuPree, MD, chief medical officer and vice-president of The Joint Commission Center for Transforming Healthcare; and Boston pediatric surgeon W. Hardy Hendren III, MD, FACS, former Second Vice-President of the ACS (see Order of Service, page 10).

The other speakers and I described Dr. Codman’s influential career. We spoke of the “ether chart” that he and Harvey Cushing, MD, FACS, devised to document and demonstrate the safety of surgical anesthesia and of his role in presenting the first morbidity and mortality conference at MGH.

We acknowledged his pioneering work in diagnostic radiology, the multiple articles he wrote on the management of surgical complications of duodenal ulcer, and his contributions to the treatment of shoulder and wrist conditions.

We noted that the College and its affiliates owe a major debt to Dr. Codman for establishing the College’s first database—the Registry for Bone Sarcoma—and for his role in developing the ACS “Minimum Standards for Hospitals.”

Most of all, however, we thanked Dr. Codman for fighting to overcome the suboptimal conditions at many hospitals of the time, for fearlessly seeking solutions, and for being a crusader for the end result idea. We expressed our gratitude for his willingness to stand up for what he knew was right, even when the Boston medical establishment shunned him for his renegade ways. When the MGH establishment refused to embrace his recommendation that faculty earn promotions based on their outcomes rather than seniority, Dr. Codman started his own 12-bed
hospital, which focused on implementation of the end result concept. He closed the faltering facility to tend to the needs of individuals who survived but were severely injured in the “Halifax explosion,” which occurred in December 1917 when a French cargo ship carrying wartime explosives collided with a Norwegian vessel off the coast of Nova Scotia. He then went on to contribute his expertise to caring for the troops fighting in World War I.

We spoke of his rebellious—some would say abrasive—streak, perhaps most apparent when, at a 1915 meeting of the Suffolk District Surgical Society, he unveiled the infamous cartoon of an ostrich with its head buried in the sand kicking golden eggs to Back Bay physicians. In his remarks, Dr. Hendren noted that for many years the only known copy of that illustration was smudged and difficult to read when reproduced. I am delighted to report that Dr. Hendren has procured a clean copy and presented it to the ACS at the dedication ceremony. (For a video of the dedication ceremony, go to http://vimeopro.com/user14801517/codman-memorial.)

In addition, two of Dr. Codman’s great-nieces attended the service. They recalled their visits with an uncle who was caring and gentle, enjoyed fishing and hunting, and loved his dog, who apparently suffered from a case of chronic canine halitosis.
Classic design for a timeless figure
The headstone we dedicated that sunny day in Cambridge pays fitting respect to this brilliant, enigmatic man. We selected classical sculptor, Daniel Altshuler of Gloucester, MA, to create the Codman memorial headstone based on his past experience in crafting similar works of art, including portrait heads of Nobel Prize Laureates Francis Harry Compton Crick and James Dewey Watson.

Dr. Warshaw and I selected some photos of Dr. Codman that Mr. Altshuler used to develop the bas-relief portrait on the headstone. Creating the headstone involved a painstaking process. He initially developed a drawing that he used to develop a clay model and finally the bronze cast of Dr. Codman with a caduceus on each side. Mr. Altshuler said that in crafting the portrait he sought to “capture this man’s seriousness and gentleness.” As the photo on page 9 reveals, he succeeded.

The bronze figure is set in the Quincy Granite used in most headstones at the historic cemetery. Complicating matters, the quarry that provided this stone in the past closed years ago. As a result, the artist worked closely with the cemetery to locate repurposed granite. In total, it took more than a year to complete the memorial headstone, but we were determined that this lasting tribute would reflect the exacting standards that Dr. Codman would have demanded.

It truly was an honor to participate in this long-overdue celebration of Dr. Codman’s life and enduring contributions to surgical patient care. But our salute to Dr. Codman cannot end with a memorial service. We must channel his spirit every day in our never-ending efforts to set the highest standards and to achieve better patient outcomes.

If you have comments or suggestions about this or other issues, please send them to Dr. Hoyt at lookingforward@facs.org.
A new era begins for ACS online properties

by Jerry Schwartz, Jim Losby, and Sally Garneski
ACS Communities’ private forums are protected by multiple security levels that give members the ability to discuss the issues that matter most to them without jeopardizing patient confidentiality.

This summer, the American College of Surgeons (ACS) retired our members-only Web portal, efacs.org, migrating some features to our new public website for members-only viewers and replacing it with a state-of-the-art online community platform that enables College members to easily and effectively connect with one another on topics of shared interest. A few days later, we launched our new public website, facs.org, designed for easy access from desktops, tablets, and smartphones (see Figure 1, this page). An 18-month period of discovery, evaluation, and content redevelopment preceded the launch of these new sites—both designed with the member experience as a top priority.

Become part of ACS Communities

ACS Communities, which can be accessed directly through the facs.org home page or by typing acscommunities.facs.org, now serves as the College’s members-only, online community. This networking tool provides an environment in which ACS members can not only connect, engage, and share critical information and best practices in real time, but also ask for advice, share experiences, exchange photos and videos, and build professional relationships. ACS Communities’ private forums are protected by multiple security levels that give members the ability to discuss the issues that matter most to them without jeopardizing patient confidentiality.

ACS Governor Tyler Hughes, MD, FACS, serves as the Medical Editor of the ACS Communities and has spent countless hours working with staff and member beta test users to make ACS Communities an outstanding place for you to connect with your colleagues.

Update your profile, join communities

It’s easy to log in and get started using ACS Communities. Unless you have specified otherwise in the College’s records, the default username is your
FIGURE 2. PHYSICIAN PROFILE IN ACS COMMUNITIES

Tyler G. Hughes, MD FACS

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FAX: +1 (620) 241-7786
tylerh@mcphersonhospital.org

Your Member ID is [REDACTED] (This information is only visible to you.)

Bio

Specialty
General Surgery

Areas of Clinical Concentration
Abdomen and Digestion Disorder/Procedure, Breast Disease/Cancer, Critical Care, Hemia Procedures, Liver, Gallbladder, Pancreas Disease/Proc, Minimal Access Surgery.

Education & Training
St Paul Medical Center
Resident
General Surgery
1978 To 1983
University of Texas Southwestern Medical Center at Dallas.

FIGURE 3. NAVIGATION BAR
eight-digit member ID, and the default password is your last name.

Profiles in ACS Communities facilitate collaboration among members by making it easy to find colleagues with similar interests and backgrounds. ACS staff used information from the member database to complete your new profile, including your name, organization, professional designations, areas of special interest, and so on (see Figure 2, page 14). Members are encouraged to fill in any gaps to take full advantage of ACS Communities’ offerings. For example, remember to upload a picture of yourself, if one is not currently in the ACS system. Digital ribbons underneath profile photos show level of involvement with the College, as well as with ACS Communities. Immediately under the ribbons is a listing of the communities to which you belong. You may join other communities that interest you by simply clicking “Join,” except for those that are closed to specific member groups, such as the Board of Governors. Use the “Communities” menu item to see all of the possible communities available for you to join. The initial communities created on the site include Board of Governors (closed), Resident and Associate Society (RAS-ACS), General Surgery, Colon and Rectal Surgery, and Rural Surgery. More communities will be added in the coming months.

Search for colleagues

Use the “Directory” link in the top navigation bar to find other members of the College. If you know someone’s name, company, or e-mail address, you can use the basic search to locate that individual. To search for people by location, areas of clinical concentration, education and training, and specialty, use the advanced search function. Once you’ve found the person(s) who you’re looking for, you can view profiles, send a message, or add as a contact.

Not only is ACS Communities accessible via desktop, tablet, or mobile device, but new features will be added in the coming months to make ACS Communities even more collaborative. The ACS is pleased to make this new tool available to members, so that users can share their knowledge with other members, and we hope that all ACS members will take advantage of this opportunity to become better surgeons. (A helpful “frequently asked questions” section, or FAQ, may be accessed from the top of any page in the event you need assistance.)

Using the new facs.org

Although it is ostensibly a public website, the new facs.org was developed expressly with you—the ACS member—in mind. You can navigate the new site with greater ease and utility on any modern, Internet-capable device. Instead of building three separate versions for various viewing devices, only one version of the site was developed using responsive Web design best practices. Responsive design means that as a user, you will see nearly the same information and enjoy the same functionality regardless of which device you use to visit facs.org. Site content is scaled to provide the best view and navigation experience based on your device’s browsing capabilities.

Manage your membership features

All members of the College are encouraged to first sign in to the new site to take advantage of the secure content areas that are available to “members only.” In this location you will find that most of your ACS-related business needs can be handled through the “My Profile” section. You can manage continuing medical education (CME) credits, update your membership profile (click on the pencil icon), pay dues, update your case log in the Surgeon Specific Registry, track ACS purchases, find out who represents you on the ACS Advisory Councils and Board of Governors, learn what chapter you belong to and how to contact its officers, and discover other member benefit highlights.

Single sign-on technology is a new feature of ACS Web properties, meaning you will not have to sign in again to take advantage of most membership features, unless you log out or try to access these features from a different device. Moreover,
you can now visit ACS Communities and the Journal of the American College of Surgeons online without having to log in again.

**Spotlight on ACS pillars**

The ACS home page is organized to emphasize the College’s pillars: Member Services, Quality Programs, Education, and Advocacy. These four pillars provide the backbone of the content for the entire website and are positioned on a prominent navigation bar that stays with you as you browse the website (see Figure 3, page 14). Clicking on any of the pillar navigation headings provides you with an extensive list of related programs and topics in those four content areas.

The Member Services Pillar provides an overview of the benefits of ACS membership. The new Member Benefits section has been organized by membership category—from medical student to ACS Fellow. In this area, you will find information on scholarship and fellowship opportunities, how to connect with your local chapter, and a link to the College job bank, ACS Career Connection.

Information regarding all ACS Quality Programs can be viewed in the same menu section of the website. This section provides an overview and specific details about our surgical quality initiatives in the areas of surgical quality improvement, bariatric and metabolic surgery, cancer center accreditation, breast center accreditation, trauma center verification and quality improvement, and the overall role that the College has played in providing leadership in quality surgical care in the U.S.

Likewise, the Education Pillar pulls in educational offerings from ACS trauma, cancer, and continuous quality improvement programs, in addition to presenting the wide range of outstanding programs that you’ve come to expect from the ACS Division of Education.

Visiting the Advocacy section on a regular basis will keep you up to date on the latest in advocacy and health policy activities at the federal and state levels—activities that represent the interests of you, the practicing surgeon, and your patients.
Federated search feature

The new website employs a federated search feature, meaning that one search box on the website can be used to search multiple sources of information. This function allows the general public to search for a qualified surgeon who is a Fellow, in addition to finding a treatment facility verified or accredited by the ACS.

By default, the search box in the header of the new website searches the text content of the current site (see Figure 4, page 16). But you can further seek out the “Search Options” menu next to the search box, which allows you to search various ACS databases. Using Search Options, you can search the following areas:

- Website content
- Find a Surgeon (our membership database)
- Commission on Cancer (CoC)-Accredited Cancer Programs
- Committee on Trauma (COT)-Verified Trauma Centers
- ACS Accredited Education Institutes
- National Accreditation Program for Breast Centers (NAPBC)-Accredited Breast Centers
- Trauma Centers enrolled in Trauma Quality Improvement Program (TQIP®)

Other controls allow you to narrow your search. You can refine your facility search by state, city, ZIP code, country, distance, and several other variables that differ by program. You can also refine a surgeon search activity by using similar controls.

Utility bar features

The grey utility bar at the top of the home page contains several links that carry over to every page of the site (see Figure 5, page 16). “Events” takes you to an online calendar that lists CME opportunities offered by the College and events organized by ACS chapters and other appropriate groups, such as surgical specialty societies and academic medical centers. Further along that utility bar, “Shop” takes you to the ACS e-commerce section. Here you can find and purchase resources for lifelong surgical educational needs, standards manuals, reference tools, and have the option to register for courses, and contribute to the ACS Foundation. The “My Profile” link is also prominently placed in this bar so that you can easily view your profile and keep it up to date. A current profile means your colleagues and patients can always find you, and you can continue to receive e-mail and print communications from the ACS without interruption.

Website audiences

Another way to browse site content is to choose the audience to which you belong. The site has a global footer that lists the College’s key audience groups (see Figure 6, this page). Surgeons, international surgeons, Associate Fellows, residents, and medical students are all directed to targeted information based on where they are on the surgical career path. Patients and families are directed to the ACS Patient Education Web pages, while the media are directed to our online newsroom, which features press releases reporting on ACS initiatives, news from the Clinical Congress and other meetings, and studies published in the Journal of the American College of Surgeons.

Users will also find a prominent “Find a Surgeon” feature in this footer, which has been developed in tandem with the federated search feature and represents a more prominent way for patients in your geographic area to find you.

The ACS encourages you to view the online tutorial video located on the home page, which contains brief descriptions on how to navigate the new website. With more than 2,200 pages and files online, we anticipate you’ll find much more to explore as you become acquainted with the new facs.org. ♦
The SAGES FUSE program:
Bridging a patient safety gap

by
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Operating rooms (ORs) and procedure suites are host to millions of patient interventions every year in the U.S. It is now well understood that many invasive procedures carry substantial risk and may lead to potentially serious complications. The risks have increased in the modern operating theater, which is defined by human interaction, increasingly challenging patient cases, and dazzling technology. Extensive knowledge, training, and skill in all of these domains are required to optimize clinical outcomes and patient safety.

Heightened public awareness about safety in the OR has led many institutions to adopt a plethora of effective performance improvement programs and tools, such as team training and checklists. Despite these efforts, many gaps in OR safety education and training remain. A striking example is a lack of inculcation in the safe application of energy-based devices commonly used by surgeons, anesthesiologists, gastroenterologists, and nurses. These instruments can cause serious harm and death in patients when applied by individuals lacking a fundamental understanding of their function, design, and application. This lack of knowledge contributes to an estimated 600 OR fires annually in the U.S., a large number of accidents due to interference with implantable cardiac devices, as well as unrecognized and, therefore, life-threatening internal injuries among patients undergoing abdominal operations.2-13

This article analyzes how energy-based surgical devices have contributed to complications and mortality in the OR. It also looks at how surgeons have been trained to use these devices. In addition, this article describes the curriculum developed by the Society of American Gastrointestinal and Endoscopic Surgeons (SAGES) called the Fundamental Use of Surgical Energy (FUSE) program (www.fuseprogram.org). The FUSE program was established to ensure that surgeons have a more comprehensive understanding of how to use energy-based surgical devices safely.

Scope of the problem

Surgeons have used devices that apply energy to tissue therapeutically for millennia. Cautery—the direct application of heat to tissue—has been used therapeutically since 3000 BC to destroy tumors and achieve hemostasis.14 At the beginning of the 20th century, several engineers developed surgical instruments based on electrical energy. The best-known instrument was invented by William T. Bovie and applies high-frequency alternating current (radiofrequency electrosurgery) to tissues, combining the action of cutting and coagulation.15 After introduction into surgical practice by Harvey W. Cushing, MD, FACS, the “bovie” is still the most widely used energy-based device today. In the 1940s, surgical energy devices started to slowly evolve. Bipolar devices were introduced, with innovations such as the incorporation of cutting blades and real-time impedance measurement.

Nurses and anesthesiologists long ago recognized the gap in knowledge about the safe use of surgical energy devices. In 1979, Chambers and Saha reported a cardiac arrest due to electrocution in a young patient undergoing laparotomy. The patient died because an electrocardiogram (EKG) monitor with a direct earth ground created an electrical circuit that included the patient. Because of a faulty electrical switch in the operating table, the patient was electrocuted.16 Although this design has been abandoned and every OR electrical device must now comply with numerous safety requirements, injuries from electrical devices still occur. In 2010, Wills and colleagues reported a case of electroshock injury to a nurse in a state-of-the-art equipped OR.17

These reports of injuries related to electric monitoring devices have led to safer standards for common electronic devices used in ORs, including EKG machines, anesthesia monitors, operating tables, electrical outlets, and switches. Surgeons, however, were not involved in the development of these safety standards and remained largely unaware of the potential dangers associated with energy sources in the OR.
A vast array of devices for tissue dissection and efficient control of larger vessels without suturing have emerged. Today’s modern practicing surgeons use a range of devices that apply energy to tissues in many different ways, including electric current at radiofrequency wavelength, ultrasonic energy, and microwave-based, water jet-based, and plasma-based energy. This broad collection of energy sources allows the technology to be used in all forms of procedures—from open, laparoscopic, and robotic procedures to percutaneous interventions and endoscopic procedures. The advent of minimally invasive surgery has fueled the introduction of an exponentially greater number of surgical energy-based devices marketed to virtually every surgical specialty. In many ways it is because of these technical innovations that the advances in minimally invasive surgery, endoscopic interventional techniques, and percutaneous approaches to diseases have become possible. This technological boom has led to a multitude of energy device platforms, configurations, generators, cost points, and vendors. 

Because of the increased complexity and number of energy devices used in surgical procedures, the susceptibility of surgeons to inadvertently harming patients has increased in the last two decades. The estimated prevalence of injuries related to electrosurgery during laparoscopic procedures is 1–2 per 1,000 patients.4 These devastating complications are often unrecognized bowel injuries and major vascular injuries.4,18 Unrecognized thermal injuries to the intestine dur-
ing laparoscopic surgery are particularly dangerous because they are difficult to detect and carry a significant associated mortality.19,20 With more than 2 million laparoscopic procedures performed annually in the U.S., these energy-based surgical devices represent a major patient safety issue.21

**Health care community’s response**

The widespread use of energy-based surgical devices carries an increased risk of adverse events, largely because the devices are not completely understood. A common practice is for a surgeon to use a new device after a short primer by a vendor without understanding the fundamental principles of its function and safety. This gap in surgeon knowledge directly affects patient safety and must be addressed.

Individual surgeons, other health care professionals, and surgical societies both in the U.S. and abroad have tried to respond to this safety issue.22-26 These pioneers have shown us the specific complications associated with electrosurgical devices and the risks involved in their use, particularly in laparoscopy. Their seminal work included a survey sponsored by the ACS to assess the complication rate associated with the use of electrosurgical devices. This study demonstrated for the first time that most surgeons reported inappropriately high-power settings (n=508).27 As early as 1998, the Society of Laparoendoscopic Surgeons proposed to educate...
A common practice is for a surgeon to use a new device after a short primer by a vendor without understanding the fundamental principles of its function and safety.

surgeons on the safe use of laparoscopic monopolar electrosurgical devices, and in 2005, the Association of periOperative Registered Nurses (AORN) published basic recommendations on the safe use of energy devices. However, these efforts had a minimal impact on surgical practice.

Fundamental knowledge concerning the correct use and inherent dangers of energy-based devices remains incomplete. In contrast to textbooks written for anesthesiologists and nurses, surgical texts contain little relevant information regarding these instruments. Furthermore, surgeons are rarely required to train on the energy-based devices they use in the OR or to document their knowledge of device-related safety issues.

Lack of fundamental knowledge
Although many surgeons believe they understand how to use energy-based devices properly and safely, their actual effectiveness in using the instruments had never been formally tested until 2011 at a SAGES postgraduate continuing medical education course on the optimal use, safety profile, and knowledge of surgical energy-based devices. The faculty developed an 11-item multiple-choice pretest to measure what they considered to be critical knowledge. This pretest was administered to all postgraduate course participants and experienced SAGES surgeons. Course participants also completed a 10-item posttest covering the same content at the end of the course.

In all, 48 experienced SAGES surgeons completed the test. The median number of correct answers out of 11 was 6.5, or 59 percent. One-third of SAGES leaders did not know how to correctly handle a fire on the patient; 31 percent could not identify the device least likely to interfere with a pacemaker; 13 percent did not know that thermal injury can extend beyond the jaws of a bipolar instrument; and 10 percent thought a dispersive return electrode should be cut to fit a child. The 27 postgraduate course participants had similar scores, with a median six correct answers out of 11. Similar results were seen for surgeons in training, revealing that knowledge regarding the safe use of energy devices does not seem to increase with experience and that surgical “experts” do not necessarily have greater understanding of energy devices compared with junior trainees.

This issue is not specific to electrosurgery; it is evident in the use of newer energy technologies, as well. In April 2014, at the SAGES annual meeting, a short video of a laparoscopic superior mesenteric artery (SMA) dissection in a Whipple procedure was shown. Using ultrasonic shears, the uncinate process was separated from the SMA. One must stay very close to the vessel to remove all potentially involved lymphatic tissues. Laparoscopy, with its magnification and superior visualization, is particularly suited for this step of the procedure. As the surgeon dissected along the SMA with the ultrasonic shears, one could observe the development of an arterial pseudoaneurysm. The surgeon immediately recognized the potentially devastating complication and repaired the vascular injury. One key point gleaned from this video is that when energy devices with lateral thermal spread are used close to major arteries, injury from proximity to the instrument’s jaw can occur.

This example highlights the importance of understanding the characteristics of surgical energy devices as more and more complex laparoscopic procedures are performed. Perhaps the knowledge of the different thermal spread characteristics and temperatures generated by different vessel sealers and dissectors may help prevent such injuries. This particular example emphasizes the potential for unintended injury from energy devices through collateral thermal damage. Surgeons must be knowledgeable and aware of the side effects and must ascertain good control of the effector tip of any energy device used near a vessel or other tissue.
Need for training
Clearly, a standardized training program on energy-based devices is needed, particularly one that provides a rigorous framework for the introduction of these potentially harmful devices into routine clinical practice. Several key developments mentioned in this article support this conclusion.

Rapid expansion of new technologies
ORs have rapidly transformed from analog workrooms into sophisticated control centers of electronic health records, anesthetic delivery machines, high-definition screens, recording equipment, and a multitude of surgical energy devices.

OR fires
The estimated 600 OR fires that occur in the U.S. annually are preventable. In each case, the ingredients are a spark from an energy device, fuel, or oxidizer. Several professional societies have created videos, monographs, and posters highlighting the dangers of OR fires, but they still occur. The U.S. Food and Drug Administration recognizes this threat to patient safety and has organized a special task force to address this hazard, but few physician groups participate. There still is no common educational pathway to teach fire prevention by safely using surgical energy devices in the operative field.

Evolving industry ties to surgical education
Today, introduction of new surgical devices for use by surgeons is left in the hands of industry representatives, and knowledge regarding new devices is largely disseminated through industry-sponsored courses. Although a certain logic underlies this approach, it is inherently problematic. The primary goal of device representatives is not to teach function and safety, and they have no standards for determining whether a surgeon is able to use a new device safely. With rising concern about the influence of industry on surgeons, boundaries have been created to keep these parties separate. As a result, it has become increasingly difficult for industry representatives to teach surgeons and nurses how to use new devices. And yet, no alternative instruction model is currently available, which raises several important questions:

• Where will the training to master new surgical energy devices originate?
• Who will create a curriculum covering their functionality and safety profiles?
• How should we offer appropriate training and certification?
Today, introduction of new surgical devices for use by surgeons is left in the hands of industry representatives, and knowledge regarding new devices is largely disseminated through industry-sponsored courses.

- What is the standard procedure when a surgeon or nurse is suddenly faced with unfamiliar equipment?
- How will we mandate and pay for fire safety training?
- Should there be a standard approach for how energy devices are introduced into the hands of surgeons—and who will create these standards?

Perhaps the most obvious solution is a nationwide, non-industry sponsored, multidisciplinary educational program with validated assessment in surgical energy-based devices to address the knowledge gap and to ensure patient safety and the use of best practices.

FUSE program
Educational programming can be based on either a top-down or bottom-up approach. The top-down approach would involve federally mandated programs, which is unappealing on many levels. It will be hard to create buy-in for yet another external mandate that will likely involve time away from patient care. Using the bottom-up approach, surgeons of all specialties, nurses, and anesthesia professionals would work together to create an educational program. The benefit of this approach, in which providers take responsibility for meeting stated goals, is that it is more likely to produce buy-in and meaningful change.

SAGES created the FUSE program using a bottom-up approach. Working in partnership with AORN, the American Association of Gynecologic Laparoscopists (AAGL), and the American Urologic Association, the FUSE team includes a variety of general and subspecialty surgeons, nurses, anesthesiologists, gynecologists, and engineers. Following in the tradition of two other SAGES educational programs—Fundamentals of Laparoscopic Surgery and Fundamentals of Endoscopic Surgery—FUSE has two central components: a standardized curriculum for surgeons and allied health care professionals of all specialties, and a high-stakes certification test that meets rigorous psychometric and accreditation standards. Test results will serve as verification that the surgeon has attained the basic knowledge necessary to safely use energy-based devices in the OR.

The FUSE curriculum was first presented at a SAGES postgraduate course in 2011 and 2012. The material was expanded into a textbook on surgical energy and safety. The SAGES Fundamental Use of Surgical Energy Manual was published in 2012 and as an online multimedia curriculum that same year. The FUSE online curriculum is available from SAGES at www.fundamentals-didactics.com.

The FUSE curriculum includes 10 sections:

1. Fundamentals of Electrosurgery
2. Mechanisms and Prevention of Adverse Events with Electrosurgery
3. Monopolar Devices
4. Bipolar Devices
5. Radiofrequency for Soft Tissue Ablation
6. Endoscopic Devices
7. Ultrasonic Energy Devices
8. Microwave Energy Systems
9. Energy-Based Devices in Pediatric Surgery
10. Integration of Energy Systems with Other Devices

The content focuses on the key principles of safe and effective use of surgical and endoscopic energy devices. For example, Fundamentals of Electrosurgery (Section 1) covers the types of electric currents used; correct nomenclature; explanation of physics, such as Ohm’s law as it is applied to electrosurgery; electrosurgical generators; differences in “coag” and “cut” waveforms; monopolar versus bipolar systems; isolated versus ground-referenced systems; active and dispersive electrodes; physical effects of temperature and alternating current on cells and tissue; resistive heating; and the different tissue effects (desiccation, coagulation, fulguration). Section 2 describes the safe use of electrosurgical devices, current diversion includ-
ing direct and capacitive coupling, insulation failure, and prevention and response to OR fires. A similar emphasis on fundamental principles and safe application is used in the sections on specific devices that include monopolar, bipolar, ultrasonic, radiofrequency ablation, and microwave and endoscopic devices. Special considerations for use of energy devices in pediatric patients and in patients with other medical devices (cardiac implantable devices) are addressed in additional sections. The FUSE manual contains supplemental hands-on chapters describing how to set up “live” stations for demonstration and teaching surgical energy principles and safe practice.

The online curriculum provides multimedia content of the FUSE curriculum, including self-assessment test questions eligible for continuing medical education, maintenance of certification, and continuing education units. An example of a “page” from the online curriculum is shown in the figure on page 23.

The FUSE curriculum is designed to provide surgeons with the knowledge they need to pass the FUSE certifying exam, which has been developed to comply with the legal and technical requirements for professional certification. More specifically, psychometricians led 15 FUSE content experts through a systematic process to define the competencies required to use energy devices safely. For each section of the curriculum, two to 20 objectives were identified, for a total of 72 objectives. For example, see the table on this page for the

### REFERENCES


continued on next page
The online curriculum provides multimedia content of the FUSE curriculum, including self-assessment test questions eligible for continuing medical education, maintenance of certification, and continuing education units.

REFERENCES (CONTINUED)


continued on next page

objectives set forth for Section 1: Fundamentals of Electrosurgery and Section 2: Mechanism and Prevention of Adverse Events with Electrosurgery. Leaders from SAGES, along with selected members of AORN and AAGL, participated in development of the test blueprint by ranking each objective and determining the number of test items for the written exam. They determined that the assessment should, most importantly, measure health care professionals’ understanding of the fundamental principles of energy devices, their electrosurgical safety, and the integration of energy systems with other devices. Beta testing of the program and assessment was completed in April of this year. More than 170 surgeons and allied health professionals achieved a passing score in beta testing of the exam, making them the first cohort of FUSE-certified surgeons.

Further additions to the FUSE curriculum are currently under way, including a structured interactive bench-top simulation component. This goal-directed, hands-on, bench-top training session has been shown to improve learning and retention of vital knowledge on surgical energy-based devices at three months.33 Simulation of surgical energy is currently being developed into a portable, virtual reality simulation-based educational tool for surgical trainees.34

Conclusion

All members of the surgical team should be able to demonstrate and apply a fundamental understanding of the use of surgical energy in the OR in order to achieve optimal clinical results and create the safest possible environment for the patient and staff. The FUSE program bridges a gap in patient safety as it relates to best practice in the use of surgical and endoscopic energy devices. It addresses the most common types of energy devices, their impact on OR fire prevention, the safety of implantable electronic devices, and safe and appropriate use of energy devices within
the operative field. This program is the first educational tool of its kind to address patient and OR team safety for energy devices in the surgical theatre or the endoscopy suite.

Future developments in the FUSE program will include specific modules tailored to individual energy devices. These modules will be designed in collaboration with industry to provide standardized education for the safe and appropriate use of new and current energy devices. Industry involvement will ensure that the FUSE program will continue to fill the unmet curricular, regulatory, safety, and competency assessment needs that exist for the use of energy devices by surgeons, endoscopists, anesthesiologists, and nurses worldwide.

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REFERENCES (CONTINUED)
The Centers for Medicare & Medicaid Services (CMS) Physician Quality Reporting System (PQRS) program is the first national program to link the reporting of quality data to physician payment. PQRS began in 2007, providing incentive payments only to eligible professionals (EPs) who voluntarily and successfully participated in the program. Although EPs include nonsurgeon health care professionals, such as other physician specialists, podiatrists, and nurses, for purposes of this Bulletin article, EPs are generically referred to as “surgeons.” In 2013, all surgeons began receiving either an incentive payment for participation or a penalty for lack of or unsuccessful participation. This policy will change again in 2015 when surgeons and other providers will no longer receive incentive payments for successful participation. However, surgeons who fail to comply with the program will receive penalties indefinitely.

Table 1 on page 29 highlights the PQRS incentive and penalty amounts for 2014 and beyond. Penalties are applied to a surgeon’s total Medicare Part B fee-for-service (FFS) amount, two years after the “performance period” ends. This article provides examples of the scenarios surgeons could face for participation or nonparticipation in 2014, as well as an overview on the PQRS program. It also describes what the American College of Surgeons (ACS) is doing to assist members with participation.

What the ACS is doing
In June, the ACS conducted a brief survey to determine the membership’s understanding of the PQRS program. The results of the survey, featured in Table 2, page 29, show that nearly half of the 189 respondents had not participated in PQRS and more than one-quarter were unaware of the incentives and penalties. The College has been doing its part to help surgeons by providing informational material and participation opportunities for surgeons so they can avoid the risks of nonparticipation and enjoy the benefits of the program. What is new for this year is that the ACS has received CMS approval for surgeons to submit data collected from two ACS registries in order to meet the 2014 PQRS reporting requirements—the Surgeon Specific Registry (SSR) and the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP). (See sidebar on page 31 for details.)

Financial importance of participating in PQRS
Unlike other CMS programs, PQRS does not have opt-out “exemptions.” EPs must participate to avoid penalties. Under the PQRS program, an EP is defined as any health care professional who is getting paid under or based on the Medicare physician fee schedule.
Surgeons and group practices may participate in the PQRS program in a variety of ways. Surgeons may report individually and choose one of the methods from the following reporting options that are described in greater detail in Table 3, page 302:

- Claims-based reporting option for individual EPs
- Registry-based reporting option
- Electronic health records-based reporting option
- Qualified clinical data registry (QCDR) reporting option

Each option requires adherence to some complex rules and time lines. The ACS has assembled a list and discussion of each of these options at https://www.facs.org/~media/files/advocacy/pqrs/pqrsresources_7_9_14.ashx. Successful compliance with any of the appropriate reporting options will allow EPs to earn an incentive payment of 0.5 percent.

Note that group practices have the option to participate in PQRS through the Group Practice Reporting Option (GPRO). These options differ from the individual EP options listed in Table 3. The only circumstance in which a group practice may choose from the GPRO reporting options is if the group practice has sent a request to CMS to participate via the GPRO option by September 30, 2014, and has received CMS approval.

2014 PQRS individual reporting options

Surgeons may face one of three scenarios in the coming years based on their participation in the 2014 PQRS program, as follows.

Scenario one: Smart Surgeon A
Surgeon A is participating in the PQRS program for calendar year (CY) 2014 using the ACS SSR, allowing Surgeon A to complete and meet all of the requirements necessary to successfully comply with the 2014 PQRS program. This surgeon has a Medicare allowable payment amount of $100,000 in 2014. As a result of
### Table 3. Summary of Requirements for the 2014 PQRS Incentive for Surgeons

Individual reporting criteria for satisfactory reporting of individual quality measures via claims, qualified registries, and EHRs and satisfactory participation criterion in qualified clinical data registries

<table>
<thead>
<tr>
<th>Reporting period</th>
<th>Measure type</th>
<th>Reporting mechanism</th>
<th>Satisfactory reporting criteria/satisfactory participation criterion</th>
</tr>
</thead>
<tbody>
<tr>
<td>12-month (January 1–December 31)</td>
<td>Individual measures</td>
<td>Claims</td>
<td>Report at least 9 measures covering at least 3 National Quality Strategy (NQS) domains; if less than 9 measures covering at least 3 NQS domains apply to the EP, report 1 to 8 measures covering 1 to 3 NQS domains, and report each measure for at least 50 percent of the Medicare Part B fee-for-service patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate would not be counted.* For an EP who reports fewer than 9 measures covering 3 NQS domains via the claims-based reporting mechanism, the EP will be subject to the claims Measures Applicability Validation (MAV) process, which would allow [CMS] to determine whether an EP should have reported quality data codes for additional measures and/or covering additional NQS domains.</td>
</tr>
<tr>
<td>12-month (January 1–December 31)</td>
<td>Individual measures</td>
<td>Qualified registry</td>
<td>Report at least 9 measures covering at least 3 of the NQS domains; if less than 9 measures covering at least 3 NQS domains apply to the EP, report 1 to 8 measures covering 1 to 3 NQS domains for which there is Medicare patient data, and report each measure for at least 50 percent of the EP’s Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate would not be counted.* For an EP who reports fewer than 9 measures covering 3 NQS domains via the registry-based reporting mechanism, the EP will be subject to the registry MAV process, which would allow [CMS] to determine whether an EP should have reported on additional measures and/or measures covering additional NQS domains.</td>
</tr>
<tr>
<td>12-month (January 1–December 31)</td>
<td>Measures groups</td>
<td>Direct EHR product and data submission vendor</td>
<td>Report 9 measures covering at least 3 of the NQS domains. If an EP’s certified EHR technology does not contain patient data for at least 9 measures covering at least 3 domains, then the EP must report the measures for which there is Medicare patient data. An EP must report on at least 1 measure for which Medicare patient data are available.</td>
</tr>
<tr>
<td>12-month (January 1–December 31)</td>
<td>Measures groups</td>
<td>Qualified registry</td>
<td>Report at least 1 measures group, and report each measures group for at least 20 patients, a majority of whom must be Medicare Part B FFS patients.</td>
</tr>
<tr>
<td>6-month (July 1–December 31)</td>
<td>Measures groups</td>
<td>Qualified registry</td>
<td>Report at least 1 measures group, and report each measures group for at least 20 patients, a majority of whom must be Medicare Part B FFS patients.</td>
</tr>
<tr>
<td>12-month (January 1–December 31)</td>
<td>Measures selected by qualified clinical data registry</td>
<td>Qualified clinical data registry</td>
<td>Report at least 9 measures covering at least 3 NQS domains and report each measure for at least 50 percent of the EP’s applicable patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate would not be counted.* Of the measures reported via a qualified clinical data registry, the EP must report on at least one outcome measure.</td>
</tr>
</tbody>
</table>

*Subject to the Measures Applicability Validation process for claims-based or registry-based reporting.

†Finalized in the CY 2013 PFS final rule (see Table 91 at 77 FR 69194).
Each option requires adherence to some complex rules and time lines. The ACS has assembled a list and discussion of each of these options at https://www.facs.org/~/media/files/advocacy/pqrs/pqrsresources_7_9_14.ashx.

Successful participation in PQRS 2014, Surgeon A will receive a bonus payment of 0.5 percent, or $500, and, more importantly, will avoid a 2 percent penalty, or $2,000, in 2016. In addition, Surgeon A will be identified as a successful PQRS participant on the CMS Physician Compare website.

Scenario two: Poor Surgeon B
Surgeon B does not participate in the PQRS program in CY 2014 because of time constraints. Like Surgeon A, Surgeon B has a Medicare allowable amount of $100,000 in 2014. However, due to nonparticipation, Surgeon B will not receive an incentive payment. Instead, Surgeon B will receive a penalty of 2 percent of the total Medicare charges, or $2,000, in 2016. Note that the penalty is applied to Surgeon B two years after the current CY, otherwise known as the performance period. Furthermore, Surgeon B will not be listed as a PQRS participant on the CMS Physician Compare website.

Scenario three:
It gets worse for Surgeon B
What could be worse? The penalty can double by adding in the effect of the CMS value-based payment modifier for physicians. The value-based payment modifier provides for differential payment to a physician or group of physicians under the Medicare physician fee schedule and based on the quality of care furnished compared to cost during a performance period.

ACS PROGRAMS TO ASSIST IN PQRS REPORTING
The ACS recognizes that it may be difficult for most surgeons to comply with PQRS reporting by using the claims- or EHR-based method. The registry-based reporting option, available through the ACS SSR, and the QCDR, available through ACS MBSAQIP, may be better options for some surgeons to pursue.

SSR
The SSR, formerly known as the ACS Case Log, allows surgeons to track their cases and outcomes in a convenient, easy-to-use, and confidential manner. The SSR can also be used to comply with regulatory requirements, such as submitting 2014 PQRS data. The SSR allows individual EPs to report on the four measures within the Perioperative Care Measures Group or the five measures (if applicable) and/or surgical outcome measures within the General Surgery Measures Group. Surgeons can choose to report on 20 majority Medicare patients for either one of these groups and will have until January 31, 2015, to submit CY 2014 patient information in the SSR. The SSR will submit the PQRS data to CMS.

The SSR is available at no cost to ACS surgeon members and will be available to non-member surgeons later this year for a nominal fee. Surgeons who have used the Case Log in the past can log on to the SSR with the same username and password and begin entering cases at https://acspbls.resiliencesoftware.com/. For current users, the SSR can produce a report that indicates the surgeon’s eligible PQRS cases, based on measures group Current Procedural Terminology codes. These cases may be easily edited with PQRS-specific data through the report. If surgeons have not used the Case Log in the past, they can register at http://www.facs.org/members/pbls.html. Surgeons will need to consent to and sign up for PQRS reporting through the SSR if they want the registry to submit data on their behalf.

MBSAQIP
The MBSAQIP has been approved by CMS as a QCDR for PQRS 2014. MBSAQIP participants will have the opportunity to voluntarily elect that their MBSAQIP QCDR quality measures results be submitted to CMS for PQRS participation. Metabolic and bariatric surgeons will receive reports of their QCDR measures results so they can track, and have the opportunity to improve, their results. The MBSAQIP will submit approved 2014 QCDR measures during the first quarter of 2015 on behalf of MBSAQIP participants who elect to have their data submitted. One benefit of using the MBSAQIP is that data are already being collected as part of participation in the MBSAQIP, whereas other options to satisfy PQRS may have additional data burden. Specifications of the approved MBSAQIP QCDR quality measures are available at http://www.mbsaqip.info/wp-content/uploads/2014/03/MBSAQIP-QCDR-specifications.pdf.
If Surgeon B belongs to a group practice of 10 or more physicians in 2014 and that group does not participate in one of the PQRS GPRO options, or if 50 percent of that group does not participate in PQRS via one of the individual reporting options, Surgeon B will receive an additional 2 percent penalty under the value-based payment modifier in 2016. Thus, Surgeon B will face a combined PQRS and value-based payment modifier penalty totaling $4,000 based on a Medicare allowable amount of $100,000 in 2014. On the other hand, successful PQRS reporters, like Surgeon A, will be eligible for value-based payment modifier bonuses.

As outlined in the previous scenarios, successful participation in PQRS is essential for avoiding substantial payment penalties. The PQRS payment penalty will occur indefinitely in future years. In addition to the PQRS and value-based payment modifier programs, other CMS quality programs, such as the Electronic Health Record (EHR) Incentive Program, have penalties that take effect around the same time. (Additional information on the EHR Incentive Program is available at [http://www.facs.org/ahp/ehr/](http://www.facs.org/ahp/ehr/))

**Resources for surgeons**


Furthermore, ACS staff members are available to answer questions and assist members participating in the 2014 PQRS program, and to facilitate enrollment in the SSR and the MBSAQIP. For PQRS-related questions, surgeons can contact the following ACS staff:

- **General PQRS program questions:** Sana Gokak, ACS Division of Advocacy and Health Policy, 202-337-2701 or sgokak@facs.org

- **Information on the SSR:** Bianca Reyes, ACS Division of Research and Optimal Patient Care (DROPC), 312-202-5000 or ssr@facs.org

- **Information on the MBSAQIP:** Rasa Kraprikas, ACS DROPC, 312-202-5000 or rkrapikas@facs.org.

- **CMS is also available to answer PQRS-related questions:** at 1-866-288-8912 or qnetsupport@hcqis.org. ◆

**REFERENCES**


The American College of Surgeons (ACS) advocates for several health policy issues that affect health care at the state level. As the strained political climate intensifies in Washington, DC, due to the upcoming 2014 elections and the many effects and implications of the Affordable Care Act that have surfaced, much of the action on major health policy issues is increasingly occurring at the state level. Hence, surgeons need to be prepared to advocate in their state legislatures for policies that move the needle toward establishing a high-quality, high-value health care system. This article outlines why the surgeon’s voice is critical in health care policy debates, how surgeons can be effective advocates, and how the College can support such efforts at the regional level.

The importance of surgeon advocates

In 1932, former U.S. Supreme Court Justice Louis Brandeis wrote in the opinion New State Ice Co. v. Liebmann that “a state may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country.”* Justice Brandeis’ statement rings true now more than ever in health policy, where states are looking for innovative ways to address the problems facing the U.S. health care system, including stabilizing Medicaid, fighting for medical liability reform, expanding scope of practice, improving public health, increasing transparency with respect to cost and quality, and implementing the Affordable Care Act. With the current partisan gridlock in Washington, little is being accomplished at the federal level, making state governments that much more powerful. In 2014, statehouses considered hundreds of bills addressing various facets of medical liability reform, scope of practice,

Surgeons are natural leaders who can and should capitalize on the power they have as thought leaders and respected members of the community to influence the health care policy formulated in state legislatures.

and health care reform, as well as policies related to specific health care issues, such as cancer prevention, treatment, and diagnosis, as well as injury prevention.

As the state legislatures turn their focus increasingly toward health care policy issues, input from those constituents most affected by the policies being discussed, particularly surgeons, is increasingly important. For surgeons, the responsibility to patients extends far beyond the operating room. State lawmakers are making decisions that directly affect the practice of surgery and surgeons’ ability to provide high-quality care to patients. Surgeons are natural leaders who can and should capitalize on the power they have as thought leaders and respected members of the community to influence the health care policy formulated in state legislatures.

One surgeon who is actively advocating for colleagues and patients at the state level is J. Patrick Walker, MD, FACS, Immediate Past-President of the South Texas Chapter of the ACS. “No one knows more than we do what is best for our patients,” noted Dr. Walker, a general surgeon at East Texas Medical Center, Crockett (e-mail communication with the authors, May 6, 2014). “Don’t count on the beneficence of the government to do what is right for your patient.”

Seasoned College staff view surgeons as the best advocates on health care issues, providing a strong and experienced voice as a guide for state legislators as they consider policies that have wide-ranging effects on surgical practice and the practice of medicine overall. In fact, it is widely understood that lawmakers want and need to hear what surgeons have to say.

Building important relationships
Advocacy is about influencing the individuals who make policy decisions in order to advance a cause. Before undertaking any sort of advocacy campaign, it is important to build relationships with elected officials, their legislative staff or state agency staff, peers, and other organizations.

“The first step in the political process has to be building a relationship with your legislator.” Dr. Walker said. It is important to cultivate relationships with both elected officials and other stakeholders before you need to lobby an issue, because these individuals are more likely to be responsive than are legislators or policymakers who are just getting to know you and what you do and are uncertain as to why they should listen to you.

Reaching out to your ACS state chapter is a good place to start. Many chapters already have legislative committees and advocate on surgery’s behalf, so they can steer advocates in the right direction or provide useful contacts. The ACS also provides funding to chapters for state lobby days, and attending one of these events can be a great introduction to state lawmakers and the legislative process.

Attend a fundraiser
Fundraisers for political candidates provide a great venue for building a relationship with current and aspiring lawmakers. Although not always viewed in a positive light, attending a fundraising event or donating a small amount to a campaign can help improve access to legislators when action is necessary.

Dr. Walker recommends participating in an event in the legislative off-season, when the legislators are less likely to have their attention pulled in multiple directions. “There is no question that fundraising is a great way to get to know a politician,” Dr. Walker said. “You don’t have to raise massive amounts of money. They appreciate your effort.” It is critical to keep in mind that laws vary from state to state with regard to how much an individual may contribute to a candidate’s campaign, and it is recommended that any Fellow wanting to make a contribution first consult with the state elections board to determine what is permissible. If a surgeon is unable to make a financial contribution, other ways to support a campaign include volunteering in the campaign office and serving as a health policy advisor.

Benefits of face-to-face meetings
Another powerful tactic in building a relationship with legislators and their staff is to meet with them face-to-face, either in their office or by inviting them to visit your practice. “Legislators and their staff love hearing front-line stories from us about the care we provide to our patients, who live in their districts and are their constituents,” said Naveen Sangji, MD, a surgical resident at Massachusetts General Hospital, Boston (e-mail communication with the authors, May 13, 2014). “We
can highlight our requests, which are typically patient-centered, with personal stories and experiences. The impact of that is immeasurable. We have the power to make a real difference in our home states.”

Indeed, personal stories and information are vital to make a lasting impression, and these meetings offer a way to relay those stories and information. A site visit provides an opportunity for the legislator to see where surgeons work, to interact with the patient care team, and to learn what it takes to run a successful practice. Lawmakers also get to experience firsthand how the policies they make affect patients, physicians, and constituents.

Leverage legislative staff
It is also important to build a rapport with legislative staff. Legislators are responsible for a range of issues and can’t possibly be experts on every issue that affects surgery. Hence, they leave much of the research and fact gathering to their staff, who help prepare legislators for hearings, write correspondence, make scheduling decisions, and more. Quite often advocates are discouraged when they find they will be meeting with legislative staff rather than their elected officials directly; however, meetings with staff can be as beneficial as meeting with a legislator. Keep in mind that legislators will always go back to staff for advice and recommendations on how to move forward with a policy position or how to vote. Remaining on good terms with legislative staff can go a long way toward gaining access to the legislator and achieving advocacy goals and gaining access to the legislator.

Communicate effectively
The cornerstone of a productive relationship with state lawmakers is effective communication. Advocates can communicate via letter, fax, e-mail, telephone, in-person meeting, and social media outlets, such as Facebook and Twitter. Legislators want to hear from their constituents and are sensitive to their opinions. Thoughtful, sincere, and precise comments are extremely useful and may be used by a legislator or regulator when debating or discussing a bill or proposed rule, and can help build a solid, long-term relationship. When preparing to advocate on an issue, “Know what you want, and know how to explain it succinctly and with persistence,” Dr. Walker suggested.

An easy way to write an e-mail to a legislator is through the Surgery State Legislative Action Center (SSLAC), described in the “ACS resources” section of this article. The ACS State Affairs team will send several SSLAC alerts throughout the year, and it is important for surgeon advocates to take action when these alerts are received.

Telephone communication is useful when the issue is urgent and an opinion must quickly be provided. The call is usually directed to the staff person who manages health care issues, which in itself can be seen as positive because it can be a step toward developing that important personal connection.

An in-person meeting, either in the capitol or in the district office, is a more effective tactic when building a long-term relationship with policymakers and their staff. Lastly, attending a town hall meeting hosted by your legislators can also be an effective way to raise a specific issue in front of not only legislators, but also their other constituents. By their nature, town halls do not allow for much one-on-one interaction, but they are a chance to increase awareness of an issue affecting surgeons and surgical patients in the community.

Understanding the issue is important, but it is equally important to connect with legislators and their staff. Tell them your story. Tell them why this issue is important to you and your patients. Provide strong, convincing data. Nothing is better than a good narrative about a real situation backed up with good data to explain how an issue is affecting their constituents.

ACS resources
One substantive resource for Fellows who want to get involved in state advocacy is the ACS State Affairs team. The College not only provides support to ACS chapters in their advocacy efforts, but also works with state medical and specialty societies, allowing a broad understanding of what is happening on the ground and where surgeons may be most effective.

The ACS State Affairs team offers a wide variety of services, including the following:
SUCCESS STORIES

Several surgeons have found that applying the tools and information presented in this article has been useful in ensuring the passage of sound health policy. Peter Masiakos, MD, FACS, a pediatric surgeon at Massachusetts General Hospital, Boston, put the concepts and resources discussed in this article to use in achieving passage of “Sean’s Law,” an Act to Regulate the Use of Off-Highway and Recreation Vehicles. This legislation provides stricter safeguards for the use of all-terrain vehicles (ATVs) by prohibiting children under the age of 14 from operating these powerful machines.

Dr. Masiakos was inspired to advocate for the legislation after providing care to Sean Kearney. “On a Sunday afternoon in late October of 2006, Mark and Katie Kearney of Plymouth, MA, dropped their eight-year-old son off at a friend’s home for a play date. Several hours later, Sean sustained a severe brain injury because of an ATV accident. I cared for Sean in the intensive care unit until he died from his injuries five days later. On that day, the Kearneys asked me how this could have happened to Sean. I did not realize the far-reaching implications that their question would have in redefining the laws regulating ATV use in Massachusetts and redefining my responsibilities as a pediatric surgeon,” he recalled (e-mail communication with the authors, May 8, 2014).

To help build the case for the legislation, “I requested injury data from the state’s Department of Public Health. The information that I received was astounding. For the year spanning 2004 to 2005, the most recent complete data set, there were 935 pediatric ATV-related injuries recorded in Massachusetts, about 30 percent of all reported ATV injuries. The average age of the injured child was 13.3 years. Once I established my knowledge base, I started meeting with specific legislators and testified at the initial hearing of the bill,” Dr. Masiakos said. “I provided data about injury prevention to the politicians and answered the questions about injury outcomes and cost containment. I used the medical literature to teach them the facts. In time, they would call me to discuss the ATV bill and then other injury prevention bills that were being written,” he said. (In 2011, the Bulletin published an article written by Dr. Masiakos on the dangers of ATV use and the development of Sean’s Law.)1

“On July 31, 2010, after nearly four years and two legislative sessions, a new law was passed,” he said, encouraging other surgeons to be patient yet persistent in their dealings with lawmakers. “Many of us feel that we cannot effect change at the grassroots level. I have discovered that this is not true. Getting over the initial inertia associated with this attitude is the most challenging issue. Once the ball gets rolling, the process is quite rewarding,” Dr. Masiakos said.

“The second challenge is to overcome the urge that we have as surgeons to expect that things will get done quickly,” Dr. Masiakos added. “Very little in government is done quickly. You must enter the process with an unfappable attitude. You must be prepared to lose some arguments and to encounter some legislators that you cannot win over. The key to successful advocacy is to find a policymaker with a sympathetic ear who will champion your cause, and not quit.”

Dr. Walker also discovered the rewards and frustrations of political advocacy when he worked to achieve passage of the Texas’ Uniform Emergency Volunteer Health Practitioners Act (UEVHPA). “It began about six years ago, when I first heard about the UEVHPA at our chapter meeting. I thought the idea was great and a noble project. I didn’t know it would take three legislative sessions and numerous meetings and committee appearances for the bill to pass,” Dr. Walker said.

“I was good friends with my state representative at the time, so I approached him with the issue. He agreed that it would be a worthwhile undertaking, but by the time it got to the Homeland Security and Public Safety Committee, the trial lawyers were already exhibiting opposition to it. We ran out of time in that session, so I brought it back the next session,” Dr. Walker said. “I spent a lot of time in that session, so I brought it back the next session,” Dr. Walker said. “I spent a lot of time in that session, so I brought it back the next session,” Dr. Walker said. “I spent a lot of time in that session, so“I brought it back the next session,” Dr. Walker said. “I spent a lot of time in that session, so“I brought it back the next session,” Dr. Walker said. “I spent a lot of time in that session, so“I brought it back the next session,” Dr. Walker said. “I spent a lot of time in that session, so“I brought it back the next session,” Dr. Walker said. “I spent a lot of time in that session, so“I brought it back the next session,” Dr. Walker said. “I spent a lot of time in that session, so“I brought it back the next session,” Dr. Walker said. “I spent a lot of time in that session, so“I brought it back the next session,” Dr. Walker said. “I spent a lot of time in that session, so“I brought it back the next session,” Dr. Walker said. “I spent a lot of time in that session, so“... the entire legislature was tied up in budget negotiations, and almost no bills were passed out of committee.”

“Last year, I was ready. I made sure to get the bill submitted early, pushed hard to get it read before the committee, and was available to testify when called. The trial lawyers were no longer expressing significant opposition to the issue, the Texas Medical Board signed off in advance, and there was very little opposition. It sailed through committee, on to the House floor, and we had arranged for Senate approval in advance. The governor signed it, and our bill became a law!”

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• Speaking at chapter events or other stakeholder group meetings. Topics range from specific, regional issues to advocacy training workshops. A sample program outline, objectives, and a timetable are provided.

• Coordinating plans for a lobby day at the state capitol or a legislative site visit.

• Assisting with advocacy efforts for or against legislation introduced in the state legislature.

• Providing input on advocacy planning and strategy issues, including development of a chapter advocacy and health policy committee.

• Developing background information/briefing materials and researching legislative issues.

• Drafting testimony for presentation at state legislative committee hearings.

Dr. Walker noted that the ACS State Affairs staff was helpful in his advocacy efforts. “The College State Affairs team was always supportive and helped me with briefs, supplied a copy of the bill and some testimony from other states. They offered to come to Austin, but, in truth, the best testimony is always a physician who only has the best interests of his or her patient at the center of the issue,” Dr. Walker added.

As previously mentioned, the College provides an online tool, the SSLAC, where the ACS, along with more than a dozen other surgical specialty societies, posts alerts on critical issues pending in state legislatures. The SSLAC can be accessed at http://capwiz.com/sslac/home. This online tool is easy to navigate, user-friendly, and an excellent way for surgeons to begin to participate in state advocacy. The SSLAC is a public website, and any interested party may use and share alerts with others. In addition to serving as the conduit for e-mail campaigns, the SSLAC also contains general information on state lawmakers.

The ACS Facebook and Twitter pages are useful in promoting advocacy, disseminating SSLAC alerts, and interacting with industry and political leaders. Follow the ACS on Twitter at https://twitter.com/AmCollSurgeons, and “like” the College on Facebook at https://www.facebook.com/AmCollSurgeons. As the use of social media continues to grow, online social media is becoming a more acceptable form of professional communication at the College. If you come across material that should be featured on ACS social media platforms, contact the ACS State Affairs team.

The ACS State Affairs staff also coordinates the State Advocacy Representative (StAR) Program, through which the College and StARs share information, mainly through regular conference calls. Each state has at least one StAR whose main responsibility is to be the eyes and ears for the College at the state level. StARs monitor legislation in their state and then confer with the State Affairs team. Becoming a StAR for your state is a great way to stay informed and can be a precursor to becoming more actively engaged in advocating for the College’s state legislative priorities.

Get involved
As Dr. Walker’s and Dr. Masiakos’ stories indicate (see sidebar, page 36), surgeons can effect real change in the state legislatures. If you are interested in getting involved in advocating for your patients and the practice of surgery in your state, contact the ACS State Affairs team:

• Tara Leystra Ackerman, MPH, State Affairs Associate, 202-562-1522, tleystra@facs.org

• Justin Rosen, State Affairs Associate, 202-562-1528, jrosen@facs.org

• Jon Sutton, Manager, State Affairs, 202-562-1526, jsutton@facs.org

These individuals will work with you to identify opportunities to advocate for policies that affect surgical practice and patient care in your state. With a can-do attitude and perseverance, surgeons can help to shape policy that ensures patients have access to high-quality care in their states.
Founding surgeon reflects on 25 years of UNICAR, the Guatemalan Heart Institute

by Francis Robicsek, MD, PhD, FACS
In past decades, cardiac care, particularly cardiac surgery, in Central America remained well behind the medical progress made in industrialized countries. Among the six countries of the subcontinent, only Costa Rica had well-organized cardiac care, whereas medical and surgical care for heart conditions throughout the rest of Central America was either vastly inferior or nonexistent. Even today, in most of these countries, only a few cases are performed by fledging cardiac surgical programs or by visiting “brigades” of cardiac teams from the U.S. and Europe. The general public has virtually no access to cardiac surgical care, whereas wealthy individuals have the option of flying to Mexico City, Mexico, or to the U.S. for their operations. There is, however, an exception; a bright spot in the dark picture—Unidad de Cirugía Cardiovascular de Guatemala (UNICAR), the Guatemalan Heart Institute. This is a brief overview of UNICAR.

**Beginnings**

I have always been interested in Central American archaeology, and in the 1960s and 1970s, spent most of my free time roaming the Mayan ruins of Guatemala. On one of my Mayan jaunts in 1971, my friend, John M. Keshishian, MD, FACS, a thoracic surgeon from Washington, DC, introduced me to the country’s president at the time, Carlos Manuel Arana Osorio, who also was deeply interested in pre-Columbian cultures. One evening, sitting at the campfire, President Osorio asked me what I did when I was not in the jungle.

“Mainly operating on hearts,” was my answer.
He suddenly became very interested and asked, “Do we have heart surgery in Guatemala?”
“No,” I said.
I did not have to wait too long for his next question: “Could you start a heart surgery program?”
“Yes,” I replied, “but you have to help me.”

From that point on, it was only a matter of time until it became possible to start developing a cardiac program. The fact that the president was personally involved allowed us to rapidly cut through the usual Central American bureaucratic red tape. The Guatemalan Ministry of Public Health and Social Assistance assigned a young Guatemalan surgeon, Raul Cruz Molina, MD, who trained at Baylor College of Medicine, Houston, TX, to serve as the future head of the cardiac program. Dr. Cruz immediately flew to Charlotte, NC, where he began an 18-month intensive cardiac surgery fellowship at Carolinas Medical Center, then Charlotte Memorial Hospital. His supportive team of cardiologists, anesthesiologist, perfusionists, and intensive care nurses trained at these institutions, as well.

The entire operation began on a shoestring budget. Because Guatemalan health care professionals usually stayed with their hosts, the only training-related cost incurred was airfare. At the same time the training occurred, we were able to procure used and refurbished perfusion equipment and vital-sign monitors. In a year and a half, the Guatemalan team was ready to initiate the program.

**Cardiac surgery comes to Guatemala**

In 1974, with a grant from the Heineman Foundation, I returned with our friends to Guatemala and carefully selected some patients with relatively simple anomalies, such as atrial and ventricular septal defects and pure mitral stenosis, as the first surgical candidates. (The diagnostic studies were conducted in Charlotte.) And then—the great day arrived. The Guatemalans were backed by a full Charlotte-based team of eight. The operations performed at Roosevelt Hospital in Guatemala City went smoothly and the patients came through well. We usually slept after surgery in the spartan recovery room.
The program proceeded in an orderly fashion. Dr. Cruz gradually accepted more and more complex cases. Soon, however, it became evident that the trafficking of patients between Guatemala and Charlotte for diagnostic studies would exhaust our limited financial resources. So, we again called on President Osorio for assistance. From then on, a Guatemalan Air Force transport plane carried 35 to 40 patients in need of diagnostic work to the Charlotte-Douglas International Airport. Patients requiring heart catheterization underwent the procedure around the clock. It was a most welcome event that Federico Alfaro, MD—now a renowned cardiologist practicing in Guatemala and then a resident at Baylor Houston, TX—heard of the project and arrived unexpectedly in Charlotte at midnight one day in March of 1978 and joined our efforts.

After diagnosis, patients were flown back to Guatemala, where those who needed surgery were operated on by Dr. Cruz and his crew, actively supported by the Charlotte team. These efforts started to evolve, and in 1976, under the leadership of Dr. Cruz, the cardiac program was officially established at the Roosevelt Hospital, the largest health care institution in Guatemala. The Carolinas Medical Center team continued to play a supportive role; however, within a year, their numbers decreased from eight to three, then to a single surgeon, and finally to none. By and large, the Guatemalans were on their own in the operating room.

**UNICAR: An ongoing success story**

Over the course of the next three decades, the Guatemalan cardiac program at Roosevelt grew from a service of a half-dozen beds to a modern department of cardiac surgery. The program not only performed an important clinical task, it also served as the nucleus of training for Guatemalan cardiac surgeons. An especially important year in Guatemalan cardiac surgery was 1989—the opening of UNICAR, the Guatemalan Heart Institute, in a dedicated building on the Roosevelt Hospital campus.

Incorporated as UNICAR, the Guatemalan cardiology and cardiac surgery program now serves not only Guatemala, but receives patients from neighboring Honduras, Belize, and Nicaragua. With its home-trained staff supplemented with noted cardiac surgeons and educators, specifically Rafael Espada, MD, and Aldo Castaneda, MD, FACS, both of Guatemalan origin, the scope of services involves not only complex adult but also neonatal cases, and in 1977 led to the establishment of UNICAR’s internationally recognized department of pediatric surgery.

In 2000 UNICAR, having already received acclaim from around the globe, obtained autonomic status, and in 2013 the number of open heart operations exceeded 800. Both Dr. Cruz and our supportive team were recognized by receiving the highest civilian decoration of the Guatemalan government: The Order of the Quetzal. In addition, I was recently honored with the Rose of Peace from the First Lady of Guatemala, Rosa María Leal de Perez, and Dr. Adrian Coye received the Order of the British Empire for his work with the Belize Heart Program.

In addition, the Carolinas Health Care System formally established the International Medical Outreach Program in 2004. Since my retirement from clinical practice, I have been working with the program full-time. Having access to de-accessioned material from the...
system’s 40 hospitals and engaging their staff in volunteer work rather than just shipping a large amount of hospital equipment and disposable material to different countries in the world, we have delivered to Central America seven heart catheterization laboratories, furnished five intensive care units and a burn institute, built an echocardiographic network connecting 10 rural hospital with UNICAR and the Sanger Heart and Vascular Institute, and established an online consultation between Guatemala, Belize, and Charlotte. We also started and are maintaining cardiology and cardiac surgery programs in Belize. Our immediate plans include furnishing and supporting a network of rural infirmaries and establishing several women’s cancer screening units.

Why UNICAR works
So, what has been the secret of UNICAR’s success? How did UNICAR conquer the difficulties that still plague the cardiac surgical programs of other Central American countries?

The answer is complex. The primary factor was, without question, the dedication and hard work of our Guatemalan colleagues and the support they received from a government committed to its task, despite the country’s ongoing financial difficulties. Did the International Medical Outreach Program also play a role? Undoubtedly. We were at the right place at the right time. I want to emphasize, however, one very important point: We have been surgically active in Central America for a long time, but seldom have we actually operated. We assisted the local surgeons and ensured that their initial results were good. We made certain these surgeons received reliable support from the team and remained available for any need that arose. This approach differs radically from the visiting brigades, where the work is done entirely by the visitors who, after a limited number of procedures, depart and leave very little behind except for ongoing need and a feeling of helplessness. Some lives may be saved, and the visitors have a feeling of satisfaction, but the local health care providers are deprived of the glory of being the “first” to deliver high-level care. They provide no continuity of care and often create resentment or even hostility within the local health care community.

Is the approach of shipping patients to the U.S for surgical care any better? Again, this process may save a few lives, but it does not respond to the needs of a country, and the cost is enormous. The total cost to initiate and maintain UNICAR has been less than the cost of a few heart operations at a U.S. hospital.

Our cooperation and friendship with UNICAR still continues today, including an ongoing exchange of health care and other skilled professionals between Guatemala City and Charlotte. Recently, our engineers assisted in converting UNICAR’s recordkeeping system from manual to digital. We are also helping UNICAR to establish a unique, nationwide referral network of echocardiographic laboratories, a service previously available only in a few private clinics. Tests are performed in echo stations located in 12 rural hospitals by technicians who trained at both UNICAR and in Charlotte. The images are transmitted digitally and read at UNICAR, which then relays the results to the patient’s treating physician. Any images may also be transmitted and problems discussed “live” through a special digital communication “bridge” with the cardiologists and surgeons of UNICAR and Carolinas Medical Center.

Carolinias Medical Center and the Heineman Foundation are proud to be friends with UNICAR, 25 years, 21,768 hemodynamic studies, and 13,047 heart operations later. We look forward to many more successful years.
“How many cases did you do?” This quickly became the most common question I was asked after returning from a month-long surgical rotation in Zimbabwe. As the first resident to embark on a new international surgery elective at Stanford University, Palo Alto, CA, I certainly felt some pressure to compile a good operative case load to prove the value of the rotation to our program. However, once I arrived in Zimbabwe, the lessons I learned simply from practicing in a new and unique environment rapidly became more important than the number of cases logged. The focus that my peers, attending surgeons, and family and friends placed on operative volume seemed to only distract from these lessons.

Valuable experiences
One of the most valuable aspects of training abroad is exposure to new disease processes in a unique patient population. The patient with right lower quadrant pain and fever does not have appendicitis, but rather has perforated typhoid. The cause of the small bowel obstruction is not adhesions from prior surgery, but instead is intra-abdominal tuberculosis. Due to the absence of, or poor adherence to, cancer screening, patients with breast or colon cancer often first present with disease in advanced stages—
a situation to which those of us who trained recently or are in training in the West are typically unaccustomed.

One of the first patients I met at Parirenyatwa Hospital in Harare, Zimbabwe’s capital, was a woman with a large lower extremity wound from a crocodile bite. Inaccessibility of adequate care in this rural area forced the wound to go largely untreated for several weeks. She eventually presented to the only university-affiliated hospital in the country with pseudomonas wound sepsis, which required aggressive debridement, antibiotics, and eventually soft tissue coverage. I witnessed countless cases like this one during my month abroad: The young child who required a scalp skin graft after being bitten by a venomous snake, the untreated epileptic with a large third-degree burn after falling into his cooking fire, and the woman who developed a Marjolin’s ulcer in a chronic burn scar. A significant portion of my experience was learning to manage late complications of burns and traumatic wounds.

The presence of multiple operating rooms (ORs), and a small intensive care unit could make it easy to forget the significant constraints on available resources, but seeing patients who are expected to produce the necessary funds before receiving care was a new experience. You quickly learn a few simple rules—almost everything is reusable, hardly anything is disposable, and nothing is wasted. This is especially true of blood products, which are a scarce commodity.

An anesthesia colleague told me of a striking case involving a patient undergoing a resection of a large neck tumor who had significant intraoperative bleeding. Although cross-matched blood had been prepared preoperatively, the anesthesia team would not administer it until the surgeon had proven he could control the hemorrhage. For similar reasons, trauma patients could only receive blood transfusions if survival was expected. Triage of scarce resources was a new concept for me.

Without access to computed tomography or magnetic resonance imaging, greater reliance on plain radiographs and occasionally sonography is required. Without daily labs available, postoperative management depends on astute history and physical exam skills. Without routine access to advanced endoscopy, surgery is the mainstay treatment for cholelithiasis, bleeding peptic ulcer disease, or gastrointestinal obstruction. Without capabilities for minimally invasive surgery, familiarity with open surgery is required. This type of experience cannot be gained nowadays at large academic medical centers in the U.S., and the lessons learned through this international experience were invaluable.

**Challenges to international training**

Considering all I learned on this rotation, both in the OR and out, I would recommend this experience for other general surgery residents, particularly those who plan to practice in rural areas. In fact, a 2009 survey of general surgery residents in the Resident and Associate Society of the American College of Surgeons (RAS-ACS) indicates that most surgery residents would value this opportunity (n=724). Notably, 92 percent of the respondents said they were interested in an international health elective, and 82 percent stated they would prioritize an international experience over other electives.

Despite this strong interest among trainees, many obstacles have prevented wide adoption of formal international surgical training. Factors such as funding, timing of experience (that is, vacation, research years, or elective time), and identification of supervising surgeons who have received Residency Review Committee
Considering all I learned on this rotation, both in the OR and out, I would recommend this experience for other general surgery residents, particularly those who plan to practice in rural areas.

(RRC) approval are difficult to address. In part because of these challenges, a recent survey of U.S. general surgery residency program directors showed that only 11 percent of programs had formal international health electives, though many had reported informal international opportunities.²

Many of these informal programs consist of short-term missions, whereby U.S. volunteers from surgery, anesthesia, and nursing visit a resource-poor area, bring necessary equipment and supplies, provide basic surgical services, and then return home. In this scenario, the primary objective is philanthropic; resident education is secondary and mainly achieved through operative experience. (This type of experience also more closely mirrors what residents see and learn in the U.S. and not the practices of health care professionals in the local resource-constrained environment.) In fact, a previous survey of general surgery residents (n=52) found that 94 percent believed that the acquisition of technical and clinical skills was what they most expected to gain from participation in an international training program.³ Due to trends in training in the U.S. with regard to work hours, increased supervision, and decreased autonomy, some residents may increasingly feel that international case experiences are an opportunity to augment or replace those training gaps. Importantly, the involvement of trainees in surgical volunteerism in developing countries may raise important ethical issues that are sometimes set aside, such as quality of unsupervised practice and potential displacement of local trainees.⁴

Collaboration breeds opportunities
With these challenges in mind, the department of surgery at Stanford University has developed an international partnership with the University of Zimbabwe College of Health Sciences (UZCHS). U.S. residents complete a one-month general surgical rotation during postgraduate year three, working alongside Zimbabwean residents, interns, and medical students and learning from Zimbabwean faculty. The experience includes elective and emergency surgery, formal inpatient rounds, preoperative conferences, and didactic lectures. It is based primarily at the university-affiliated Parirenyatwa Hospital.

Approval from the Accreditation Council for Graduate Medical Education and the RRC has permitted credit towards American Board of Surgery graduation requirements. The on-site supervising surgeon is Zimbabwean, making this experience one of its kind. The reciprocal agreement includes Stanford faculty providing educational modules as requested by UZCHS and visiting opportunities for Zimbabwean faculty and residents at Stanford.

The Stanford-Zimbabwe rotation has been constructed in a way to maximize the learning opportunities of training in a resource-poor environment halfway across the world. It is designed not only to offer a rich operative experience but also to emphasize a diverse patient population, uncommon disease processes, atypical patient presentations, cultural competency, and the practice of medicine with significant constraints on available resources. Although the operative experience gained while abroad is an important part of the international surgical experience, for me, the lessons learned outside the OR were just as valuable.

It is our hope that the Stanford-UZCHS relationship will serve as a collaborative model that other surgical training programs will choose to follow. This type of international partnership should serve to both enhance the training of U.S. residents and at the same time equip health care professionals in underserved nations to better care for their patients.

REFERENCES
The ACS and its Committee on Trauma recognize the importance of injury prevention in the spectrum of care of the trauma patient. Cycling remains an important means of transportation and recreation; however, the bicycle rider can be at significant risk of serious injury.

The College recognizes the following facts:

- Approximately 800 people die and 500,000 people are injured in the U.S. annually due to bicycle-related injuries. Bicycle crashes are the fourth largest contributor to childhood injury costs and quality-of-life losses and the leading cause of injury in school-age children. Adolescents and adults ages 45 years and older have the highest bicycle death rates.  

- Helmets reduce the risk of head injury by at least 45 percent, brain injury by 33 percent, facial injury by 27 percent, and fatal injury by 29 percent. One study suggests that helmet use may reduce the risk of head injury by 85 percent and severe brain injury by 88 percent.

- Bicycle-related injuries and deaths have decreased in states that have enacted youth bicycle helmet laws.

- Non-legislative educational programs have been proven to increase helmet use by children.

- Helmets can benefit adult riders as well as children. As more helmet laws target youth, the proportion of adults comprising bicycle fatalities has risen.

- Peer and adult companion helmet use is associated with increased bicycle helmet use by children.

In addition to head injuries, significant abdominal wall, solid organ, hollow viscus, as well as major vascular injuries are common after abdominal pelvic handlebar injury.

Therefore, supported by these and other epidemiologic and outcomes data, the ACS supports efforts to promote, enact, and sustain universal bicycle helmet legislation and enforcement.

REFERENCES:


The ACS recognizes that intimate partner violence (IPV) is a major public health problem for intimate partners of both genders, including heterosexual and same-sex partners, with victims frequently needing surgical care.

IPV, also referred to as domestic violence, can be defined as actual or threatened physical, sexual, verbal, or emotional abuse by a current or former partner or spouse.

- IPV among women of child-bearing age is the leading cause of serious injury and the second-leading cause of injury and death. There is no distinction for age, race, culture, status, class, education, or religion. The cumulative lifetime risk of battering for women is estimated to be 24 percent to 54 percent. IPV is associated with 33 percent to 50 percent of female homicides and 25 percent of female suicide attempts. ¹

- IPV abuse victims are at increased risk for developing major depression, post-traumatic stress disorder, and getting involved with drugs and abusing alcohol.²

- The failure to diagnose IPV is the failure to identify a disease process that is likely to recur, possibly with lethal consequences. Routine screening with explicit questioning using the Partner Violence Screen without the partner present is the most effective way to make the diagnosis.³ The three-question Partner Violence Screen can be accessed at: http://www.medicine.uiowa.edu/uploadedFiles/Departments/FamilyMedicine/Content/Research/Research_Projects/partner.pdf.

- It is the responsibility of the treating surgeon not only to care for the immediate injury and to reassure the patient, but also to identify resources in his or her hospital and to help identify resources in the community.⁴,⁵

- Surgeons are encouraged to play a leadership role in their communities, hospitals, and medical schools in initiatives to prevent and treat domestic violence.⁴,⁵

The ACS supports legislation and policies that enhance judicial and law enforcement tools to combat IPV, to improve services for victims of IPV, and to prevent violence, including youth violence and violence against women. ♦
Statement on older adult falls and falls prevention

The following statement was developed by the American College of Surgeons (ACS) Committee on Trauma and was approved by the Board of Regents at its June 6–7 meeting.

The following statement was developed by the ACS Committee on Trauma’s Committee on Injury Prevention and Control to educate surgeons and other medical professionals about the significance of older adult falls and evidence-based prevention activities.

The ACS recognizes the following facts:

• Falls are the leading cause of both fatal and nonfatal injuries for older adults.1

• One out of three older adults falls each year. Of these, fewer than half talk to their health care providers about it.2

• Many people who fall, even if they are not injured, develop a fear of falling, which may cause them to limit activities, leading to reduced mobility, loss of physical fitness, and, in turn, an increased risk of falling.3,4

• A person who has fallen once is two to three times more likely to fall again within a year.5

The ACS supports efforts to promote, enact, and sustain legislation and policies that encourage:

• Older adult care providers to implement comprehensive fall prevention programming including:
  – Developing community partnerships with community-based centers, such as YMCAs, churches, senior centers, and older adult living centers.
  – Incorporating an evidence-based exercise/physical therapy fall prevention program. Helpful information can be found at this and other websites: http://www.cdc.gov/homeandrecreationsafety/Falls/compendium.html.
  – Partnering with home-based visiting programs to complete multi-factorial risk assessments, including: medication review, including the use of opioids; assessment of vision, home safety, and balance and gait; and consideration of vitamin D supplementation.
  – Assessment of the risk/benefit of anticoagulation and anti-platelet therapies in older adult patients.
  – Collaboration with regional and statewide fall prevention coalitions for local networking/resources.

REFERENCES

Physician Payments Sunshine Act data scheduled for release

By September 30, data on payments and other transfers of value made to physicians and teaching hospitals will be available via a searchable federal database. The Physician Payments Sunshine Act (Sunshine Act), also known as Open Payments, was established under the Affordable Care Act and seeks to increase transparency of the financial relationships between the medical industry and health care providers to the public. The Sunshine Act requires applicable manufacturers (AMs) of drugs, medical devices, biologicals, and medical supplies to track payments and other transfers of value to physicians and teaching hospitals and report these payments to the Centers for Medicare & Medicaid Services (CMS) annually. AMs and group purchasing organizations (GPOs) must also report certain ownership interests held by physicians and immediate family members to CMS. Data will be made publicly available in a searchable database by September 30 for this reporting year and by June 30 in subsequent years.

As implementation of the Sunshine Act gains momentum, there are several reporting factors that surgeons need to know about before data become available.

For instance, although the Sunshine Act does not impose any penalties on physicians, registration in the Open Payments system is required for physicians to review and dispute their data. This column discusses the registration process, types of data included in the Open Payments system, the review and dispute process, key dates, and recommendations from the American College of Surgeons (ACS) concerning the Sunshine Act.

Is registration mandatory, and how do I enroll in the Open Payments system?
Physicians are not required to register or send information to the Open Payments system unless they want to review and dispute reports. It is recommended, however, that surgeons participate in this process, so they may dispute and correct information they believe to be inaccurate or incomplete. Physician registration was
conducted in two phases for this first reporting year:

- Phase 1 began June 1 and includes user registration in CMS’ Enterprise Portal.
- Phase 2 began July 14 and includes physician registration in the Open Payments system to complete the registration process and begin reviewing data submitted by industry prior to public posting. Note that registration in the Enterprise Portal is required to register in the Open Payments system.

How will the review/dispute process unfold?
Table 2, this page, provides a summary of the review, dispute, and correction process and timing.

What is included in the reports?
AMs are required to identify reportable payments using one of the categories listed in Table 1, this page.

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### TABLE 1.
**CATEGORIES OF REPORTABLE PAYMENTS**

<table>
<thead>
<tr>
<th>Consulting fees</th>
<th>Grants</th>
<th>Honoraria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gifts</td>
<td>Entertainment</td>
<td>Current or prospective ownership or investment interest</td>
</tr>
<tr>
<td>Travel and lodging</td>
<td>Education</td>
<td>Compensation for serving as faculty or as a speaker for an unaccredited and non-certified continuing education program</td>
</tr>
<tr>
<td>Charitable contributions</td>
<td>Royalty or license</td>
<td>Compensation for serving as faculty or as a speaker for an accredited or certified continuing education program</td>
</tr>
<tr>
<td>Research</td>
<td>Food and beverage</td>
<td>Compensation for services other than consulting, including serving as faculty or as a speaker at an event other than a continuing education program</td>
</tr>
</tbody>
</table>

### TABLE 2.
**REVIEW, DISPUTE, AND CORRECTION PROCESSES**

<table>
<thead>
<tr>
<th>Time period</th>
<th>What happens during review?</th>
<th>What happens during dispute?</th>
<th>What happens during correction?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days 1–45</td>
<td>Physicians review their information before it is made public.</td>
<td>Physicians may dispute information reported about them. Disputes initiated in this 45-day period that go unresolved will be in the public database but shown as “under dispute.” CMS will not mediate any dispute.</td>
<td>AMs and GPOs should work with physicians to correct disputed data. AMs or GPOs must send CMS a revised report to make the appropriate corrections and re-attest to the updated data.</td>
</tr>
<tr>
<td>Days 46–60</td>
<td>AMs and GPOs work to resolve disputes received from physicians. Physicians may continue to review their information.</td>
<td>Physicians may continue to initiate disputes during this period, but resolutions may not be reflected in publicly displayed data. CMS will not mediate any dispute.</td>
<td>AMs and GPOs should work with physicians to correct disputed data. Corrections made to disputes issued in this 15-day window (and resubmitted) may not be in the public database. AMs and GPOs must send CMS a revised report to make the appropriate corrections and re-attest to the updated data.</td>
</tr>
</tbody>
</table>
update corrected data from the current and previous year at least once annually, in addition to the initial publication that followed the data submission. Updates will be included when possible during this period of data refresh.

CMS notes the following:

- Data corrections made by AMs and GPOs may be submitted at any time.
- If the AM or GPO is unable to resolve the dispute with the physician in the initial 45-day or subsequent 15-day period, both parties should continue to seek a resolution.
- In the cases where a dispute cannot be resolved, the latest attested-to data submitted by the AMs or GPOs will be published and marked as disputed.

May I delegate Open Payments access to other users?
Yes, once physicians have registered in both the CMS Enterprise Portal and Open Payments system, they may designate one authorized representative who may review and dispute data on their behalf. Physicians may select one of three access levels for their authorized representative:

- **View only**, which will enable the authorized representative to view only the data that were submitted about the physician
- **Review and dispute**, which will enable the authorized representative to dispute records that were reported relating to that physician
- **Modify profile**, which enables the authorized representative to modify information in a physician’s profile, such as updating their business address or phone number

The representative must register through the CMS Enterprise Portal and Open Payments system as well. The authorized representative will be able to view a physician’s first and last name, business address, business telephone number and e-mail address, National Provider Identifier, and state license numbers. The authorized representative will not have access to physician user IDs or passwords and will be unable to modify or reset them.4

What are key dates to keep in mind?
- June 1, 2014: Phase 1 of physician registration in CMS’ Enterprise Portal began. Physicians may register at any time.
ADDITIONAL RESOURCES OF INFORMATION ON OPEN PAYMENTS


To track reportable payment transfers on your smartphone, download a free app via:


REFERENCES


What does the ACS recommend surgeons do with respect to this statute?

The College recommends that surgeons take the following actions:

- Become familiar with the information that will be reported about physicians
- Keep records of all payments and other transfers of value received from AMs and GPOs
- Register with CMS and subscribe to the listserv to receive updates on the Open Payments program
- Register in CMS’ Enterprise Portal and Open Payments system to review information AMs and GPOs submitted on physicians’ behalf
- Work with AMs and GPOs to make sure the information submitted about physicians is correct
- Keep track of payments and transfers of value made to physicians and be mindful of ownership and investment interests held by both physicians and their immediate families

July 14, 2014: Phase 2 of physician registration in the Open Payments system began. Physicians had 45 days immediately following this date to review and correct data and have it reflected in the September 30, 2014, public database.

September 30, 2014: Data from 2013 will be released on a searchable public database.

June 30, 2015, and beyond: Data from the previous year will be released on a searchable public database.
All of the image-guided biopsy codes, 19081–19086, specify that the biopsy is inclusive of the placement of breast localization devices, including clips and metallic pellet when performed, and imaging of the biopsy specimen, when performed.

Coding for surgical services can be complicated due to the numerous rules, guidelines, and exceptions—all of which the Centers for Medicare & Medicaid Services frequently updates and revises. Consequently, the American College of Surgeons (ACS) General Surgery Coding and Reimbursement Committee (GSCRC) often receives questions about coding, particularly for breast surgery. This column responds to some frequently asked coding questions related to breast cancer operations, sentinel node biopsy, ultrasound-guided core biopsies, excision with wires, intraoperative assessment of margins, and more.

Why are there two separate codes to report for breast cancer operations with sentinel node biopsy and one unified code for mastectomy or lumpectomy with axillary node dissection?

The breast surgery Current Procedural Terminology (CPT) codes were developed when axillary dissection was standard therapy for breast cancer. Modified radical mastectomy is coded 19307; lumpectomy with axillary dissection is coded 19302. When sentinel lymph node biopsy was developed, the code needed to be applied to both breast and melanoma procedures. Code 38900 is an add-on code to be used with any lymph node biopsy or lymphadenectomy code.
to indicate the intraoperative work done to identify the sentinel lymph nodes. Therefore, lumpectomy with sentinel node biopsy is billed using codes 19301, 38525-51, and 38900. Total mastectomy with sentinel node biopsy uses codes 19303, 38525-51, and 38900.

When a total mastectomy with sentinel node biopsy is performed, I obtain a frozen section of the nodes and proceed to dissect the axilla if positive. Can I use multiple codes for this procedure? This is a modified radical mastectomy (19307) with sentinel node mapping procedure (38900). The axillary node biopsy cannot be reported separately from the axillary dissection.

Can I code for injection of radioactive tracer and blue dye for sentinel lymph node biopsy? If you preoperatively inject radioactive tracer, report 38792. Injection of blue dye, when performed, is included in the sentinel node code, 38900.

I perform ultrasound-guided core biopsies but do not leave localization devices in the biopsy location. Should I use codes 19083 and 19084? Yes. All of the image-guided biopsy codes, 19081–19086, specify that the biopsy is inclusive of the placement of breast localization devices, including clips and metallic pellet when performed, and imaging of the biopsy specimen, when performed. In other words, you cannot report separately for clip placement or specimen imaging, but that the code is appropriate for the biopsy regardless of whether clip placement or specimen imaging are included.

Do you code differently for excision with multiple wires for localization than with one wire? The new image-guided localization codes are per lesion, not per wire. Multiple wires may be placed to identify any lesion. An excision may only be reported once through a single incision, regardless of the number of wires used for the localization.

How do you code re-excision of a lumpectomy cavity when you must return for positive margins on final pathology a week after a lumpectomy? Use code 19301-58 for lumpectomy with modifier for “staged/related procedure in the postoperative period.” Indicate in the operative report that this procedure is a planned return to the operating room for a more extensive work.

Could I code for the X ray of the operative specimen with CPT code 76098? For all image-guided breast excisions, the radiographic evaluation of the specimen is bundled into the localization procedure, and should not be coded separately.

How would I code for intraoperative assessment of margins, for instance, with radiofrequency spectroscopy? There is no specific CPT code for reporting intraoperative assessment of margins by
For all image-guided breast excisions, the radiographic evaluation of the specimen is bundled into the localization procedure, and should not be coded separately.

any particular method, such as preparing touch-prep or frozen specimens, which are considered integral to the work of a lumpectomy for malignancy (CPT code 19301). Intraoperative guidance with ultrasound imaging for assessment of margins can be reported (CPT code 76998) only if permanent images are obtained and saved, and an ultrasound report is entered into the medical record.

How should I code for nipple-sparing mastectomy and skin-sparing mastectomy to distinguish them from total mastectomy?
All of these procedures are classified mastectomy for cancer and should all be coded with 19303. No special distinctions are made for the type of incision. The operative report should use the wording “total nipple-sparing” or “total skin-sparing” mastectomy to avoid confusion with a subcutaneous mastectomy.

How do you code for intraoperative radiation or placement of the different devices for brachytherapy?
At present, no code has been designated for intraoperative radiation treatment of the breast. Codes for placement of brachytherapy catheters are available and can be used regardless of the brand (Mammosite, SAVI, Contura, and so on). These codes are 19296 for delayed insertion and 19297 for immediate insertion at the time of lumpectomy.

How do you code for ablation of breast lesions with cryotherapy, microwave, RFA, or laser?
The Food and Drug Administration (FDA) has not approved ablation of breast lesions with cryotherapy, microwave, or radiofrequency ablation (RFA), or laser for treatment of breast cancer. The CPT code for cryotherapy of fibroadenomas is 19105. The FDA has also approved laser ablation of fibroadenomas, but a CPT code has yet to be established. RFA and high-frequency microwave ablation are considered investigational.

If you have questions or comments regarding this column, contact Sarah Kurusz, ACS Practice Affairs Associate, at skurusz@facs.org or 202-672-1505. If you have additional coding questions, contact the ACS Coding Hotline at 800-227-7911 between 8:00 am and 5:00 pm, CST, excluding holidays.

Editor’s note
Accurate coding is the responsibility of the provider. This summary is only a resource to assist in the billing process.
Treating metastatic prostate cancer now and in the future

The public focus on prostate cancer has largely shifted from metastatic disease to low-risk, localized disease with controversy surrounding the routine use of prostate-specific antigen (PSA) for screening. Although the prostate cancer screening debate has highlighted important issues for men’s health and cancer screening efforts, the fact remains that prostate cancer is not only the most common malignancy among men in the U.S., but is expected to cause 29,480 deaths in 2014.1 Thus, many cases of prostate cancer progress, and the management of more advanced and metastatic disease is of continued importance.

Previous advances in prostate treatment

The use of methods to manipulate the hormonal axis in the treatment of prostate cancer dates back more than 70 years ago, when researchers found that metastatic disease responded to surgical castration, thereby demonstrating that the prostate is dependent on androgens.2 Androgen deprivation therapy (ADT) has been the primary form of treatment in men with metastatic prostate cancer and has been accomplished by either orchiectomy or by reducing testosterone synthesis through central blockage of luteinizing hormone release from the pituitary gland using luteinizing hormone releasing hormone (LHRH) agonists or antagonists. In addition, medications that block the androgen receptors, so-called antiandrogens, were discovered in the 1960s and have been used in conjunction with medications that lower the levels of testosterone.

Significant advances in the treatment of men with metastatic prostate cancer have occurred in the last decade through drug development and clinical trials (see table, page 56.) Despite the use of ADT, disease progression and emergence of castration-resistant prostate cancer (CRPC) can occur over time. Options for CRPC had been limited and were generally palliative, until docetaxel, a microtubule inhibitor, was approved in 2004 for men with metastatic CRPC based on two trials demonstrating a survival benefit.3,4 Since then, multiple phase III trials have been conducted, adding a variety of agents to docetaxel with disappointing results (for example, bevacizumab in cancer and leukemia group [CALGB] 90401).5 In 2010, the U.S. Food and Drug Administration approved two additional agents. The first was sipuleucel-T, an autologous active cellular immunotherapy, which reduced the risk of death by 22 percent in men with asymptomatic or minimally symptomatic metastatic CRPC.6 The second was cabazitaxel, a docetaxel derivative, which demonstrated a survival benefit in men who had progression after prior docetaxel.7

In 2011, abiraterone was approved in the post-chemotherapy setting.8 This drug, an inhibitor of the enzyme CYP17A1, further reduces testosterone levels by affecting synthesis of the precursors dehydroepiandrosterone and androstenedione within all tissues, particularly the adrenal glands, which continue to produce low levels of testosterone despite orchiectomy or LHRH inhibition. A subsequent trial has demonstrated improved radiographic progression-free survival and a trend toward improved overall survival, even in patients who had not received prior chemotherapy.9 As mentioned earlier, blockage of the androgen receptor has been possible for many decades, but used alone, it was not highly effective for CRPC. Enzalutamide was discovered and found to be a
**CRITICAL TRIALS IN METASTATIC CASTRATION-RESISTANT PROSTATE CANCER**

<table>
<thead>
<tr>
<th>Agent</th>
<th>Clinical setting</th>
<th>Mechanism of action</th>
<th>Comparator</th>
<th>N</th>
<th>HR</th>
<th>Survival (months)</th>
<th>FDA approval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Docetaxel2</td>
<td>+/- symptoms</td>
<td>Microtubule inhibitor</td>
<td>Mitoxantrone</td>
<td>1,006</td>
<td>0.76</td>
<td>19.2 v 16.3*</td>
<td>2004</td>
</tr>
<tr>
<td>Docetaxel+ estramustine3</td>
<td>+/- symptoms</td>
<td>Microtubule inhibitor</td>
<td>Mitoxantrone</td>
<td>770</td>
<td>0.80</td>
<td>17.5 v 15.6</td>
<td>2004</td>
</tr>
<tr>
<td>Sipuleucel T5</td>
<td>– or minimal symptoms</td>
<td>Immunotherapy</td>
<td>Placebo</td>
<td>512</td>
<td>0.78</td>
<td>25.8 v 21.7</td>
<td>2010</td>
</tr>
<tr>
<td>Cabazitaxel6</td>
<td>Post-docetaxel</td>
<td>Microtubule inhibitor</td>
<td>Mitoxantrone</td>
<td>755</td>
<td>0.70</td>
<td>15.1 v 12.7</td>
<td>2010</td>
</tr>
<tr>
<td>Abiraterone7</td>
<td>Post-docetaxel</td>
<td>CYP17A1 inhibitor (adrenal androgens)</td>
<td>Placebo</td>
<td>1,195</td>
<td>0.65</td>
<td>14.8 v 10.9</td>
<td>2011</td>
</tr>
<tr>
<td>Abiraterone8</td>
<td>Pre-docetaxel most asymptomatic</td>
<td>CYP17A1 inhibitor (adrenal androgens)</td>
<td>Placebo</td>
<td>1,088</td>
<td>0.75</td>
<td>rPFS 35.3 v 30.1 (ns)</td>
<td>2012</td>
</tr>
<tr>
<td>Enzalutamide9</td>
<td>Asymptomatic post-docetaxel</td>
<td>Antiandrogen</td>
<td>Placebo</td>
<td>1,199</td>
<td>0.63</td>
<td>18.4 v 13.6</td>
<td>2012</td>
</tr>
<tr>
<td>Radium-22315</td>
<td>Bone but no visceral metastases</td>
<td>Alpha emitter</td>
<td>Placebo</td>
<td>921</td>
<td>0.70</td>
<td>14.9 v 11.3</td>
<td>2013</td>
</tr>
<tr>
<td>Enzalutamide9</td>
<td>Asymptomatic pre-chemotherapy</td>
<td>Antiandrogen</td>
<td>Placebo</td>
<td>1,717</td>
<td>0.71</td>
<td>32.4 v 30.2</td>
<td>Pending</td>
</tr>
</tbody>
</table>

HR=hazard ratio of death; rPFS=radiographic progression-free survival; ns=not statistically significant; NR=not reported


more potent antiandrogen by having a higher affinity for the androgen reception, preventing receptor translocation to the nucleus, and preventing receptor binding to DNA and co-activator proteins. Phase III trials have demonstrated the efficacy of enzalutamide in men with metastatic CRPC both before and after chemotherapy.10,11

**New Alliance trial**

Given the availability of multiple new agents for metastatic CRPC and the different mechanisms of action, current studies are exploring the optimal timing, sequence, and combination of these drugs. The Alliance A031201 is a prospective randomized trial comparing enzalutamide alone versus enzalutamide and abiraterone in men with metastatic CRPC who have not received docetaxel chemotherapy. The primary endpoint is overall survival, with secondary endpoints including PSA response, radiographic progression-free survival, and toxicity of combined therapy; target accrual is 1,224 men.

Consideration of bone health is particularly important in men with metastatic CRPC, given the propensity of metastases to the bone as well as the adverse long-term impact of ADT on bone mineral density. ADT-induced osteoporosis increases the risk of fracture more than five-fold per year, which is associated with significant risk of morbidity and mortality. The use of the bisphosphonate zoledronic acid decreases the risk of skeletal-related events (SREs) and is indicated in men with CRPC and bone metastases, as well as in men with osteoporosis receiving ADT.12 It has been hypothesized that the administration of zoledronic acid earlier in the course of disease, used to modulate the bone microenvironment, may be advantageous. CALGB 90202 addressed this question by giving zoledronic acid to men with castration sensitive prostate cancer and bone metastases. The randomized, placebo-controlled trial accrued 645 patients and did not observe a difference in time to first SRE nor overall survival.13 The recently reported Zometa European Study also did not report an advantage of earlier administration of zoledronic acid in men with high-risk localized prostate cancer, with the rate of developing bone metastases at 4.8 years of 14.7 percent and 13.2 percent in the treatment and control groups, respectively.14
Given the availability of multiple new agents for metastatic CRPC and the different mechanisms of action, current studies are exploring the optimal timing, sequence, and combination of these drugs.

In another advancement in treatment options, denosumab—a human monoclonal antibody that binds and inhibits RANK ligand—has proven superior to zoledronic acid with respect to prevention of SREs. In addition, compared with placebo, denosumab delayed the time to first bone metastasis but did not improve overall survival in men with non-metastatic CRPC. The most recently approved drug for CRPC with bone-only metastasis is radium-223. The alpha-particle emitting drug improved overall survival, as well as time to first SRE, time to increase in alkaline phosphatase, and time to increased PSA.

The past decade has seen a paradigm shift in the treatment of men with advanced prostate cancer. The numerous available, approved agents are the result of improved understanding of disease biology, investment in basic research and identification of rational therapeutic targets, collaboration with industry, and design and completion of well-designed clinical trials. It is anticipated that continued efforts in these areas will translate into novel agents and optimization of drug sequencing and combination, leading to improvements in the modest absolute survival currently observed.

REFERENCES

Two lines from Peter Allen’s memorable song, “Everything Old Is New Again,” are:

Don’t throw the past away
You might need it
some rainy day*

History is being resurrected at the American College of Surgeons (ACS) as we embrace the notion that “the past is prologue.” In the College’s centennial year, 2012–2013, a steering committee was formed to help maintain and promote surgery’s rich history. This committee hosted an organizational meeting at the 2013 Clinical Congress in Washington, DC. An open invitation was extended to those attendees with an interest in forming a new program of the ACS centered on American surgical history, with a focus on the rich, meaningful, and colorful history of our College. A large group gathered for a 6:30 am breakfast on October 8. That meeting resulted in the formation of the ACS Surgical History Group (ACSSHG).

At that founding meeting, we defined the group’s mission, developed a position statement, identified the group’s purpose, and reviewed an enumeration of the College’s historical assets and a listing of some potential opportunities for action, for both the short and the long term. The College’s leadership has been most supportive of this new group and its charge to organize, promote, sustain, and expand the appreciation, presentation, preservation, and study of American surgical history and to stimulate and facilitate research and other scholarly activities on this subject. Furthermore, we agree that the surgical curriculum could be bolstered and enhanced by appropriate inclusion of pertinent surgical history at all levels of education and training. On March 17, 2014, a subset of the Steering Committee met at the Hilton Chicago O’Hare Airport, IL, to brainstorm and add focus to the group’s ideas for action.

As the ACSSHG has evolved, a flurry of activity has ensued. Adam Carey has been recruited to serve as the College’s Archivist, and several committees have been appointed and are in the early stages of functionality (see sidebar, page 59).

Our goal is to establish a sustainable, ongoing ACS program to keep surgical history at the forefront, to bring our Archives to life, to better use and expand our assets, to enhance the visibility of the College’s historical material, and to establish mutually beneficial relationships/collaborations with other organizations currently active in surgical and medical history. Opportunities and interest abound in this arena.

Clinical Congress programs
The 2014 Clinical Congress will include an array of programming that is specifically geared toward surgical history devotees. The ACSSHG is sponsoring a Panel Session titled Factors Shaping Surgery in the 20th Century, 2:30–4:00 pm, Tuesday, October 28, at the Moscone Center in San Francisco, CA. Following is the agenda for the session, moderated by LaMar S. McGinnis, Jr., MD, FACS, and Norman M. Rich, MD, FACS:

• The Education and Training of a Surgeon: John Cameron, MD, FACS

• Professional Organizations and Their Impact upon American Surgery: David L. Nahrwold, MD, FACS

• What Surgeons Learn from Wars: Basil A. Pruitt, Jr., MD, FACS, FCCM, MCCM
Our goal is to establish a sustainable, ongoing ACS program to keep surgical history at the forefront, to bring our Archives to life, to better use and expand our assets, to enhance the visibility of the College’s historical material, and to establish mutually beneficial relationships/collaborations with other organizations currently active in surgical and medical history.

• A Fruitful Partnership—Surgeons and Technology: Mark Talamini, MD, FACS

In addition, a one-hour session on Monday, October 27, is aimed at increasing awareness of surgical history among medical students. This presentation, part of the Medical Student Program—Session II, will be moderated by Leo A. Gordon, MD, FACS, Los Angeles, CA, and Justin Barr, a medical student at the University of Virginia, Charlottesville.

On Tuesday, October 28, 7:00–8:00 am, another open continental breakfast meeting will convene at the Moscone Center. Craig Miller, MD, FACS, will discuss his recently published book, The Big Z: The Life of Robert Zollinger, which will be released at the conference. ACS Second Vice-President-Elect Kenneth L. Mattox, MD, FACS, along with Tyler Hughes, MD, FACS, will discuss the newly evolving surgical history community coming to the new ACS website.

The Charles G. Drake History of Surgery Lecture: Symbiotics and Serendipity in Aortic Trauma Management, which Dr. Mattox will deliver, 2:30–3:30 pm, Monday, October 27, also should be of great interest to surgical history aficionados. A Clinical Congress Video-based Education Session, Heroes in Surgery: Our Legacy, will be co-moderated by William O. Richards, MD, FACS, and Steven D. Schwaitzberg, MD, FACS. The presentation will take place on Tuesday, October 28, 9:45–11:15 am. Also on Tuesday, 9:45–10:45, Dr. Rich will present the Excelsior/Churchill Lecture, titled Military Surgeons and Surgeons in the Military.

The ACSSHG has further proposed a Panel Session for presentation at the 2015 Clinical Congress, which would adhere to this year’s theme of Factors Shaping Surgery in the 20th Century. Dr. Pruitt and William Barlow Inabnet III, MD, FACS, would co-moderate. Topics for discussion at this session include:

• Infection control
• The pump and the pipes
• Transplantation (new and used parts)
• Clinical judgment and imaging

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William Barlow Inabnet III, MD, FACS
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SEPT 2014 BULLETIN American College of Surgeons
There is considerable interest in this revitalized history-related activity within our College’s surgical community, and even beyond. You are invited to join and participate in our listserv/surgical community at surgical-history-club@yahoo.com. Share news, information, announcements, and so on, related to our mutual interests. Also, we suggest that you make the ACSSHG aware of your interests and special, related talents so that we may put those abilities to good use.

George Santayana, philosopher and writer, said it best: “Those who cannot remember the past are condemned to repeat it.”‡ And as author Ronald Wright has proclaimed, “Each time history repeats itself, the price goes up.”

More for surgical history buffs

The following activities and programs may be of interest to surgeons who would like to learn more about surgical history and tradition:

• Our history listserv began morphing into a surgical history community this summer as part of the ACS website overhaul described in the article on page 12. This new resource will greatly facilitate our ability to access our history community anytime, anywhere, on any communication device, thereby enhancing interaction, participation, and engagement. Dr. Mattox has agreed to be the Editor.

• Surgical and medical history buffs may be interested in watching a new drama series, The Knick, which premiered August 8 on Cinemax. The series, which airs at 8:00 pm Eastern, is set in a fictional New York, NY, hospital in 1900. Stanley Burns, MD, FACS, is the scientific/technical adviser for this program, and Academy Award winner Steven Soderbergh is the director.

• On July 22, 2014, the ACS; The Joint Commission; the American Society for Shoulder and Elbow Surgery; Massachusetts General Hospital, Boston; the American Hospital Association; and the ACS West Virginia Chapter dedicated a beautiful headstone at the previously unmarked gravesite of Ernest Amory Codman, MD, FACS, a founder of the College and the originator of outcomes studies with his "end result idea." (See this month’s “Looking forward” column, page 8, for more details.)

• ACSSHG member James G. Chandler, MD, FACS, discovered a website that will be of interest and utility for our group: History of Health Sciences World Wide Web Links, which is available at http://www.mla-hhss.org/histlink.htm.

• The College’s footprint is extending at the Chicago, IL, headquarters building, as we rent out less space to other businesses, and use the room to promote College initiatives.

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Dr. Hoyt has indicated that this may be an opportunity to better display historical exhibits. Our Washington, DC, office building may also be included in this endeavor. An interactive digital display of our archival/history collection may also be considered. In this regard, the ACSSHG will be reviewing and updating our ACS history acquisition policy.

Come join us

There is considerable interest in this revitalized history-related activity within our College’s surgical community, and even beyond. You are invited to join and participate in our listserv/surgical community at surgical-history-club@yahoo.com. Share news, information, announcements, and so on, related to our mutual interests. Also, we suggest that you make the ACSSHG aware of your interests and special, related talents so that we may put those abilities to good use.

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A LOOK AT THE JOINT COMMISSION

JCI can be a resource for patients receiving care abroad

An estimated 750,000 U.S. residents travel abroad each year to receive medical care.* This multibillion-dollar business known as “medical tourism” continues to grow annually, particularly among patients seeking cosmetic, dental, cardiothoracic, and orthopaedic procedures, according to the Centers for Disease Control and Prevention (CDC).†

Surgeons and primary care physicians should encourage patients who are considering undergoing a procedure outside of the U.S. to learn as much as possible about a prospective foreign health care institution, warn them of the potential risks of medical tourism, and make sure they receive proper follow-up care when they return home.

U.S.-based health care providers can look to The Joint Commission’s affiliate, Joint Commission International (JCI), as a resource for their patients considering medical tourism. JCI is the leader in international health care accreditation, and its rigorous accreditation process evaluates organizations for compliance with scientifically based standards that focus on quality improvement and safe patient care, similar to the processes used in the U.S. for Joint Commission accreditation.

Risks of medical tourism
Although the direct impact of medical tourism on U.S.-based physicians is minimal, its potential risks may be serious for patients, including the following identified by the CDC*:

• Communication barriers:
   Communication barriers may occur when patients do not fluently speak the primary language of the country where the medical procedure is taking place, which may result in misunderstandings regarding their care. JCI-accredited health care institutions must ensure that patient education and follow-up instructions are presented in a form and language that the patient understands.

• Different standards of care:
   Different standards of care may exist abroad. For example, blood donor selection and collection may vary. JCI standards address quality-control measures for blood banks and transfusion services and require that organizations adhere to

U.S.-based health care providers can look to The Joint Commission’s affiliate, Joint Commission International (JCI), as a resource for their patients considering medical tourism.

Applicable laws, regulations, and recognized standards of practice. JCI standards require a qualified individual to oversee the services and processes for blood donor selection and collection, storage, compatibility testing, and distribution. In addition, clinical guidelines and procedures must be implemented for the handling, use, and administration of blood and blood products.

**Counterfeit or poor-quality medication:** Counterfeit or poor-quality medications may be more common outside the U.S. JCI standards address the management and safety of medication, including specific requirements for storage and establishment of a medication recall system. The standards also require facilities to identify and evaluate potential supply chain risks for critical supplies, including medication, to prevent contaminated or counterfeit products from reaching patients.

**Complications when returning home:** Flying home after undergoing a medical procedure can increase the risk of blood clots and other complications in the recovery period. Providers at JCI-accredited organizations must use relevant criteria or indications when assessing a patient’s readiness for discharge and transportation needs. Follow-up instructions must include information about when to obtain urgent care.

Ideally, medical tourists should receive a copy of their medical record and test results from their foreign health care provider; at a minimum, they should be provided with a copy of their discharge summary. JCI standards require organizations to provide a discharge summary to the health care practitioner responsible for the patient’s continuing or follow-up care. If the health care professional is unknown, the discharge summary should be given directly to the patient and include specific information, such as diagnoses, significant findings, procedures performed, medications administered during hospitalization or treatment, medications to be taken after discharge, and follow-up instructions.

Medical tourism has associated risks, but JCI accreditation is one way U.S. patients and providers can evaluate a potential health care institution located abroad. To date, the JCI has awarded accreditation to more than 600 health care facilities in 60 countries.‡

A resource for patients considering medical tourism outside the U.S., and for all Americans traveling internationally, is JCI’s consumer website, www.worldhospitalsearch.org. JCI-accredited organizations may be searched by country or specialty. The website also includes information on being an informed patient, immunizations and vaccines, staying healthy when traveling abroad, useful international health care-related terms and symbols, and country health profiles.

For more information on JCI, go to www.jointcommissioninternational.org. ♦

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Don’t chance it: Use your seatbelt

by Richard J. Fantus, MD, FACS

In 1948, G. Q. Chance, a 20th-century English radiologist, described three cases involving a rare fracture in the thoracolumbar spine that now bears his name.* These Chance fractures resulted from extreme flexion, causing a “horizontal splitting of the spine and neural arch, ending in an upward curve which usually reached the upper surface of the body just in front of the neural foramen.”† With the introduction of automobile lap-type seat belts in the 1950s and their increased use by the 1960s, there was an upsurge in frequency of these fractures that resulted from the jackknife-like restraint forces applied to the spine during a collision, especially when the belts were improperly worn.

Lap belts and Chance fractures
A typical hyperflexion fracture of the thoracolumbar spine results from forces on the anterior half of the vertebral body and would normally result in a wedge or compression fracture, most commonly in the 12th thoracic vertebra or the first lumbar vertebra. Wearing a lap belt shifts the fulcrum of the forces from the anterior portion of the vertebral body far forward to the area where the lap belt actually contacts the anterior abdominal wall. The spine is now posterior to this flexion axis, and the entire spine then becomes subject to these stress forces. This can result in posterior ligamentous injury or posterior element fracture with or without vertebral body fracture.‡ These transverse fractures are more commonly found in the first, second, or third lumbar vertebrae. Chance fractures can also result from falls or injuries where the patient was thrown forward, and the anterior abdominal wall came in contact with some fixed object (tree limb, bannister, fence railing, ledge, and so on) that acted as a fulcrum resulting in forces that put the torso into acute flexion.

To examine the occurrence of motor vehicle-related injuries that would include Chance fractures in the National Trauma Data Bank® (NTDB®) research dataset for 2013, admissions medical records were searched using the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnoses codes. Specifically


The NTDB Annual Report 2013 is available on the ACS website as a PDF file and as a PowerPoint presentation at www.ntdb.org.
In addition, information regarding how to obtain NTDB data for more detailed study is available on the website.
searched were records for motor vehicle passengers containing an external cause of injury code (E-code) E810–E816 (motor vehicle traffic crashes) with a post decimal value of 0.1 for passenger, or E819 (motor vehicle crash unspecified) with a post decimal value of 0.1 for passenger and either a diagnosis code of 805.4 (lumbar fracture closed) or 806.4 (lumbar fracture closed with spinal cord injury). These records were then searched for a protective device field choice = 2 (lap belt). A total of 1,923 records were found, 1,821 of which contained a discharge status, including 1,187 patients discharged to home, 334 to acute care/rehab, and 229 to skilled nursing facilities; 71 died. These patients were 66 percent female, on average 23.8 years of age, had an average hospital length of stay of 10.4 days, an intensive care unit length of stay of 8.8 days, an average injury severity score of 11.4, and were on the ventilator for an average of 10.8 days.

Of the 1,020 tested for alcohol more than one-fifth (219) were positive. (See figure, this page.) Even though seat belt use is legislated at the state level, on January 1, 1968, Title 49 of the U.S. Code, Chapter 208, Motor Vehicle Safety Standard, took effect, requiring all vehicles (except buses) to be fitted with seat belts in all designated seating positions.‡ Subsequently, the law has been modified to include three-point restraints in outboard seating positions, and finally three-point restraints in all seating positions. With the overwhelming majority of seat belts in use being three-point restraints, the risk of a hyperflexion lap-belt type injury is greatly reduced. Seat belts save lives. Don’t chance it; buckle up. Throughout the year, we will be highlighting these data through brief reports in the Bulletin. The National Trauma Data Bank 2013 Annual Report is available on the ACS website as a PDF file at www.ntdb.org. In addition, information about how to obtain NTDB data for more detailed study is available on the website. To learn more about submitting your trauma center’s data, contact Melanie L. Neal, Manager, NTDB, at mneal@facs.org.

Acknowledgment
Statistical support for this article has been provided by Crystal Caden-Price, Data Analyst, and Alice Rollins, NTDB Coordinator.

Dear sir or madam,

I read with interest the Resident and Associate Society essays on surgical complications in the January Bulletin. The challenge for surgeons at all levels is to analyze the complication in such a manner that sustained lessons emerge from that analysis.

The traditional surgical morbidity and mortality conference addresses this challenge. Unfortunately, the traditional conference has several failings. The greatest failing is that, despite the preparation, presentation, and discussion of complications, there is no reliable method of collating and distributing all of the error- and complication-reducing points raised in a moderated discussion. The great lessons of surgery die at the exit door.

Changes to this conference are needed and are needed now. The moderator of the morbidity and mortality conference should have the responsibility of selecting cases, preparing the resident staff for the presentation of those cases, moderating the often spirited discussions, and then summarizing those discussions. E-mail distribution should follow, along with quarterly testing for the resident and attending staff. If such changes are implemented, an ongoing, constantly renewed patient safety curriculum would emerge, rather than an isolated weekly meeting.


Organized surgery has opened up to dramatic cultural change but still clings to an outmoded teaching methodology. The ultimate goal of discussing complications is to prevent them. Surgical residents need a teaching methodology that ensures that this goal is being met.

As a first step toward updating the morbidity and mortality conference, its name should be changed. Call it the Matrix Conference—The Department of Surgery’s Patient Safety Curriculum. The Matrix concept is designed to ensure that the surgical community is making progress in improving patient safety by preventing the same mistakes from happening over and over again.

Full disclosure: I have discussed this concept at all levels of American surgery, written essays and books about it to the point that I am now crusading for a change. The job of transforming the traditional conference to a valuable teaching tool falls to the authors of these perceptive essays. They are the future of surgery.

It has recently been reported that 24 percent of graduating surgical residents fail to recognize the early signs of a surgical complication.* This indicates a pressing and immediate need to change the conference that analyzes complications.

The time has come for surgical teaching to move on from unstructured tribal lore passed down orally in an entertaining but ineffective venue, to a more reliable curriculum that uses all available technology.

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To whom it may concern,

Dear sir or madam,

This change will assure the public that every resident knows what every surgeon needs to know to minimize mistakes and prevent complications.

These essays show that ACS-affiliated residents care enough to analyze the impact of a complication. Converting the traditional morbidity and mortality conference to a Matrix conference offers these residents and all surgeons a method of lifelong learning from surgical complications.

Leo A. Gordon, MD, FACS
Los Angeles, CA

Google Glass implications
I read with interest Tony Peregrin’s “Surgeons see future applications for Google Glass” in the July Bulletin. Briefly, the article is an anthology of surgical promoters’ favorable experience with Google Glass in the operating room. The article also points readers to an important legal issue associated with Google Glass: The need for compliance with the Health Insurance Portability and Accountability Act.

Unfortunately, the article does not address a much larger legal issue. It is very likely that the courts will hold that the intraoperative video recordings created by Google Glass are medical records. As a medical record, Google Glass video recordings will have to comply with a number of statutes, including those governing the maintenance of a medical record. Thus, surgeons who use Google Glass in the operating room should be prepared to store the video for at least six years. See 45 CFR 164.316(b)(2). Moreover, while the Google Glass video is in storage, it is potentially discoverable, should there be subsequent litigation.

While I am not a Luddite or a technophobe, I do think the American College of Surgeons should warn the early adopters of Google Glass of the potential legal liability associated with the creation of a medical record.

Thomas R. McLean, MD, JD, FACS, ESQ
Shawnee, KS

Sunshine Act
I am writing regarding the article “Preparing for implementation of the Physician Payments Sunshine Act,” which was published in the March Bulletin. I fully agree with the Affordable Care Act’s intent in developing these provisions: To increase transparency in the financial relationships between physician and special interest groups (drug and medical device manufacturers). This transparency allows patients to make more informed decisions regarding their care.

I would hope that the American College of Surgeons would be the leader in suggesting that Congress and state legislators impose their own “Sunshine Act” upon themselves. I’m sure members of Congress and state legislators are bestowed with large financial contributions and other valuable items for themselves and their families by special interest groups.

I would be deeply offended if members of Congress and state legislators believe they are above increased transparency and we, as one of the noblest professions, are not. I hope that the College would ask that our representatives’ feet should be held to the same fire that they ask of us.

Scott C. Thornton, MD, FACS, FASCRS
Fairfield, CT

Disciplinary actions
The Bulletin occasionally posts disciplinary actions taken against Fellows of the American College of Surgeons. While publication of this information may be necessary to demonstrate that the College is, indeed, policing its members and upholding the highest standards in our profession, the postings also sometimes graphically announce the offense that prompted action. I would ask the College to reconsider this practice. It is enough to list the names and locations of these surgeons. Adding the offense adds insult to injury and, in my mind, is completely unnecessary and, as far as the general readership, is nobody’s business. In addition, I would wonder if this practice borders on slander, as some of the offenses may still be under dispute. Please reconsider this policy. Let these tortured souls maintain some level of dignity and respect as they try to rebuild their lives.

Thomas S. Helling, MD, FACS
Jackson, MS
The Board of Governors’ (B/G) Surgical Volunteerism and Humanitarian Awards Workgroup has announced the recipients of the 2014 American College of Surgeons (ACS)/Pfizer Surgical Humanitarian Award and Surgical Volunteerism Awards. As in previous years, the Workgroup received exceptional nominations, reflecting the remarkable commitment of ACS Fellows to providing care to underserved populations.

The extraordinary contributions of the award recipients are summarized in this article and will be formally recognized at the 2014 Clinical Congress in San Francisco, CA, during the annual B/G reception and dinner, starting at 7:00 pm Tuesday, October 28, at the Hilton San Francisco Union Square. Clinical Congress attendees also are invited to hear the honorees speak at a Panel Session, Humanitarian Surgical Outreach at Home and Abroad: Reports of the 2014 Volunteerism and Humanitarian Award Winners, Monday, October 27, 9:45 am to 1:00 pm, at the Moscone Center.

Surgical Humanitarian Award
The ACS/Pfizer Surgical Humanitarian Award recognizes Fellows who have dedicated much of their careers to ensuring that underserved populations have access to surgical care and have done so without expecting commensurate compensation.

Harry S. Brown, MD, FACS, an ophthalmologist from Santa Barbara, CA, will receive the Surgical Humanitarian Award for starting an international health care organization dedicated to restoring sight and preventing blindness in disadvantaged individuals.

Dr. Brown first became concerned with the issue of blindness in developing nations—home to 90 percent of the people who have the condition—as a resident at the Jules Stein Eye Institute, University of California, Los Angeles (UCLA). He spent a year abroad working with ophthalmologists in various countries and recognized the need to develop a means of connecting the global pool of eye surgeons who had the requisite skills, desire, and tools to serve these patients, but lacked the time to participate in lengthy clinics and maintain their regular practices. Dr. Brown founded Surgical Eye Expeditions (SEE) International in 1974. The organization connects volunteer surgeons with colleagues in low-income countries to conduct short-term surgical clinics where sight-restoring operations are performed. Through this program,
physicians are able to participate periodically throughout their professional lifetime.

Dr. Brown has made more than 50 surgical trips to more than 30 developing countries. On these trips, he and the volunteers use educational seminars and skills exchange programs to teach and train local eye surgeons in ophthalmic techniques. In return, local surgeons expose visiting professionals to surgical techniques and advanced ocular diseases seldom seen in their home clinics. Supplies used to perform the operations are donated to SEE International by major ophthalmic and surgical supply companies. Members of visiting surgical teams travel at their own expense to low-income countries, while the host country provides in-country transportation, food, and lodging for the four- to five-day surgery clinics.

SEE International, headquartered in Santa Barbara, CA, recruits, organizes, and deploys 130 to 140 small surgical eye teams every year to sight-restoring eye clinics in Asia, Africa, Latin America, Eastern Europe, the Middle East, the Pan-Pacific area, and the Caribbean. Those teams perform 15,000 to 20,000 procedures annually.

Since Dr. Brown founded SEE International 40 years ago, the organization has screened approximately 3.2 million individuals, and more than 400,000 people worldwide have received surgical care through a global volunteer network of more than 600 ophthalmic surgeons, registered nurses, and technicians from 75 countries.

Surgical Volunteerism Award
The ACS/Pfizer Surgical Volunteerism Award recognizes ACS Fellows and members committed to giving back to society through significant contributions to surgical care as volunteers. This year, three awards will be granted.

Joseph V. Sakran, MD, MPH, a general surgeon from Fairfax Station, VA, will receive the Surgical Resident Volunteerism Award for developing long-term interventions aimed at reducing the global burden of surgical disease, participating in numerous international disaster relief efforts, and compiling an abundance of medical supplies for communities of low- and middle-income countries (LMIC). Dr. Sakran is an assistant professor of surgery and director of global health and disaster preparedness at the Medical University of South Carolina (MUSC), Charleston. As an acute care surgeon, Dr. Sakran spends most of his time caring for critically ill and injured patients. His research interests are in biomarkers for sepsis, trauma system development, public policy, and the advancement of surgery in resource-poor settings. His interest in medicine stems partly from having nearly lost his life after a gunshot wound to the throat in his senior year of high school.

Dr. Sakran has been interested in global health care issues since he started his medical training. He has treated suicide bomb victims in Jerusalem during the second Intifada of the Israeli-Palestinian conflict, provided medical care to the Bedouin population in Israel’s Negev Desert, and treated the black Hebrews in Dimona. In response to the Indian Ocean tsunami in 2004, he helped to organize a group of clinicians to provide care to patients in the damaged city of
Pondicherry, India. Dr. Sakran also played a vital role in setting up a clinic after the 2010 Haiti earthquake outside Port-au-Prince. He integrated his medical studies with public health when he attended the Johns Hopkins Bloomberg School of Public Health, Baltimore, MD, where he completed a master’s degree in public health in the global health track.

As a resident, Dr. Sakran co-founded a not-for-profit organization called Surgeons for Global Health (SGH) to address the surgical burden of disease in LMIC. Dr. Sakran started this initiative when he became frustrated with how inadequately surgical care needs were addressed in many underserved countries and recognized the need for a more sustainable model that would allow for capacity-building in these settings.

SGH’s first mission occurred in the spring of 2007, when Dr. Sakran had the privilege of providing care to many Malawians who sought help at their local hospital in Embangweni. There is one physician for every 100,000 people in Malawi, according to Dr. Sakran. Hence, the backbone of the Malawi health care system is composed of clinical officers. In Malawi, he trained a number of clinical officers to perform basic surgical procedures. Those health care practitioners continue to provide surgical care in their communities today.

Dr. Sakran has used this model to deliver care and sustainable solutions throughout India, the Middle East, and Africa.

As a resident, Dr. Sakran also led an effort to collect surgical supplies for LMIC. At MUSC, he is the physician champion for the Recovered Medical Equipment for the Developing World (REMEDY) program. MUSC recruited Dr. Sakran as part of an effort to develop a program to continue reducing the global burden of surgical disease, while integrating domestic and international trainees into the process. His goal is to bring other academic institutions and organizations together so that more like-minded individuals would work together rather than in silos. The development phase of this program has taken him on exploratory trips to Kenya and Rwanda.

Dr. Sakran has been actively involved in the ACS and is the Vice-Chair of the Resident and Associate Society (RAS). At present, Dr. Sakran is spending a year at the Harvard Kennedy School of Government, Boston, MA, where he is developing a unique skill set focused on economics, public policy, and leadership development in underserved and minority populations.

Robert D. Bach, MD, FACS, a general surgeon from North Haven, ME, will receive the Surgical Volunteerism International Award for his decades of medical service to the impoverished and isolated population of northeastern Nicaragua. Through the establishment of a not-for-profit organization called Partners in Health of Maine (PIHM), he continues to provide Nicaraguans with free medical care, equipment, and education.

Dr. Bach has been performing volunteer surgery since he first traveled to Nicaragua’s north Atlantic coastal region in 1976, where he performed many surgical procedures in a well-known mission hospital run by the Moravian Church. During
the Sandanista-Contra war, he volunteered in Honduras, Guatemala, and St. Lucia. He returned to Nicaragua in 1990 and found that Puerto Cabezas had become a refugee center for the indigenous Miskito Indians who had been deported from the war zone, with the population increasing from 15,000 to more than 35,000. The regional hospital was deteriorating dramatically, prompting him to push for construction of a new hospital. Funds were obtained from the United Nations through the United States Agency for International Development (USAID) with the agreement that PIHM would fully equip the hospital. Partners collected more than 66,000 pounds of equipment from hospitals in Maine, which the Maine Air National Guard and the U.S. Air Force transported to Puerto Cabezas. The new hospital was dedicated in 1992, bearing the name of Dr. Bach’s late wife, Nancy. It was named Hospital Nuevo Amanecer de Enfermera Nancy Bach, which translates to New Hospital Sunrise Nurse Nancy Bach.

Dr. Bach develops teams of nurses, dentists, pediatricians, surgeons, emergency physicians, and medical technicians to serve the population. He performs operations during his visits every spring and fall, and volunteers have established outreach programs in the villages along the Rio Coco River to the north on the Honduras border. In 2007, the organization provided food, shelter, and public health assistance in the aftermath of Hurricane Felix. The latest project will be to provide wells, clean water, and waste disposal for rural communities.

Dr. Bach has always emphasized the importance of volunteers establishing one-to-one relationships with the Nicaraguan providers. Nicaraguan physicians, surgeons, and nurses have been included as volunteer members of PIHM, providing for sustainability.

Dr. Bach was awarded the Orden de Rubén Dario, or the Nicaraguan Humanitarian Award, from the country’s president in 2006 for his contributions to the health and well-being of the Nicaraguan people. He is currently an active staff member of the palliative care team at Eastern Maine Medical Center, Bangor.

Scott A. Leckman, MD, FACS, a general surgeon from Salt Lake City, UT, will receive the Surgical Volunteerism Domestic Award for his efforts to provide free health care to low-income, uninsured residents of Salt Lake County. Dr. Leckman helped establish the Health Access Project (HAP) in 2001 after he traveled to Buncombe County, NC, to learn how a similar program—the only one in the U.S. at that time—was being implemented. As president-elect and later president of the Utah Medical Association, Dr. Leckman led the effort to recruit members of the Salt Lake County Medical Society to participate in HAP’s volunteer provider network, speaking at medical meetings throughout the country. The network currently includes more than 600 physicians who provide a wide range of health care services.

Dr. Leckman is also chairman of the board of RESULTS, a not-for-profit organization that creates political will to end poverty, where he has volunteered for 30 years. He is involved in lobbying for the fight against the diseases of poverty, such as the human immunodeficiency virus,
tuberculosis, and malaria, as well as for microfinance and universal access to basic education. He is also leading an effort to lobby Congress to support a resolution at the World Health Assembly that would call for making access to essential surgical and anesthesia services a priority in low- and middle-income countries.

Dr. Leckman served as a volunteer surgeon with the U.S. Navy as part of Project HOPE (Health Opportunities for People Everywhere). Project HOPE provides medical training, health education, and humanitarian assistance around the world. Dr. Leckman has served on U.S. Navy ships in Indonesia after the tsunami; Latin America; Papua, New Guinea; the Solomon Islands; and off the coast of Mississippi after Hurricane Katrina. Dr. Leckman furthermore has also trained native surgeons in Nigeria, Peru, Cambodia, and Ecuador to repair hernias using mesh from mosquito nets.

Dr. Leckman is the past-president of the Rotary Club of Salt Lake City, and assistant governor for Utah’s District 5420. As the district’s PolioPlus chairman, he regularly organizes trips for Utah Rotarians to India, where they work to eradicate polio through childhood immunization. ♦

**Official notice:**

**Annual Business Meeting of Members, American College of Surgeons**

In accordance with Article I, Section 6, of the Bylaws, the Annual Business Meeting of Members of the American College of Surgeons (ACS) is called for 4:15 pm, the afternoon of Wednesday, October 29, 2014, at the Moscone Center, San Francisco, CA.

This session constitutes the Annual Business Meeting of Members, at which time Officers and Governors will be elected and reports from officials will be presented. Items of general interest to the Members will also be presented. Members are respectfully urged to be present. ♦

Edward E. Cornwell III, MD, FACS
Secretary
American College of Surgeons
September 1, 2014
Leaders of the American College of Surgeons (ACS) and several other medical organizations gathered July 22 to place a memorial headstone at the previously unmarked interment site of Ernest Amory Codman, MD, FACS. The dedication ceremony took place at historic Mount Auburn Cemetery, Cambridge, MA, with speakers paying homage to the unconventional surgeon from Boston, best known for advocating the “end result idea” in medicine. (For details regarding the memorial service, see the “Looking forward” column, page 8.)

Dr. Codman’s end result idea centered on the common-sense premise that hospital staffs should record the outcomes for every patient they treat long enough to determine if the treatment was successful, make the results public, and learn from any failures so as to prevent similar problems in the future. Although Dr. Codman’s ideas placed him at odds with the medical establishment of his time, these ideas have become the basis of patient-centered, quality-based surgery promoted in ACS standards and in present-day medical practice.

When Dr. Codman died of melanoma in 1940, his family reportedly lacked the financial means to purchase a headstone for his gravesite, so he was interred in an unmarked site in the burial lot of his wife’s family.*

The newly installed headstone contains his portrait in bas-relief. A bronze tablet is inset into the granite headstone that is mounted in an upright position. Classical sculptor Daniel Altshuler, DIA Sculpture Studios Ltd., Boston, crafted the memorial using the historic Quincy Granite that can be found at many gravesites at Mount Auburn.

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Father of outcomes assessment

“The American College of Surgeons and medicine in general owe a huge debt of gratitude to Dr. Codman, who was one of our organization’s early leaders,” said ACS Executive Director David B. Hoyt, MD, FACS. “He contributed immensely to our early hospital standardization activities that eventually led to the establishment of what is now known as The Joint Commission in 1951. He would be proud to see how his advocacy for tracking patients’ outcomes contributed to the development of robust surgical data registries—one of the most valuable tools surgeons use to improve the quality of patient care today.”

Dr. Codman graduated from Harvard Medical School in 1895 after spending a year visiting medical centers in Europe. While in Vienna, he encountered the problem of disease of the subdeltoid bursa and became fascinated with the shoulder joint, culminating in his 1934 book, *The Shoulder.* His interest in bone cancer also was directly responsible for the development of the ACS Registry of Bone Sarcoma, established in 1920.

Dr. Codman served at Massachusetts General Hospital (MGH) as surgeon to outpatients in 1899, and from 1902 to 1914, was an assistant visiting surgeon at the hospital. He held the post of lecturer at the Harvard Medical School from 1913 to 1915. However, Dr. Codman became discouraged by hospital administrators’ lack of interest in his end result idea, so he resigned from MGH and established his own small hospital. Fittingly, the epitaph on Dr. Codman’s headstone includes a statement that he is reported to have once made: “It may take a hundred years for my ideas to be accepted.”

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Surgeons influence AMA policy

by John H. Armstrong, MD, FACS, and Jon H. Sutton, MBA

The annual meeting of the American Medical Association (AMA) House of Delegates (HOD) took place June 7–11 in Chicago, IL. Late spring weather welcomed more than 800 delegates and alternate delegates to the Windy City for lengthy days of policymaking, educational programming, and electioneering.

ACS delegation
The five delegates from the American College of Surgeons (ACS) at the meeting were: John H. Armstrong, MD, FACS, Surgeon General and Secretary of Health for the State of Florida and co-author of this article; Jacob Moalem, MD, FACS, endocrine surgeon, University of Rochester, NY; Leigh Neumayer, MD, FACS, general surgeon and professor and the University of Utah School of Medicine, Salt Lake City; Patricia L. Turner, MD, FACS, general surgeon and Director, ACS Division of Member Services; and Richard Reiling, MD, FACS, Board of Directors, ACS Foundation.

With this meeting, Dr. Reiling completed his 22-year tenure as an ACS Delegate. He chaired the delegation from 2006 to 2010 and was the first Fellow in the modern era to be elected to an AMA Council as a nominee of the College. The ACS Delegation recognized his leadership, and he was on the list of retiring delegates presented to the HOD.

The College delegation was assisted at the meeting by Timothy Kresowik, MD, FACS, a vascular surgeon, University of Hospitals and Clinics, Iowa City, and an alternate delegate from the Society for Vascular Surgery; and Kenneth Louis, MD, FACS, a neurosurgeon affiliated with multiple hospitals in Tampa, FL, and an alternate delegate for the Florida Medical Association.

AMA elections
The June meeting of the HOD generally includes the elections of AMA officers, trustees, and council members. This year, three members of the ACS were among several health care professionals elected to serve on the AMA board and councils: Andrew Gurman, MD, FACS, a hand surgeon in Altoona, PA, was re-elected as speaker of the HOD, and announced his intention to run for AMA president in June 2015; Russell Kridel, MD, FACS, a plastic surgeon in Houston, TX, was elected to the AMA Board of Trustees; and Luke Selby, MD, a surgical resident from New York, NY, was elected as the resident/fellow member of the AMA Council on Medical Education.

An announcement card was distributed for Dr. Turner, an ACS nominee running for re-election in 2015 to the AMA Council on Medical Education.

Policymaking at work
The primary function of the HOD is to adopt AMA policy, and the June meeting provided many opportunities to influence the organization’s position on a number of issues. The HOD considered 176 resolutions and 72 reports for business at the June meeting, with multiple reference committee hearings pruning them to more manageable forms.

A great deal of behind-the-scenes collaboration helps the HOD achieve successful results for each delegation.

Issues relevant to surgeons that came before the HOD included the following:

• Bariatric surgery as part of the essential benefits plan (Resolution 111): This resolution was authored by the College and asked the AMA to advocate for coverage of bariatric surgery as part of the essential benefits package for health insurance plans sold through the state health insurance exchanges. More than 25 states do not require this coverage. After recognizing existing AMA policy that advocates for limited benefits...
With this meeting, Dr. Reiling completed his 22-year tenure as an ACS Delegate. He chaired the delegation from 2006 to 2010 and was the first Fellow in the modern era to be elected to an AMA Council as a nominee of the College.

packages to promote market solutions, the College worked with the American Society of Clinical Endocrinologists and the American Society for Metabolic and Bariatric Surgery to propose a substitute resolution: The AMA will advocate for patient access to the full continuum of evidence-based obesity treatment modalities, such as behavioral, pharmaceutical, psychosocial, nutrition, and surgical interventions. The HOD adopted this quality-focused language.

• Opposition to genetic testing restrictions based on specialty (Resolution 115): Working with the lead sponsor of this resolution, the American Society of Clinical Oncologists, the ACS Commission on Cancer, and the ACS delegation provided assistance in reshaping the original resolution so that a substitute was adopted. This policy states that the AMA opposes public and private payors’ imposition of a practice standard that requires utilization review by external medical specialists or nonphysicians before ordering of genetic tests and continues to support pre- and posttest counseling by qualified health professionals for at-risk patients with a potential hereditary susceptibility for cancer and other diseases.

• Medicare claims data release (Substitute Resolution 204): Many resolutions (204, 211, and 226) introduced at this meeting centered on the recent release of individual physician Medicare claims data. The original Resolution 204 called on the AMA to condemn the Centers for Medicare & Medicaid Services (CMS) for releasing the data and to take an aggressive stance. Resolution 226 detailed the information that the AMA should seek. The College cosponsored Resolution 211, and the HOD adopted a substitute that incorporated the various related resolutions so that the AMA will continue to work with CMS to identify appropriate modifications that improve the usefulness and accuracy of any existing or future provider-specific data released by that agency.

• Physician workforce shortage: Approaches to GME financing (CME Report 7): Policy recommendations are made not only through resolutions, but also through recommendations from AMA Council reports. The ACS delegation succeeded in shaping final recommendations regarding AMA workforce policy to ensure an inclusive approach with all specialties to workforce financing. The AMA will continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians. The AMA will also encourage Congress to work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following:

  - Train more physicians to meet state and regional workforce needs
  - Train physicians who will practice in physician shortage/underserved areas or train physicians in undersupplied specialties and subspecialties in the state/region
  - Work with stakeholders such as the Association of American Medical Colleges, Accreditation Council for Graduate Medical Education, American Osteopathic Association, American Academy of Family Physicians, American College of Physicians, and other specialty organizations to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce...
**Breast density notification**
(Resolution 502): Many state legislatures are considering legislation to require that breast density information be provided to patients following mammograms, and in some cases requiring insurers to pay for follow-up testing. As adopted, AMA policy now supports the inclusion of breast tissue density information in the mammography report when appropriate and the education of patients about the clinical relevance of such information, but opposes state requirements for mandatory notification of breast tissue density to patients.

**Encouraging physician participation in veterans’ care**
(Resolution 231): In response to recent revelations of poor outcomes in Veterans Affairs (VA) facilities related to hidden wait lists, the AMA will advocate that: (1) the U.S. President take immediate action to provide timely access to health care for eligible veterans outside the VA until it can make necessary changes; (2) Congress act rapidly to enact a bipartisan long-term solution for timely access to entitled care for eligible veterans; and (3) state and local medical societies create and make available a registry of physicians offering to provide care to veterans to communities and the VA.

**Surgical Caucus**
The Surgical Caucus of the AMA is administered by the College and brings together surgeons, anesthesiologists, and emergency physicians for focused discussions regarding AMA resolutions relevant to surgical patient care. The Caucus held a one-hour continuing medical education program titled PQRS [Physician Quality Reporting System]—Not Just Alphabet Soup: Practical Tips and Tricks to Get Paid for Your Quality in an Evolving Healthcare System. Speakers provided a description of perioperative and surgical quality reporting.

**Next meeting**
The Interim Meeting of the HOD will take place November 8–11 in Dallas, TX. The ACS delegation will be ready and honored to represent the College in this policymaking forum. Fellows with questions, comments, or issues to bring forward to the HOD should contact the delegation at jsutton@facs.org.

The ACS delegation to the AMA continues to inspire quality in AMA policymaking through robust participation in the HOD.

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**Correction**

The article “The ACS Accredited Education Institutes Fellowship Program: Training leaders in simulation-based education” (July 2014, page 17) misstated that the American College of Surgeons (ACS) began to address the use of simulation in surgical education in 2004. The College’s first efforts to adapt simulation to education began in April 2002 when the ACS and the National Board on Educational Testing and Public Policy hosted a two-day symposium on the potential use of simulation as an educational tool in surgery. The meeting was held at Boston College, Chestnut Hill, MA, under the direction of ACS Past-President Gerald B. Healy, MD, FACS, and Past-Executive Director, Thomas R. Russell, MD, FACS.
The American College of Surgeons (ACS) hosted the ACS Surgical Health Care Quality Forum Iowa, June 27, in Des Moines. This forum, part of the College’s Inspiring Quality (IQ) program, was the 19th in a series of community meetings that the College has presented across the U.S. since 2011 to highlight quality improvement programs that have set higher standards for surgical care, reduced costs, and improved patient outcomes at the state and national levels.

**Issues in rural Iowa**

A panel of health care leaders shared their insights into the unique issues that affect surgical care in rural areas, including workforce shortages, surgical education and training, and access to trauma care. Panelists discussed how Iowa’s trauma system, which was initiated in 2001, has evolved and how best practices are being used to improve patient outcomes and reduce health care costs in rural areas.

“The issues related to access to quality rural surgical care continue to burden many Iowa...
“From rural residency training programs to recruitment and retention support, continuing education and training, to trauma system verification, the College is committed to working with rural surgeons and hospitals to help identify and rectify the challenges that they face on a daily basis.”

—Dr. Hoyt

Co-host Ronald J. Weigel, MD, PhD, MBA, FACS. Dr. Weigel is associate vice-president for the University of Iowa (UI) Health Alliance; and the EA Crowell Jr. Professor and Chair of Surgery; professor of surgery, surgical oncology, and endocrine surgery; and professor of biochemistry, anatomy, and cell biology, UI Carver College of Medicine (UICCM), Iowa City.

“A big issue many of us are concerned about right now is workforce shortages and the impact that will have on the future of rural health care,” Dr. Weigel said. “Many general surgeons in rural areas are nearing retirement, and at the same time residents and younger surgeons are choosing to specialize. It will be important for our profession to focus on recruiting highly skilled and qualified general surgeons to the communities that need them most. Finding a way to fund graduate medical education is a serious problem facing our country and will affect this as well.”

Co-host Carol Scott-Conner, MD, PhD, MBA, FACS, professor of surgery, division of oncology, said, “Quality can mean many different things for patient care, but for rural surgical care, it really boils down to having access to the right surgeon at the right time and for that surgeon to have the necessary resources to do the job well. It can be a real challenge, but having discussions like these and coming together as a network to share resources and best practices will make a big difference.”

Forum presenters discussed the start of Iowa’s trauma system in 2001 and how it has helped improve outcomes for trauma patients throughout the state. According to the Iowa Trauma System Ten-Year Report, released by the Iowa Department of Public Health in 2010, since the system was implemented, there has been a 49 percent decrease in traumatic brain injury, a 35 percent decrease in chest injury, and a 20 percent overall decrease in mortality among non-transfer patients.* In addition, the trauma system has enabled faster arrival to definitive care, faster and more appropriate resuscitation, patients to be seen by a trauma surgeon sooner, and more patients discharged home.

ACS activities
The forum also highlighted ACS programs and initiatives that support rural surgeons, including the creation of the ACS Advisory Council on Rural Surgery and the ACS rural listserv, a “hub” for approximately 1,000 rural surgeons across the country to use in sharing information. The listserv has proven to be a valued resource, already facilitating more than 5 million e-mail exchanges on a variety of topics and clinical questions affecting rural surgery practice. “The Iowa Forum’s focus on rural quality couldn’t align more with ACS’ mission to ensure all patients have access to high-quality surgical care, wherever they are,” said David B. Hoyt, MD, FACS, ACS Executive Director. “From rural residency training programs to recruitment and retention support, continuing education and training, to trauma system verification, the College is committed to working with rural surgeons and hospitals to help identify and rectify the challenges that they face on a daily basis.”

Panelists also discussed the resources and metrics available to rural surgeons and hospitals to assess performance, including the ACS National Surgical Quality Improvement Program (ACS NSQIP®).

The full video of the Iowa forum is available at InspiringQuality.facs.org and on the College’s YouTube channel, at https://www.youtube.com/user/AmCollegeofSurgeons.

The Board of Governors (B/G) of the American College of Surgeons (ACS) recently underwent a major reorganization. Formerly, Governors served on a range of ACS committees, which often led to disparity, confusion, and organizational inertia, resulting in a limited number of recommendations and fewer issues reaching appropriate College divisions and leadership. In 2012, the Executive Committee of the B/G, under the vision and leadership of Immediate Past-Chair Lena Napolitano, MD, FACS, completed a redesign of the entire B/G committee structure. This effort resulted in the creation of five pillars—Communications, Education, Advocacy and Health Policy, Member Services, and Quality—each correlating to a division of the College and thus enabling the Governors to work toward a common goal with the divisions and Regents.

A total of 13 workgroups populate the pillars, providing ample opportunity for Governors to participate in the areas that complement their strengths and interests. Rolled out in the fall of 2013, the new pillars and workgroups have sparked enthusiasm, participation, and relevance for the Governors and their work. The following information details the first year’s (2013–2014) accomplishments for the workgroups and their respective pillars. With gratitude, I acknowledge the extraordinary efforts of the pillar leads and the workgroup chairs and vice-chairs.

**Communications Pillar**

**Joseph J. Tepas, MD, FACS, Pillar Lead**

The Communications Pillar has worked on the following initiatives throughout 2013–2014:

- Development of better communication between the ACS leadership and grassroots Fellows and rapid feedback from grassroots to leadership
- Discussion led by Ali Kasraeian, MD, FACS, with the Young Fellows Association regarding the use of broadcast technology to enhance communication exchange with younger Fellows
- Proposed development of slides for Governors and Fellows to use to illustrate the history and status of the U.S. health care system, proposed legislative solutions, and opportunities for surgeons to serve as leaders in the quality and patient advocacy arenas
- Solicited articles and information for inclusion in the Bulletin
- Suggested enhancement of the ACS website
A total of 13 workgroups populate the pillars, providing ample opportunity for Governors to participate in the areas that complement their strengths and interests.

The Board of Governors Communications Pillar comprises two workgroups:

• Newsletter Workgroup (Michael Sarap, MD, FACS, Chair, and John Kortbeek, MD, FACS, Vice-Chair)

• Survey Workgroup (Mark Puls, MD, FACS, Chair, and Nicholas Vedder, MD, FACS, Vice-Chair)

**Newsletter Workgroup**
- The B/G publishes a quarterly newsletter, which includes human interest stories, pillar updates, and other timely topics.
- Columns published in the newsletter include:
  - “International Café,” which focuses on international Governors/Fellows
  - “Fascinating Facts,” which provides details on little-known facts about the ACS
  - “On the Shoulders of Giants,” which highlights the achievements of surgical pioneers

**Survey Workgroup**
- Conducted the annual Governors survey. Concerns raised in the survey responses are addressed by the College’s leadership.

### Education Pillar
**Karen J. Brasel, MD, FACS, Pillar Lead**

The Education Pillar has worked on the following initiatives throughout 2013–2014:

- Assessed on an ongoing basis the College’s educational programs, leading to recommendations on how these offerings can be enhanced to make them more relevant to surgeons
- Conducted surveys to gain feedback on what’s working with respect to education and what may be needed in the future

The Education Pillar comprises three Workgroups:

- **Continuing Education Workgroup** (Mark Watson, MD, FACS, Chair, and Daniel Dent, MD, FACS, Vice-Chair)
- **Patient Education Workgroup** (Rebecca Sippel, MD, FACS, Chair, and Edward Raab, MD, FACS, Vice-Chair)
- **Surgical Training Workgroup** (Fred Luchette, MD, FACS, Chair, and Carol Scott-Conner, MD, FACS, Vice-Chair)

### Continuing Education Workgroup
- Worked on concepts that address continuing medical education (CME) statewide and across states, and issues of self-assessment CME as they relate to state requirements
- Discussed the possibility of creating a legacy depository for various state topic requirements, such as pain management, ethics, and palliative care
- Considered the expansion of the My CME page on the ACS website to include information on state-level CME requirements, as well as licensure mandates

### Patient Education Workgroup
- Conducted a patient education survey in conjunction with the ACS Committee on Patient Education to get feedback regarding surgical patient education practices and needs and to help determine how the ACS can enhance surgical patient education programs

### Surgical Training Workgroup
- Jeffrey Bumpous, MD, FACS, is leading efforts to construct a standardized Letter of Recommendation form for fourth-year medical students entering surgery.
- David Berger, MD, FACS, is leading an effort to offer ACS chapters educational talks/seminars similar to those
presented in the Surgeons as Educators Course. This information has been shared with John P. Rioux, MD, FACS, Chair of the Domestic Chapter Activities Workgroup for potential chapter collaboration.

Advocacy and Health Policy Pillar
James C. Denneny III, MD, FACS, Pillar Lead

The Health Policy and Advocacy Pillar has worked on the following initiatives in 2013–2014:

• Worked closely with the ACS Division of Advocacy and Health Policy (DAHP) to raise awareness and spread the word among ACS members about vital policy issues that affect surgeons.

• Sent e-mails to surgeons with information about how they can get involved in advocacy and how to contact their representatives and senators to make them aware of the issues facing surgical practice and patient care.

• Promoted discussion on the ACS’ role in coordinating registries and databases, both for quality and proliferation.

The Health Policy and Advocacy Pillar has two workgroups:

• Coalition Workgroup (Dr. Denneny, Chair, and Susan Mosier, MD, FACS, Vice-Chair)

• Health Policy and Advocacy Workgroup (Nipun Merchant, MD, FACS, Chair, and David Adams, MD, FACS, Vice-Chair)

Coalition Workgroup
• Committed to fight for common issues

• Noted that attempts to address the flawed sustainable growth rate formula that Medicare uses to calculate physician payment demonstrated the remarkable combined effects of surgical/medical societies working toward a common goal and should be sustained

• Worked with the ACS DAHP to assemble multispecialty advocacy teams to meet with legislators while in their home districts

Health Policy and Advocacy Workgroup
• Worked on tort reform and legislative attempts to remove caps on noneconomic damage awards in several states

• Developed a white paper on the topic of instruments to measure and report on patient satisfaction

Member Services Pillar
Fabrizio Michelassi, MD, FACS, Pillar Lead

The Member Services Pillar has worked on the following initiatives throughout 2013–2014:

• Strengthened existing chapters and providing resources and mentors to those chapters that request the College’s assistance

• Encouraged international chapter members and Governors to become more involved, both with their chapters and at a national level

• Publicized the awards program to generate increased awareness about the program and continued to attract applicants

The Member Services Pillar comprises three workgroups:

• Chapter Activities Domestic Workgroup (Dr. Rioux, Chair, and S. Rob Todd, MD, FACS)

• Chapter Activities International Workgroup (Raymond Price, MD, FACS, Chair, and Jamal Hoballah, MD, FACS, Vice-Chair)

• Surgical Volunteerism and Humanitarian Awards Workgroup (Kevin Behrns,
E-mails are sent to surgeons with information about how they can get involved in advocacy and how to contact their representatives and senators to make them aware of the issues facing surgical practice and patient care.

MD, FACS, Chair, and Francis Ferdinand, MD, FACS, Vice-Chair)

Chapter Activities

Domestic Workgroup

• Four subcommittees have been working on a variety of projects:

  - Subcommittee for Best Practices Presentation/Event at Clinical Congress, Anthony R. Vigil, MD, FACS, Chair: Presenting an hour-long panel discussion of success stories and how to run a chapter followed by a one-hour reception at the 2014 Clinical Congress. The program will be called Setting Conditions for Chapter Success: A Panel and Reception for Domestic and International Chapters. Scheduled panelists include ACS Governors John H. Armstrong, MD, FACS; Dr. Rioux; and Dr. Price.

  - Chapter Advisory Subcommittee, Frank T. Padberg, Jr., MD, FACS, Chair: Organizing stronger chapters to advise others when requested for help and best practices.

  - Subcommittee on Centralization of Chapter Dues Collection, S. Rob Todd, MD, FACS, Chair: Researching centralization of dues for chapters (that is, have the College collect chapter dues and forward them to the chapters). Dr. Todd is working on several models to vet this opportunity. The final recommendation will be offered to the Member Services Liaison Committee.

    - Subcommittee to Develop a Domestic/International “Chapter Partner Program,” Dr. Price, Dr. Rioux, and Donna Tieberg, ACS Chapter Services Manager: Working with the International Chapter Activities Workgroup on a Chapter Partner Program.

Chapter Activities

International Workgroup

• Developed a schedule of the best times to conduct conference calls so international Governors can participate.

• Divided the workgroup into four regions, similar to the trauma region model, and region chiefs are inviting Governors to meetings and communicating ideas via e-mail. All region chiefs know with whom to communicate and the new Governors in their region. Updated Excel spreadsheets of contacts are sent to Dr. Price and the region chiefs as needed.

• Defined the benefits of ACS membership for international surgeons.

• Met with chapter leaders at Clinical Congress.

• Received Board of Regents approval in February for the establishment of the UAE (United Arab Emirates) Chapter and presented the chapter with their official charter from the College. The newest chapter to be approved is Bolivia, with Esteban Foianini, MD, FACS, as the new Governor. Regents approved the Bolivia Chapter at their June meeting. A Guam chapter is under consideration.

• Worked with the Domestic Chapters Activities Workgroup on a Chapter Partner Program.

Surgical Volunteerism and Humanitarian Awards Workgroup

• The awards review system has been restructured and streamlined.

• The Workgroup received 16 applications in 2014.

• Applicants were reviewed and selected during a conference call in April.

• Efforts will be made to continuously publicize the program by:

  - Keeping in touch with past applicants.
Quality Pillar
Sherry M. Wren, MD, FACS, Pillar Lead

The Quality Pillar has worked on the following initiatives throughout 2013–2014:

- Collaborated with the ACS Division of Research and Optimal Patient Care
- Established and revised surgical guidelines
- Addressed issues such as the aging surgeon and fatigue mitigation
- Created programs for the Clinical Congress on the topic of electronic health records

The Quality Pillar comprises three Workgroups:

- Best Practices Workgroup (Joseph Minei, MD, FACS, Chair, and Brian Harbrecht, MD, FACS, Vice-Chair)
- Physician Competency and Health Workgroup (Roger Perry, MD, FACS, Chair, and Vice-Chairs Christian de Virgilio, MD, FACS, and Michael Vezeridis, MD, FACS)
- Surgical Care Delivery Workgroup (Steven De Jong, MD, FACS, Chair, and Vice-Chairs Christopher McHenry, MD, FACS, and Danny Robinette, MD, FACS, Vice-Chair)

**Best Practices Workgroup**
- Continued to work with Evidence-Based Decisions in Surgery publications and with the ACS National Surgical Quality Improvement Program® to create one or two guidelines annually regarding common problems in surgery. The first guideline is “The Prevention and Treatment of Ileus in Surgery.”

**Physician Competency and Health Workgroup**
- Addressed issues related to the aging surgeon and fatigue mitigation. This group has an enormous task to evaluate data, guidelines, and expert input from consultants. The work product will be a white paper ready for publication after approval from the Regents and a Panel Session at the 2014 Clinical Congress.

**Surgical Care Delivery Workgroup**
- Coordinated with Clifford Ko, MD, MS, MSHS, FACS, Director of the ACS Division of Research and Optimal Patient Care, a session on electronic health records for both workflow and quality data extraction.
- Has revised several guidelines and position statements.

The new Board of Governors pillar structure has had a profound impact on the development of meaningful products and worthwhile projects, not only for the Governors, but also ACS Fellows in general and the patients we serve. The ACS Advisory Councils are considering adopting a similar pillar structure, which serves to provide vertical and horizontal communication and effort across the many divisions and committees of the College. This opportunity for crosstalk enables the College to effectively communicate its mission and goals with all of its members. ♦
Surgeons who are committed to pursuing professional excellence as individual surgeons and as members of the surgical community, particularly Associate Fellows of the American College of Surgeons (ACS), are encouraged to apply now for Fellowship in the organization. Applications for initiation at the 2015 Clinical Congress must be submitted by October 31, 2014.

Taking membership to a higher level
The ACS admits to its Fellowship only those surgeons whose professional activity is devoted to surgical practice and who agree without compromise to practice by the professional and ethical standards of the College. The standards of practice established by the College are contained in the Fellowship Pledge and the Statements on Principles posted on the ACS website at www.facs.org. All Fellows of the College and applicants for Fellowship are expected to adhere to these standards.

Because Associate Fellowship in the College is limited to a period of six years in order to foster progression to the Fellowship level, the ACS encourages these individuals to apply for Fellowship once they meet the following requirements:

• Certification by an appropriate American Board of Medical Specialties surgical specialty board, an American osteopathic surgical specialty board, or the Royal College of Surgeons in Canada
• One year of surgical practice after the completion of all formal training (including fellowships)
• A current appointment at a primary hospital with no reportable action pending


How to apply
Associate Fellows will find the application on the ACS website. You will need your log-in information to access the application. If you do not have your log-in, contact College staff at 800-293-9623 or via e-mail at chicks@facs.org for assistance.

The application requests basic information regarding licensure, certification, education, and current hospital affiliations. You are also asked to list the names of five Fellows of the College, preferably from your current practice location, to serve as references for your application. You do not need to request letters; just list the names on your application and the College staff will contact your references for you. If you need assistance finding FACS members in your area, you may view a list on the ACS website at www.facs.org (click on the “Find a Surgeon” link at the top of the page).

Surgeons who request and voluntarily submit applications for Fellowship are inviting an evaluation of their practice by their peers. In determining the eligibility of applicants for Fellowship, the College investigates each applicant’s entire surgical practice. Applicants for Fellowship are required to provide to the appointed committees of the College all information deemed necessary for the investigation and evaluation of their surgical practice.

When your application is processed, you will receive an e-mail notification providing more information about the application timetable, along with a request for your surgical summary. The College provides several options for the submission of your surgical summary, including a list generated from the ACS Surgeon Specific Registry.*

U.S. and Canadian applicants will be invited by an ACS committee in their local area to attend a personal interview. Exceptions are made for military applicants. Following the interview, you will receive notification by July 15, 2015, of the action taken on your application. Approved applicants are designated as Initiates to be inducted as Fellows at the Convocation Ceremony.

Feel free to contact the staff at any time throughout the application process. The College looks forward to welcoming you as a Fellow of the American College of Surgeons. ♦

*Applicable to domestic surgeons only.
Editor’s note: Media around the world, including social media, frequently report on American College of Surgeons (ACS) activities. Following are brief excerpts from news stories published from March through July 2014 that mention key ACS programs and initiatives, including research findings that appear in the Journal of the American College of Surgeons. To access the news items in their entirety, visit the online ACS Newsroom.

Outcomes pioneer memorialized nearly 74 years after his death
Modern Healthcare, July 23, 2014
“The grave of a Boston surgeon considered by many to be the pioneer advocate for tracking patient outcomes and acknowledging medical errors was memorialized Tuesday by the American College of Surgeons.
“Dr. Ernest Codman [FACS] criticized by colleagues of his time for wanting to increase transparency, died in 1940, and his grave in a Cambridge, Mass., cemetery remained unmarked for nearly 74 years. More than a century after he introduced new concepts to drive improvements in healthcare outcomes, patient-safety experts say there’s still a long way to go.”

Surgeons tout benefits of Google Glass in operating room
FierceMedicalDevices, July 7, 2014
“A group of surgeons dubbed ‘Glass Explorers’ looked at applications for the wearable device in the operating room, such as integrated imaging, communicating with other surgeons, training new physicians and creating patient safety checklist apps. The surgeons found that using Glass in surgical procedures improved their concentration and allowed them to share a first-person perspective with other physicians or trainees, according to a recent article in the Bulletin of the American College of Surgeons.”

10 Changes in Surgery in 25 Years
“The American College of Surgeons says it has seen reduced infections during the past few years thanks to new standards in care, such as decreasing operating room traffic and using chlorhexidine for preoperative baths. The Joint Commission created an implementation guide for hospitals that defines effective practices for better surgery outcomes. In Tennessee, for instance, a 10-hospital collaborative reduced complications and saved $2.2 million per 100 cases and saw a significant reduction in site infections, according to a study published in 2012 in the Journal of the American College of Surgeons.”

Surgery for Melanoma Liver Mets Can Prolong Survival
Medscape, July 3, 2014
“Patients who can undergo complete surgical treatment of melanoma liver metastases should consider this option, say oncologists...”
Media around the world, including social media, frequently report on American College of Surgeons (ACS) activities.

from California. In their experience, hepatic resection for metastatic melanoma significantly improves survival over medical treatment alone, they report in the July issue of the *Journal of the American College of Surgeons*.

**Trauma surgeons want more people trained to assist in mass casualty incidents**
*Catholic Health World*, May 13, 2014

“The efforts of the Hartford Consensus are having an impact. The American College of Surgeons and the Major Cities Chiefs Police Association, two of the organizations that helped drive the Hartford Consensus, say more than 36,000 police officers in Los Angeles [CA], Philadelphia [PA], Houston [TX], Phoenix [AZ], Dallas [TX], New Orleans [LA], Tampa, Fla., and Washington, D.C., will receive bleeding control kits and training this year.”

**Expanding Medicaid increases access to subspecialty procedures: Researchers**
*Modern Healthcare*, May 8, 2014

“Dr. Aviram Giladi, a University of Michigan [Ann Arbor] plastic surgery resident, and colleagues examined the records of 185,526 adults between ages 19 and 64 who underwent one of three surgical procedures between 1998 and 2006. The study in the *Journal of the American College of Surgeons* was funded by the National Institutes of Health and the Plastic Surgery Foundation.”

**Urologists Urged to Shape Health Policy—With Eye on Quality**
*OncLive*, May 5, 2014

“‘Reform really needs realistic input,’ said the speaker, David Hoyt, MD, [FACS.] executive director of the American College of Surgeons (ACS). ‘It needs to be framed by what works. We are the ones that provide Congress that concept of what really works. We have got to participate in the regulatory phase; it is our mid-ship opportunity, and ultimately our patients depend upon it.’”

**Find a cancer-patient support group near you**
*The Seattle Times*, April 20, 2014

“Fortunately, this lapse in the continuum of care has been recognized by the American Society of Clinical Oncology, by cancer-center-accrediting programs such as the Commission on Cancer and by government agencies such as the Centers for Disease Control, which support cancer-control programs including the Survivorship Task Force. The result is that supportive services are increasingly available with cancer treatment.”

**No Surgery Required for Children’s Appendicitis**
*Yahoo! Health*, April 17, 2014

“A research team tested whether appendicitis in children could be treated effectively with antibiotics, avoiding the serious procedure and recovery period associated with surgery…. This study was published April 12 in the *Journal of the American College of Surgeons*.”

**Marathon bombing prompts police to carry tourniquets**
*USA Today*, April 17, 2014

“While the Boston tragedy served to accelerate the new equipment distribution, the series of mass-casualty shootings—especially the 2012 Connecticut elementary school massacre—started...
an examination last March of crisis response led by the American College of Surgeons, the FBI, the Major Cities Chiefs Association and other groups.”

**ACS NSQIP Formula May Predict Readmission Risk After Surgery**

*Medscape*, April 3, 2014

“Existing formulas used to identify patients at high risk for postsurgical complications may also prospectively identify patients at high risk for unplanned readmission after surgery, according to a recent study. Among patients deemed to be at very high risk for complications, defined as a risk higher than 15% based on the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP) model, the odds of readmission were 10-fold greater than those of patients considered to be at very low risk.”

**Safe Surgery Checklist Suggested At Recent Seminar**

*WLTX 19 TV*, April 3, 2014

“Representatives from the American College of Surgeons and the state’s hospital association are working to make surgery safer. Today they hosted a surgical health care forum to start up a community discussion on improving patient care. The safe surgery checklist includes procedures and patient identification, briefing the operating team and instrument protocol.... By implementing the safe surgery checklist experts say they expect more than 500 lives per year in South Carolina to be saved.”

**How to reform the Medicare physician payment system**

*Boston Globe*, March 25, 2014, Opinion Page, by Andrew L. Warshaw, MD, FACS, President-Elect, ACS

“Over the last year, a group of congressional leaders have led a bipartisan, bicameral, and inclusive process to reach consensus on how to repeal SGR [surgical growth rate] and reform the Medicare physician payment system. They allowed the members of the medical community, including my organization, the American College of Surgeons, to work as partners with them to help resolve this difficult issue.”

**The Doc Fix Broke—Health Care Edge: Brought to you by FixMedicareNow.org and the AMA**

*National Journal*, March 5, 2014

“Auditors concluded that the county should contract with the American College of Surgeons to undertake a comprehensive assessment of its trauma care system and look at ways to better serve areas including Malibu, the eastern San Gabriel Valley, and large swathes of the Antelope Valley that don’t have nearby trauma centers.”
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The American College of Surgeons (ACS) is offering two-year faculty research fellowships for surgeons entering academic careers in surgery or a surgical specialty, including a newly established Thomas R. Russell, MD, FACS, Faculty Research Fellowship, which honors the former Executive Director of the ACS. The closing date for receipt of completed applications and all supporting documents is November 3, 2014. These fellowships are supported through the generosity of Fellows, chapters, and friends of the College. Applicants should have demonstrated their potential to work as independent investigators. The fellowship award is $40,000 per year for each of two years, to support the research.

There are five ACS Faculty Research Fellowships now available, and three of them have been established to honor an ACS leader:

• The Franklin H. Martin, MD, FACS, Faculty Research Fellowship of the American College of Surgeons, which honors the founder of the ACS
• The Thomas R. Russell, MD, FACS, Faculty Research Fellowship, which is designated to support research aimed at improving surgical outcomes

General guidelines
General policies covering the granting of the ACS Faculty Research Fellowships include the following:

• The fellowships are open to Fellows or Associate Fellows of the College who have: (1) completed the chief residency year or accredited fellowship training within the preceding five years; and (2) received a full-time faculty appointment in a department of surgery or a surgical specialty at a medical school accredited by the Liaison Committee on Medical Education in the U.S. or by the Committee for Accreditation of Canadian Medical Schools in Canada. Applicants who directly enter academic surgery following residency or fellowship will receive preference.

• Each recipient may use the award to support his/her research or academic enrichment in any fashion that the recipient deems maximally supportive of his/her investigations. Each fellowship grant must support the research of the recipient and is not intended to diminish or replace the usual, expected compensation or benefits. Indirect costs are not paid to a recipient or to a recipient’s institution.

• Applications for these fellowships may be submitted even if comparable applications have been made to organizations such as the National Institutes of Health (NIH) or industry sources. If a recipient is offered a scholarship, fellowship, or research career development award from such an agency or organization, that individual is responsible for contacting the College’s Scholarships Administrator to request approval of the additional award.

• The Scholarship Committee reserves the right to review potentially overlapping awards and adjust its award accordingly.

• The College encourages each applicant to leverage the funds provided through one of these fellowships with time and money provided by the applicant’s department. Formal statements of matching funds and time from the applicant’s department will promote favorable review by the College.

• Supporting letters from the head of the department of surgery

Applications now being accepted for 2015 Faculty Research Fellowships honoring ACS leaders
Each fellowship grant must support the research of the recipient and is not intended to diminish or replace the usual, expected compensation or benefits. Indirect costs are not paid to a recipient or to a recipient’s institution.

Each applicant must submit a research plan and budget for the two-year period of the respective fellowship, even though renewed approval by the Scholarships Committee of the College is required for the second year.

A minimum of 50 percent of a Fellow’s time must be spent conducting the research proposed in the application. This percentage may run concurrently with the time requirements of NIH or other accepted funding.

Faculty Research Fellows are expected to attend the ACS Clinical Congress in 2017 to present a report at the Surgical Forum and to receive a certificate at the annual meeting of the Scholarships Committee.

Application forms may be obtained from the College’s website, www.facs.org, or upon request from the Scholarships Administrator at scholarships@facs.org.
It is with great pleasure and tremendous gratitude that I submit this report on my experiences as the 2014 American College of Surgeons (ACS) Traveling Fellow to Japan. As a surgical oncologist specializing in the treatment of gastric cancer, I have long been interested in traveling to Japan to observe and learn from the leading gastric cancer surgeons in the world. As soon as I became aware of this unique fellowship opportunity, I applied, and I am grateful and honored to have been chosen.

With the invaluable assistance of my mentors at the Massachusetts General Hospital (MGH), Boston, especially Kenneth Tanabe, MD, FACS, chief of surgical oncology, as well as my hosts in Japan, I was able to develop an efficient and educational itinerary organized to coincide with the 114th Annual Congress of the Japan Surgical Society (JSS) in Kyoto. With my itinerary in hand and having made a valiant, albeit last-ditch, effort to learn some basic Japanese, I set out for Japan.

Kyoto University
I traveled for nearly 24 hours before arriving at the architectural wonder that is the Kyoto train station. I took the Shinkansen (bullet train) from Tokyo to Kyoto, gazing at the beautiful snow-capped Mt. Fuji to the north as we headed east.

The following morning I arrived at Kyoto University Hospital and met with Prof. Shigeru Tsunoda, MD, PhD, assistant professor of surgery and a colleague of my host in Kyoto, Prof. Hiroshi Okabe, MD, PhD,
associate professor of surgery. We attended a meeting at which the surgeons discussed patients to be seen in clinic that day, including a review of the imaging studies with a radiologist. I did not go to clinic, but rather went to the operating room (OR) to observe Professors Okabe and Tsunoda performing a laparoscopic distal gastrectomy, which was specifically planned to match my scheduled time at the hospital.

Unfortunately, international visitors are prohibited from scrubbing on cases, but observing the cases was still educational. Professor Okabe is widely regarded as an accomplished laparoscopic gastric surgeon in Japan. His group performs approximately 90 gastrectomies and 25 minimally invasive esophagectomies annually. It was a pleasure to watch Professor Okabe and his team perform a meticulous, effortless distal gastrectomy and D2 lymphadenectomy. I immediately understood that the outcomes for this procedure in Japan are fantastic because the procedure is so carefully and systematically performed.

As this was my first opportunity to be in an OR outside of the U.S., several observations struck me as notable:

- OR cases tend to start later in the morning, at 9:30 or 10:00 am.
- Surgeons at the major university hospitals specialize in one field, such as esophagogastric cancer, and typically do only one major OR case per day.
- There are fewer ORs—perhaps only 15–20 for a 1,000 bed hospital.
- Japanese surgeons perform a timeout procedure just as we do in the U.S., and, in fact, a large checklist is posted on the walls of the OR at some centers.
- Surgeons use linear and circular staplers and energy devices that are similar to those used the U.S., and, at least at the hospitals I visited, there seemed to be no financial pressure to limit the use of disposable instruments.
- OR cases are almost always done by two faculty members—typically a full or associate professor together with an assistant professor—and the residents usually hold the camera and help close the wounds.
- Once the gastrectomy specimen is retrieved, an army of residents come to the OR to open the specimen, show it to the operating surgeons, and harvest the regional lymph nodes, node by node, placing them in formalin-filled jars, each labeled with the relevant lymph node station.

In addition to observing several minimally invasive gastrectomies at Kyoto University Hospital, I had the opportunity to attend a multidisciplinary pathology conference and make rounds with the surgical faculty and house staff. I have long wondered why Japanese surgeons report such long lengths of stay (LOS) in their studies. I learned that this is in part cultural, as Japanese patients expect to stay in the hospital until they feel
ready to leave. One obvious benefit of longer inpatient stays is that readmissions to the hospital are so rare that they are considered unthinkable, and any care that leads to readmission is viewed as a failure. I found this quite interesting, especially given how much we discuss efforts to reduce our 16 percent readmission rate for gastrectomy patients at MGH. The other reason for the extended LOS is financial, as most university hospitals in Japan have approximately 1,000 beds, and to maintain their government funding and staffing levels, they must demonstrate as close to full use of their beds as possible. Patients are allowed to stay significantly longer than we might ordinarily allow in the U.S. to ensure that beds are in use.

Outside of the hospital, I had several wonderful social outings, including a traditional sushi dinner with Professor Tsunoda and his wife and children at their house in northern Kyoto and a casual dinner at a local favorite restaurant of Professor Okabe and his team, who were incredibly gracious hosts.

### Japan Surgical Society

At the time of my stay in Kyoto, the 114th Annual Congress of the JSS was held at the Kyoto International Conference Center and the Grand Prince Hotel. This meeting is very similar to our ACS Clinical Congress, in that it is the largest and best-attended surgical meeting in Japan each year, with more than 14,000 attendees. Joining me were 15 to 20 other traveling fellows from around the world, including fellows from Germany, India, China, Korea, and Spain. We all attended a luncheon at which we received certificates to commemorate the occasion from Prof. Norihiro Kokudo, MD, PhD, FACS, president of the JSS, and from Prof. Shinji Uemoto, MD, PhD, FACS, congress chairman.

Though most of the program was in Japanese, I was able to attend a few outstanding lectures in English, including the ACS Presidential Lecture by Carlos Pellegrini, MD, FACS, FRCSI(Hon), on Ensuring Quality in Surgical Practice: The ACS Perspective. I also attended an Honorary Member Award Lecture by Jacques Belghiti, MD, on Advances in Liver Surgery: What We Have Learned from Japan. At the International Session on Upper Gastrointestinal Tract Surgery, I presented Predictors of Lymph Node Involvement in T1 Gastric Carcinoma. This talk generated some lively discussion from Prof. Shunji Sano, MD, PhD, and others at the meeting.

I had the honor of attending several formal Japanese kaiseke meals with traditional geisha dancing. At these receptions, I had the fortune of speaking with several notable surgeons from Japan, including Yuko Kitagawa, MD, PhD, FACS, professor and chairman, department of surgery, Keio University, Tokyo, and Kazuhiro Yoshida, MD, PhD, FACS, professor and chairman, department of surgical oncology, Gifu University, as well as Prof. Hong-Jin Kim, MD, PhD, FACS, from South Korea. I also saw some colleagues from the U.S., including Michael Kendrick, MD, FACS, from the Mayo Clinic, Rochester, MN, and Matthew Katz, MD,
SCHOLARSHIPS

FACS, from MD Anderson Cancer Center, Houston, TX, both of whom delivered invited lectures at the meeting.

We strolled along the streets of Kyoto in the evening and viewed the famous "sakura," or cherry trees, which were in full bloom. We were then treated to an after-dinner party at a traditional Japanese teahouse, or ochaya, in the Gion district, and we played drinking games with maiko (apprentice geisha). I also had the opportunity to see some beautiful sights in Kyoto, the former imperial capital of Japan, including Nijo-jo Castle, Kinkaku-ji Temple (Golden Temple), and Ginkaku-ji Temple.

Nagoya University

My next stop was Nagoya University, where my host was Prof. Yasuhiro Kodera, MD, PhD, FACS, chairman, department of surgery (II). Dr. Kodera is a world-renowned surgeon and thought leader in the field of gastric cancer. He arranged several minimally invasive esophageal and gastric cancer operations for me to observe. I also had the opportunity to watch Prof. Masato Nagino, MD, PhD, chairman of the department of surgery (I), perform an extended hepatectomy for a Klatskin tumor. I was particularly impressed by the advance preparation of the surgeons in Japan for their major surgical procedures. Beautiful hand-drawn diagrams of the planned resection with all of the portal venous, arterial, and biliary anatomy carefully detailed were posted on the OR wall, accompanied by three-dimensional computed tomography scans of the liver with the functional remnants outlined for the various possible resections.

In the course of my stay in Nagoya, I also had several long discussions with Professor Kodera regarding neoadjuvant and adjuvant therapy approaches to gastric cancer and the rationale and status of multiple clinical
I was particularly impressed by the advance preparation of the surgeons in Japan for their major surgical procedures.

trials for gastric cancer that are being conducted in Japan. Lastly, I had the opportunity to attend a meeting of young surgeons from the community hospitals in Dr. Kodera’s network, where they presented some of their more challenging cases. This meeting occurs at least once every few months and allows Dr. Kodera to learn about the surgical care that is being delivered at the community hospitals in his network in and around Nagoya, as well as the opportunity to spot a young surgeon with promise to recruit back to the academic hospital. Presentations ranged from gastrectomies to colectomies and included excellent video footage.

This meeting with the “community” surgeons stimulated a discussion about surgical training and the promotion process in academic surgery in Japan. Because one of the hats I wear is that of program director of the general surgery residency program at MGH, I have a keen interest in surgical education. Japanese physicians begin their schooling immediately after high school, enrolling in a six-year program, which includes two years of liberal arts education followed by four years of medical school.

Students interested in general surgery then complete a six-year residency program, the first two of which are focused on internal medicine, followed by three years in surgery at other hospitals, followed by a final year in surgery at one’s own institution. Most graduates then pursue postgraduate studies in basic surgical research either in the U.S. or Canada for an additional four years and typically earn a PhD in the process. Many academic surgeons in Japan confided that this is a necessary step for academic success in Japan for two reasons: (1) it is an opportunity for the trainee to learn to speak and write English, and (2) the experience provides a certain “credibility” for the trainee as a legitimate candidate for an academic post.

Nonetheless, an academic job is by no means guaranteed after such a course of study. New surgeons begin their careers in the community hospitals within the network of a major academic center, such as Professor Kodera’s network outside Nagoya University. Perhaps only 10 percent of these community surgeons are recruited to work at the university hospital as assistant professors, based on the judgment of the chairman of surgery. Only the most gifted are promoted to the rank of associate professor, a title often associated with a leadership position, such as chief of a division. Even fewer associate professors are promoted to full professor, a rank typically reserved for department chairs. For example, a large academic medical center like Nagoya University or Keio University in Tokyo might have only three or four full professors on the entire faculty.

Professor Kodera was wonderfully hospitable, and he took a visiting resident from Spain, some of his residents and junior faculty, and me out to dinner on several consecutive nights. We dined on superlative sushi one night, tasty Korean barbecue another, and, believe it or not, one of the finest Italian meals I have ever had.

Keio University

The final stop on my itinerary was Keio University in Tokyo, where Professor Kitagawa was my host. Professor Kitagawa is chairman, department of surgery, Keio University, a world-renowned surgeon specializing in esophagogastric cancers, and is particularly noted for his work in sentinel lymph node (SLN) mapping for early gastric cancers.

On the first morning of my visit, he gave me a tour of the hospital and of his new research facility, including a large animal lab for his translational research program. Professor Kitagawa and his very capable junior partner, Hiroya Takeuchi, MD, PhD, associate professor of surgery, organized several consecutive OR days of complex upper gastrointestinal cases for me to observe, including combined laparo-endoscopic resections of gastrointestinal stromal tumors (GISTS) near the gastroesophageal
junction, SLN mapping of early gastric cancers, and laparoscopic distal gastrectomies with D2 lymphadenectomies. I was again impressed by the facility with which they performed these rather complex procedures using three-dimensional laparoscopy. I was amazed by the commitment of their colleagues in gastroenterology, who completed the submucosal tumor dissection and stayed in the OR for the entire six-hour procedure to resect a GIST laparo-endoscopically.

In addition to observing OR cases, I attended a guest lecture on the role of angiogenesis in the progression and metastasis of GI tract cancers and the current status of angiogenesis inhibitors in the treatment of GI tract cancers. Coincidentally, the guest lecturer that evening happened to be my colleague and friend from the MGH, Dan Duda, PhD, a scientist with whom I collaborate on a number of translational research projects in the field of gastric cancer. We all celebrated together that evening with a kaiseki meal accompanied by beer and sake, and we discussed potential future research collaborations between MGH and Keio University.

While in Tokyo, I was joined by my wife and two children, and we made a point of visiting several famous sights, including the Tsukiji Fish Market, the Imperial Palace, Asakusa, and the Hama Rikyu Gardens. We also took an extended weekend trip on the Shinkansen out to Kyoto, where we visited Arashiyama and took a boat cruise down the Hozugawa River, and then on to Hiroshima and its neighboring island, Miyajima. We visited the Peace Memorial Park, the Peace Museum, and the Atomic Dome in Hiroshima. We then took a ferry out to Miyajima Island and viewed its famed Torii Gate—one of the most famous sites in all of Japan.

**Final thoughts**

I offer my profound thanks to the International Relations Committee of the ACS for selecting me to represent this great organization as the 2014 Traveling Fellow to Japan. I also extend my thanks to the many gracious hosts in Kyoto, Nagoya, and Tokyo, who made my visit so educational and hospitable. The knowledge and perspective I gained as a result of this fellowship will enable me to offer better care to my patients with gastric cancer, and I anticipate that the research collaborations that I made and plan to foster in the years to come will translate into exciting new treatments for this disease. For those surgeons considering this or another traveling fellowship, I cannot emphasize enough how valuable such a trip abroad can be in one’s own personal and professional development. Indeed, we have much to learn from our surgical colleagues around the world, and establishing both personal and professional connections with them is an honor and a joy.
SEPTEMBER

7th Annual ACS Accredited Education Institutes Postgraduate Course September 12–13 Tampa, FL Contact: Catherine Wojcik, cwojcik@facs.org, www.facs.org/education/accreditationprogram

Kentucky Chapter September 16 Louisville, KY Contact: Linda Silvestri, lsilv2@email.uky.edu

Illinois Chapter September 18–20 Champaign-Urbana, IL Contact: Luann H. White, lhwite26@gmail.com, http://www.ilchapteracs.org/

Iowa Chapter September 26 Iowa City Contact: Sue Hoyer, hoyerse@q.com

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

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

Arkansas Chapter November 15–16 Little Rock, AR Contact: Joni Bowers, jonib@azmed.org, www.azacs.org

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

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

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

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

OCTOBER

Bolivia Chapter October 8–10 Tarija, Bolivia Contact: Jorge Esteban Foianini, efoianini@hotmail.com

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

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

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

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

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

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2014 October 26–30 San Francisco, CA

2015 October 4–8 Chicago, IL

2016 October 16–20 Washington, DC