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Challenges for the second Century
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- The submission period begins after December 1, 2015.
- Deadline: 5:00 pm (CST), March 1, 2016.
- Late submissions are not permitted. There are no considerations made for “late-breaking abstracts.”
- Abstract specifications and requirements for each individual program will be posted on the ACS website at abstracts.facs.org. Review the information carefully prior to submission.

*Accepted authors are encouraged to submit full manuscripts to JACS.
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Looking forward

by David B. Hoyt, MD, FACS

The American College of Surgeons (ACS) had another productive and successful year in 2015, thanks to the hard work and dedication of the organization’s volunteers and staff. As I have done the last few years, I would like to take this opportunity to reflect on some of the high points of the year—all of which are discussed in greater detail in the Executive Director’s annual report on page 31.

Advocacy and Health Policy

The College and other surgical and medical societies achieved a longstanding goal in April when Congress passed and President Barack Obama signed into law H.R. 2, The Medicare Access and CHIP (Children’s Health Insurance Program) Reauthorization Act of 2015 (MACRA). This legislation repeals the flawed sustainable growth rate (SGR) formula used to calculate Medicare reimbursement for physician services. Furthermore, MACRA establishes an annual payment update of 0.5 percent for five years; seeks to establish a new Merit-based Incentive Payment System in 2019; calls for establishing processes for development, evaluation, and adoption of alternative payment models; and reauthorizes the CHIP through fiscal year 2017. Moreover, MACRA prevents the Centers for Medicare & Medicaid Services (CMS) from implementing a final rule that would have transitioned 10- and 90-day global codes to 0-day global codes beginning in 2017 and 2018, respectively.

Also on the payment front, the College has developed resources and published information to help surgeons make the transition to the 10th revision of the International Classification of Diseases coding system (ICD-10) (see related article, page 44). Successful implementation of ICD-10 is essential to ensuring that providers receive appropriate payment for inpatient services.

To address concerns about variations in patient access to quality care, the College formally established the ACS Committee on Health Care Disparities. The leaders of this committee—ACS Past-President and Committee Chair L. D. Britt, MD, MPH, DSc(Hon), FACS, FCCM, FRCSEng(Hon), FRCSEd(Hon), FWACS(Hon), FRCSI(Hon), FCS(SA)(Hon), FRCSGlasg(Hon), and Vice-Chair Adil Haider, MD, MPH, FACS—are to be commended for their efforts to establish a collaborative relationship with the National Institute on Minority Health and Health Disparities (NIMHD). As a first step in this important process, the ACS and NIMHD presented a successful symposium in May to determine key issues for further study.

Quality

The College’s National Surgical Quality Improvement Program (ACS NSQIP®) continues to grow in size and stature. ACS NSQIP was honored with the 2014 John M. Eisenberg Patient Safety and Quality Award for Innovation in Patient Safety and Quality at the National Level, presented by The Joint Commission and the National Quality Forum.

Furthermore, ACS NSQIP hosted its most widely attended conference this year. More than 1,500 surgeons and quality improvement team members from 676 institutions and 15 countries attended the 10th Annual ACS NSQIP National Conference.

To help improve the odds of survival among victims of mass casualty events, ACS Regent Lenworth M. Jacobs, Jr., MD, MPH, FACS, and members of the ACS Committee on Trauma led a multi-stakeholder effort to develop the Hartford Consensus III report on bleeding control. Dr. Jacobs also directed the publication of a compendium of strategies to enhance survival in these tragic events. The White House and leaders of law enforcement and emergency medical services agencies partnered with the ACS on this project.

The ACS is committed to improving surgical care for patients of all ages. To this end, we launched the Coalition for Quality in Geriatric Surgery Project in July with funding from the John A. Hartford Foundation and continued development of the Children’s Surgery Verification Program. In addition, the ACS Clinical Research Program continues to develop clinical trials and published the first edition of Operative Standards for Cancer Surgery—the first and only collection of guidelines for breast, lung, pancreas, and colon surgery.
I believe that interest in ACS membership is on the rise because, as these highlights of the year indicate, this organization has real value for surgeons who are striving to ensure that they are able to provide optimal care to all surgical patients.

Education
The ACS continues to ensure that surgical patients receive care from well-trained, highly qualified surgeons. This year, we have worked to improve surgical training through the efforts of the “Fix the Five” Committee on Residency Training, a newly created Committee on the Future of Surgery Residency and Training, and the Transition to Practice Program.

To help surgeons at all stages of their careers develop and sharpen their skills, expand their knowledge about clinical care, and meet Maintenance of Certification requirements, the ACS continues to present the annual Clinical Congress. This year’s meeting included a Scientific Forum featuring scientific paper and poster presentations and several member engagement events; and was attended by more than 13,480 physicians, other health care professionals, exhibitors, staff, and so on.

The ACS continues to play a leading role in advancing the field of simulation-based surgical education and training around the world through the Consortium of ACS-Accredited Education Institutes (ACS-AEIs). A total of 80 ACS-AEIs have been accredited, including 77 Comprehensive Institutes and 12 Focused Institutes. Education institutes accredited outside the U.S. include four in Canada, one in the U.K., two in Sweden, two in France, and one each in Greece, Italy, Argentina, Saudi Arabia, and Spain.

Member Services
The ACS seeks to develop and sustain programs of value to all surgeons of all specialties and of all interests at every stage of their career. To better understand your evolving needs and determine where we might be coming up short of some surgeons’ expectations, the ACS is conducting a survey of nonmember board-certified surgeons, the results of which will be analyzed to determine additional strategies to support member recruitment. We also have begun contacting members in an effort to reduce membership terminations.

To help surgeons who are interested in volunteerism and humanitarian efforts, the College recruited a new Medical Director, Girma Tefera, MD, FACS, for Operation Giving Back. Efforts are under way to assess member involvement and needs relative to volunteerism activities and to develop new programs, including a domestic volunteer program and a humanitarian volunteer boot camp. We also recruited M. Margaret “Peggy” Knudson, MD, FACS, to serve as Medical Director of the Military Health Services Surgical Partnership ACS (MHSSPACS) established in 2014. This year, the MHSSPACS led an effort to revitalize the Excelsior Surgical Society, which held its first meeting at Clinical Congress 2015, featuring a half-day program that united surgeons from the U.S. Army, Navy, and Air Force.

Finally, last year we established the online ACS Communities. More than 100 of these communities are now up and running, allowing members to share their experiences, interests, and concerns.

Going strong
It is telling that at this year’s Clinical Congress, we initiated 1,679 new Fellows—one of the largest classes in ACS history. I believe that interest in ACS membership is on the rise because, as these highlights of the year indicate, this organization has real value for surgeons who are striving to ensure that they are able to provide optimal care to all surgical patients.

On behalf the ACS volunteers and staff, I wish you all a happy and successful new year. We look forward to continuing to exceed your expectations in 2016.

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

Challenges for the second Century

by J. David Richardson, MD, FACS
In 2013, the ACS celebrated its 100th anniversary, and we have devoted considerable time to reflecting on the organization’s glorious past. The challenge as we move into the second century is to cherish the traditions and values of the past while embracing our future with enthusiasm.

Our challenge
The etymologic derivation of the word “challenge” is 13th-century French, at which time it suggested “an accusation of wrongdoing.” That is certainly not the current intent. By the late 14th century, the word came to mean “a call to fight,” and, in a figurative sense, that is part of my meaning. We often use the word “challenge” to mean “arouse or stimulate,” and hopefully, the younger Fellows will embrace that definition.

This class of ACS Initiates is reportedly the largest in the College’s history, with 1,679 new Fellows. It is much more diverse than in our remote past, with 354 women and 451 from outside the U.S. A total of 981 Initiates are in general surgery-related specialties [such as breast, endocrine, vascular, and trauma surgery], whereas 698 are in defined specialties outside of general surgery [such as neurological, cardiothoracic, and orthopaedic surgery].

Pillars of the College
The Board of Governors, which represents the many broad constituencies of the College, uses the term “pillars” to define certain core activities of the ACS. Although these areas of focus will likely change going forward, I would like to offer some brief thoughts regarding the current pillars and possible future challenges in each area.

Communications
“Communications” might seem like the most straightforward area of College activities, but in my tenure of leadership, it may have been the most difficult to accomplish. The College leadership is very sensitive to the concerns and desires of Fellows, and while responsive to those issues, it often has been difficult to communicate the activities of College Officers and staff to rank-and-file members. As a consequence, there often is a disconnect between our busy Fellows and equally hardworking leadership because of poor communication.

The future of communications is rapidly changing and younger generations of Fellows should be able to communicate better than mine. Young Fellows of the ACS should begin to communicate with the organization’s leaders now. We have a large number of online “Communities” for myriad surgical interests at present. Embrace the Young Fellows Community; become enmeshed in conversations about advocacy, rural surgery, international surgery, or wherever your interests and passions may lie.

Member Services
The mission of the Division of Member Services is to serve the many diverse interests of ACS members. As with Communications, the great challenge is, how do our Fellows engage with the ACS as an organization and vice versa?

At the April 2015 ACS Leadership & Advocacy Summit, retired U.S. Army General Stanley McChrystal offered his perspective on leadership, conveying what he learned from his command experience in the Middle Eastern theater. These lessons have been collected in his widely acclaimed book, *Team of Teams: New Rules of Engagement for a Complex World*. Stated simplistically, one theme he articulated is the need to have leadership that is not top-down but that is actively engaged...
Quality, which will be increasingly data- and outcomes-driven, is the benchmark by which future surgeons will be judged. Surgeons must own quality.

with those rank-and-file troops who have “boots on the ground.”

I would opine that a truly successful surgical group must be bottom-up with active engagement of our surgeons in the field. Several decades ago, the Board of Regents had a reputation for rigidity—whether deserved or not. I can assure all ACS Fellows that the current members of the Board of Regents and ACS Officers are actively engaged and fully committed to serving our patients and our Fellows in a flexible and timely manner. However, a top-down organizational structure from Chicago or Washington, DC, will never allow us to be the organization we desire to be.

The Advanced Trauma Life Support® program is one of the most successful programs in ACS history, and its reach is worldwide. However, establishing this program wasn’t a dream of a Regent sitting in Chicago, but rather it was a mission generated by surgeons in Nebraska who saw a need and acted on it. Similarly, our current initiatives in rural surgery were instigated by the women and men in rural areas who developed an Advisory Council for Rural Surgery and the online Rural Surgery Community, and these individuals continue to advocate for change in this important area.

Countless other efforts have similarly arisen, and the ACS leadership has responded accordingly. For young Fellows, local involvement may be an ideal starting point. Many ACS chapters are floundering and need the energy and creativity young Fellows can bring to the table. When local issues are identified, become involved and use the chapters, Members Services staff, or specialty society Governors as a conduit to ACS leadership. Good actions—those that are patient-centric rather than surgeon-centric—often are successful.

Quality: The founding pillar
Improvement in the quality of surgical care was the core principle behind the founding of the College, and quality improvement remains one of the ACS’ primary missions today. Surgeons undoubtedly want to provide high-quality patient care, but the majority of these health care professionals are unlikely to directly participate in quality efforts in their practices or at their hospitals. I would submit simply working in a hospital that has a surgical quality officer, chief medical officer overseeing quality efforts, a “quality” nurse, or the like will not suffice.

Quality, which will be increasingly data- and outcomes-driven, is the benchmark by which future surgeons will be judged. Surgeons must own quality. Its measurement must be local, personal, accurate, and risk-adjusted. If surgeons don’t become involved in quality improvement and take ownership of this space, someone else will. The ACS has invested millions of dollars in the development of quality programs, but surgeons and their institutions must put them to use to have a meaningful impact on patient care.

We have recently seen Internet rating services that rank the quality of care that surgeons provide. Some of these rankings use administrative data as a source for these evaluations. Surgeons must take a leadership role in providing the transparency of our quality improvement effort as well.

The College has the ACS National Surgical Quality Improvement Program (ACS NSQIP®) and “QIPs” for trauma, cancer, and other areas of surgery. If your hospital can’t afford to participate in ACS NSQIP, find a partner, build a consortium or cooperative, or create your own quality improvement measurement tool. Specialty societies have registries that you can tap. Tomorrow’s surgeons will need a record of all cases and outcomes and a means to critically evaluate their work. Undoubtedly, the tools will change, but the core value of quality care for our patients must not. My admonition is that you “own” quality, or the system may own you.

Education is our foundation—not a pillar
Since the first Clinical Congress more than 100 years ago, education has been at the heart of all College efforts. The ACS now engages in myriad educational activities at all levels, from “boot camps” for incoming residents to residency teaching tools. However, our primary focus has been primarily on post-residency
educational activities, whereas resident education has been organized and managed by other groups. I believe it is time to examine whether the oversight of residency training is properly structured. In my opinion, the greatest threat to the provision of quality surgical care in the future lies not with adherence to quality metrics, but with inadequacies in core surgical training. Surgical training in the U.S. has, for the past century, been among the best, if not the best, in the world. However, a variety of forces are, in my opinion, eroding the quality of our training.

Be assured, I am not railing on about duty hours; that ship has sailed. I would, however, submit that surgical training is different than in other nontechnical specialties. Six competencies are common to all surgical training—patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice—but patients are most concerned about the seventh competency: Can my surgeon diagnose my problem and render surgical treatment that is safe and effective?

Completion of a computerized checklist verified by a site visitor, who may be a retired pediatric neurologist, will not suffice to ensure quality training in the procedural aspects inherent to surgery. Pilots teach other pilots to fly aircraft, and those individuals who understand airplanes and aviation verify that training. Although surgeons teach surgeons how to operate, those individuals who verify that training and establish the standards for it often know little, if anything, about surgery.

Understand I am not an “outsider” railing about the system. I have spent 18 years as a general surgery residency program director; seven years on the American Board of Surgery, including one as chair; and seven years on the Residency Review Committee for Surgery, including one year as vice-chair. With that history, one could conclude that I am part of the problem. But the years that I have spent engaged in these endeavors have convinced me that future leaders of the College should demand radical changes in training paradigms for surgeons.

I would further suggest that the ACS should play an integral part in creating those changes. This issue affects not simply general surgery, but rather all surgical specialties. We should partner with our surgical boards to improve core training; the College has extensive experience in skills verification, and we must ensure our future surgeons have an adequate skills set.

Undoubtedly, any attempt to fundamentally change training will be met with heavy resistance from entrenched organizations currently in control. If my views are mine alone or represent the views of only a minority of surgeons, these views on training will fade away rapidly; however, if you in your practices come to believe surgical training requires substantial improvement, become part of the drumbeat for action.

We should engage existing organizations in a cooperative spirit. However, real solutions may require a surgical approach; that is, create a thoughtful, calculated plan that can be executed decisively. If leading that charge requires direct ACS engagement, we should stay true to our duty to our patients.

The Advocacy Pillar
Advocacy within the ACS is centered primarily on issues that affect U.S. Fellows, largely because most other developed nations have rigidly defined national health care systems. The College entered this arena somewhat late but has become an active force for representing the interests of our patients and their surgeons by advocating in the halls of Congress and state governments, at meetings of policymaking think tanks, with payors, and in discussions with other stakeholders in health care. We have a Washington, DC, office near Capitol Hill and a great staff who represent all of us.

The challenges of advocacy are ever-evolving and changing daily. To paraphrase a line said by Jack Nicholson when referring to the U.S. Marines in the 1992 movie A Few Good Men, “You want us on that wall. You need us on that wall.” The ACS and its Division...
We should engage existing organizations in a cooperative spirit. However, real solutions may require a surgical approach; that is, create a thoughtful, calculated plan that can be executed decisively.

of Advocacy and Health Policy stand on the wall daily for surgeons and, most of all, for our patients. Most surgeons have no concept of how our advocacy efforts affect their daily practices.

All surgeons should be involved in advocacy. Be an advocate for your profession with your patients and your health care institutions. If you are a U.S. citizen, give of your talents and your treasure—that is, consider contributing to the ACS Professional Association, a branch of the ACS focused largely on supporting congressional candidates who have demonstrated an understanding of how health policy affects surgical patient care. For those surgeons who believe too much money is spent trying to influence policy, I would remind you that Americans spend billions annually on Halloween candy. I cannot overstate the need for a vibrant advocacy effort.

Changes in health care may require a different form of advocacy in the future. Approximately 80 percent of surgeons are now employees of health care networks or institutions rather than in traditional private practice, and the number of surgeon employees will likely reach 100 percent soon. Problems have already surfaced for surgeons with contracts, terminations without cause, and other issues. Bundled care payments may come, which will mean that one lump-sum payment will be made to a hospital or large group to share for all aspects of care, including all physicians’ services. Who will represent the interests of surgeons and their patients? An organization with the College’s cachet may need to continually reaffirm the benefit of surgical therapy for our patients.

As corporate medicine continues to grow and consolidate, a new form of representation may be needed to protect the interests of surgeons and their patients. The College would be the ideal group to lead such an effort.

Whereas the ACS is the logical organization to protect the interests of general surgeons, those surgeons who practice in the surgical specialties should support the College as well. The collaboration between the ACS and your specialty group or academies can represent an enormous voice for surgical care.

The constancy of change
U.S. Founding Father Benjamin Franklin expressed his concern about the permanence of the U.S. Constitution when he opined, “Nothing can be said to be certain except death and taxes.” I posit that the third certain feature of our lives is change itself. Although this presentation has suggested challenges young College Fellows may encounter in the future, in truth, I have no earthly idea what obstacles you may face in your careers. However, I am confident there will always be a hill to climb and that there will always be another peak to scale.

When the seas get rough, and at times they likely will, be certain of your anchors: your family, your friends, your faith in whatever belief system you embrace, and your profession. The American College of Surgeons can be that professional anchor with the support of you and your fellow Initiates. Embrace the College and build your own pillars; you and your patients will be well served by your efforts. ♦

DEC 2015 BULLETIN American College of Surgeons
A quarter century has passed since CBS News correspondent Connie Chung opened her broadcast of Face to Face with Connie Chung with these words: "Most of us know very little about breast implants; we don’t know anything about the dangers." The report that followed sent a wave of fear throughout the nation. Plastic surgeons and their patients were primarily affected, but so was every surgical specialty that used silicone devices. How could breast implant toxicity be the subject of a national news program without focusing on other silicone devices that have provided patient benefits for decades?

In fact, a media focus on breast implants had preceded the December 1990 CBS broadcast by two years. In October 1988, Sidney M. Wolfe, MD, co-founder and then-director of Public Citizen’s Health Research Group, a consumer and health care lobbying organization, predicted a looming epidemic of breast cancers occurring in women with breast implants. Dr. Wolfe issued this warning at the same time as the American College of Surgeons (ACS) 1988 Clinical Congress was taking place, October 23–28 in Chicago, IL, so journalists were primed to feature news from the surgical specialties. In reality, little evidence was available to support the assertion that an epidemic was likely, and a 1986 epidemiologic study had, in fact, already demonstrated a modest decrease in breast cancer incidence among women with breast implants.
This article reviews the history of the use of silicone in medicine and surgery, the debate over the potential risks of silicone breast implants, the U.S. Food and Drug Administration’s (FDA’s) regulatory response, and how increasing government regulation has had a stifling effect on innovation.

History of silicone devices
Silicone polymers were first synthesized in the U.K. in the 1890s and then rediscovered in the 1930s by Corning Glass chemist J. Franklin Hyde, PhD. Because of their remarkable stability at extreme temperatures, the silicones served an essential military role as miracle lubricants permitting aircraft to fly at required altitudes and submarines to reach the depths necessary for survival. Scientists at newly established Dow Corning Corporation stood proud; their handiwork helped make it possible to win World War II within four years.

Soon after, toxicological studies confirmed that the human body was able to tolerate silicone remarkably well. Additional testing showed negligible influence on immune function. Peacetime uses began to appear, and, in time, medical applications proliferated. Health care professionals found that syringes and IV tubing coated with silicone functioned better. Implanted silicone catheters remained patent, allowing neurosurgeons to insert a shunt that spared the brains of hydrocephalic infants. Today, silicone is ubiquitous throughout the health care environment.

Silicone devices, unlike plastics, display their properties without the need for catalytic activators. Their physical structure varies according to molecular chain length, ranging from liquids to oils to flexible solids. In 1962 a cohesive gel was introduced that permitted the development of mammary implants. This innovation was developed by two Houston, TX, plastic surgeons—Thomas Cronin, MD, and Frank Gerow, MD—and transformed both reconstructive and cosmetic breast surgery. Subsequently, silicone gel was used in further medical advances, including testicular implants and non-adherent wound dressings.

The FDA steps in
The FDA was not assigned jurisdiction over medical devices until the Medical Device Amendments of 1976 to the Federal Food, Drug, and Cosmetic Act were passed. Previously unburdened to the medical profession, the agency was now required to establish advisory panels responsible for designating risk categories for every device in use. The General and Plastic Surgery Advisory Panel functioned effectively under the chairmanship of the late J. B. Lynch, MD, FACS, then-chair of the department of plastic surgery at Vanderbilt University Hospital and Clinic, Nashville, TN. Dr. Lynch held this position until 1988 when, in the face of increasing allegations of silicone-related disorders, the agency replaced him with Norman Anderson, MD, an internist without surgical experience with implantable devices. Under Dr. Anderson’s leadership, a panel previously dominated by surgeons was expanded to include consumer advocates and industry critics. Trial attorneys sitting in on hearings were encouraged by Dr. Anderson to voice their opinions.

In a meeting I had with Dr. Lynch soon after these events, he indicated that he believed that what he had witnessed while attending his final hearing was an event that the FDA deliberately staged to send a new message regarding breast implants and, by implication, other silicone devices.

By this time, in addition to the persisting cancer scare, reports of autoimmune diseases occurring in women with breast implants were surfacing. The scene was now set for a major media focus on the issue, commonly believed to be orchestrated by Dr. Wolfe and assisted by Fenton Communications, a public relations firm. On the evening of December 2, 1990, viewers of Face to Face with Connie Chung listened to the experiences of four women with silicone breast implants voice complaints ranging from fatigue to hair loss, total body pain to mouth ulcers. Such was the problem of defining the putative “silicone disease,” but diagnostic criteria were not discussed in any detail in the broadcast. Disease claims were confirmed by two “experts”—Canadian chemist Pierre Blais and Tennessee pathologist Douglas Shanklin, MD—both of whom......
lacked any clinical training or device experience. Although CBS producers accepted their testimony at face value, both were later disqualified from providing testimony in American courts.

Trained as both a physician and a lawyer, FDA Commissioner David A. Kessler, MD, JD, understood the difference between legal and scientific evidence. Attorneys emphasize the evidence that supports their client’s position, whereas scientists must consider all available evidence. Disregarding the recommendations of his own advisory panel and relying on trial testimony that yielded a $7.3 million judgment against Dow Corning, on January 6, 1992, Dr. Kessler called for a moratorium on the use of silicone gel breast implants.

Dr. Kessler acknowledged during an afternoon television broadcast two days later that very few women were at risk for disease from breast implants. His call for a moratorium elicited an unprecedented rebuke of his agency’s integrity. Meanwhile, doubt was effectively cast on the safety of several hundred silicone devices in use at the time. Trial attorneys promptly filed thousands of suits against implant manufacturers. By year’s end, most plastic surgeons in the nation had been named in one or more lawsuits. Plaintiff attorneys were positioned to reap 30 percent to 40 percent of every award declared by a jury or issued in a settlement conference.

Professional organizations rallied in support of the medical device industry, among them the ACS; the American College of Radiology; the American College of Rheumatology; the American College of Clinical Oncology; the American College of Pathology; and the American Psychiatric Association, whose members recognized an emotional benefit from breast reconstruction surgery. All such pleadings fell on deaf agency ears.

At an FDA hearing soon after the moratorium on silicone breast implants was announced, U.S. Representative Marilyn Lloyd (D-TN), a member of the House Science Committee, asked Dr. Kessler, “How scientific is the FDA’s decision that no woman should have implants put in and no woman should have them taken out?” A breast cancer victim herself, she reminded the commissioner that he had placed unjustified limits on the choices her surgeon, a practicing professional, could offer her for reconstruction.

Speaking on behalf of the College, ACS Regent Maurice Jurkiewicz, MD, FACS, a plastic and reconstructive surgeon and professor of surgery at Emory University, Atlanta, GA, cautioned the panel not to restrict the benefits of silicone devices for reconstructive surgery, especially for patients who had undergone a full mastectomy. Dr. Jurkiewicz further voiced the College’s strong objection to removing voting rights from the panel’s qualified surgeons who had more experience with implanted medical devices than any of the panelists. Meanwhile, manufacturers who had protested the continued chairmanship of Dr. Anderson learned he would be replaced by a distinguished gynecologist, Elizabeth Connell, MD, FACOG. Not until 1999 would silicone devices and, in particular, breast implants receive a full pardon—not from the FDA but instead from the Institute of Medicine (IOM). A panel of 13 medical scientists declared all claims of carcinogenic, teratogenic, mutagenic, and immunologic influence as invalid. Instead the panel affirmed the original toxicology findings that had been discounted by the FDA.

Regrettably, the IOM’s reprieve came too late for some manufacturers who by then had expended billions of dollars to preserve their commercial viability and appease the demands of America’s litigation industry. Dow Corning was forced into bankruptcy, while several other manufacturers discontinued their medical product lines. Implantable device innovation in the U.S. nearly came to a standstill, and for the first time, silicone product development gained traction in Europe and Asia.

The evolution of a leviathan

I had the privilege of serving as a spokesperson for the Plastic Surgery Education Foundation and its ad hoc breast implant research committee during our most
intense battles with regulators regarding the safety of silicone breast implants. Consequently, I developed a deep interest in the growth of regulatory power in America, with a specific focus on the role of the FDA. The FDA started as the Bureau of Chemistry in 1906 when it first gained legislative backing in the form of the Pure Food and Drugs Act, but, in time, the agency became an evolving leviathan, controlling access to products worth $1 trillion dollars annually.19

Following retirement from academic surgical practice, I formalized my interest with a period of graduate study in U.S. political and economic history. One important lesson learned: government regulation is a political process and not a scientific one, even when a product is based on technology.

Given the reality that some people are inherently risk-averse while others are remarkably tolerant of potential danger, whose perception of risk should take precedence? The challenge for policymakers and regulators is to find a balance between risk estimates and statutory limits, product innovation and market barriers, and between unanticipated outcomes and rational compensation for avoidable hazards. Meanwhile, no one should be surprised by the inevitable conflicts that arise between risk-taking innovators and regulators who are mandated by the electorate to avoid risk.

Regulatory power has grown in the U.S. in response to isolated events featuring, at times, negative outcomes. A 1938 revision of the original Pure Food and Drugs Act immediately followed the elixir sulfanilamide tragedy when a small company inexcusably blended the compound with a toxic glycol instead of a harmless glycerol, resulting in the death of 107 children. After several major pharmaceutical houses declined to lease a new German sedative because of inadequate testing, a little-known company known for its medicated salves elected to bring thalidomide to the U.S. market, resulting in 17 deformed newborns. Amendments to the 1938 law soon followed, replacing required premarket notification with mandated premarket approval of all drugs. And because
of a single unethical surgeon and his business partners who lied about the safety of their intrauterine device, efforts to pass medical device amendments advanced quickly to become law in 1976.  

Impact on surgical innovation

Today’s surgical innovator must be prepared for an encounter with regulators. Whether it be an improved procedure, a new device, or an untested treatment regimen, regulatory approval will require justification based on measured outcomes. Surgeons of all stripes, including residents in training, are advised to learn more about the origins and expanding power of regulation, how the FDA is organized and what it requires from innovators, and why significant change may not come quickly or easily—certainly not without new legislation to support it.

To this day, the FDA has yet to accept the conclusions of the IOM panel. In fact, its website continues to list autoimmune disease as a possible risk of breast implants, even though the number of epidemiologic studies that disprove any disease linkage now exceeds 30.  

It took seven more years of filing applications, conducting studies, monitoring results, responding to demands for more data, resolving deficiency reports, testifying at hearings, receiving denials, resubmitting applications, gaining advisory panel support, negotiating label requirements, and accepting limitations on product use before the two remaining manufacturers received conditional approval to market a full line of devices for reconstructive and cosmetic surgery in November 2006.

Regulation does not have to function in this manner. The evaluation and approval of medical devices in Europe does not involve government regulators directly. Instead, “notified bodies” test and certify according to established standards. Silicone devices in Europe now benefit from polymer innovations a decade ahead of the U.S., where a polymer change requires a new filing that starts the approval clock ticking all over again. The European Medicines Agency (EMA) is

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considered lean and efficient by the drug industry. Furthermore, unlike the FDA, the EMA maintains a close liaison with medical professionals and draws willingly from their clinical expertise. 23

There is no shortage of inventive proposals for correcting the problems that plague the FDA, many of them coming from the agency’s previous leadership.24 For example, former FDA Commissioner Andrew von Eschenbach, MD, makes a strong case for accelerated drug approvals based on safety trials alone, reserving efficacy determination for post-market monitoring of the same test subjects.25 For devices, Henry I. Miller MD, MSc, founding Director of the FDA Office of Biotechnology, urges adoption of the nationally recognized and proven testing laboratory model, best exemplified by the highly successful Underwriters Laboratory, Inc.26

But these revisions cannot become reality without congressional action. Consider, for example, a bill now under debate, the Promise for Antibiotics and Therapeutics for Health (PATH) Act. With bipartisan sponsorship, it provides for accelerated approval of new antibiotics for an emerging class of resistant organisms. Any endeavor that promises new antibiotics is a noble cause but there are outspoken critics of the measure. Readers of this article are now primed to monitor the bill’s progress and learn who supports and who opposes the legislation.27

Meanwhile, surgical specialty organizations are free to maintain their preferred relationship with regulators. The American Academy of Orthopaedic Surgeons represents a model for sustaining a productive liaison with the FDA, and plastic surgeons have learned to pursue a more proactive stance with the agency. Expanding on the advisory panel format, the American Society of Plastic Surgeons and its foundation, The Plastic Surgery Foundation, remain vigilant regarding problems involving the use of devices. These entities seek advice from their own advisory panels and, on their own initiative, forward relevant information to the FDA.

One such problem is the risk that never seems to go away—cancer following breast implantation. Beginning in 1998, reports of a lymphoma developing in the fibrous

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capsule surrounding breast implants first appeared.\textsuperscript{28} None are cancers involving the breast gland itself but instead anaplastic large cell lymphoma (ALCL). Without an exact number of women with implants worldwide (estimates range from 10 million to 20 million), an incidence rate cannot be precisely determined. The FDA places the risk of ALCL at two or three per million.\textsuperscript{29}

Fortunately, the FDA has taken a more measured view than its 1991 reaction to unsubstantiated breast implant linked diseases by stating, “The FDA believes that women with breast implants may have a very low but increased risk of developing ALCL adjacent to the breast implant.”\textsuperscript{30} Because these tumors are believed to be a manifestation of chronic inflammation and not specific to silicone, it is not unreasonable to expect they might arise in capsules known to form around any implanted device, so there is ample motivation for all surgical specialties to monitor the problem and maintain a liaison with the FDA.\textsuperscript{31}

In the face of power, we are advised to speak truth. When the opponent is a government agency, success requires a listener willing to act on the basis of scientific principle, not political bias. James Madison said it another way: “In framing a government to be administered by men over men, first enable the government to control the governed; then oblige it to control itself.”\textsuperscript{32} ♦

Note

For more information, see Silicone on Trial: Breast Implants and the Politics of Risk, by Jack C. Fisher, The Sager Group, La Jolla CA, 2015.

Residency program directors wanting their residents to learn more about regulation in America including policies for drug and device approval should contact Dr. Fisher for access to discounted copies at Jfisher37@icloud.com
Bariatric surgery, liability, and trauma: Key issues debated in state legislatures

by Justin Rosen and Jon H. Sutton, MBA

The states kicked off their 2015 legislative sessions in early January. All of the states convened sessions this year, and three-quarters of them wrapped up their business by the end of May. Budgets and transportation were the biggest legislative themes for 2015; most states had budget deficits or crumbling transportation infrastructure that needed to be addressed. As a result, little room was left on lawmakers’ agendas for surgery-specific legislation. Nonetheless, the American College of Surgeons (ACS) was able to play a role in numerous legislative victories, defeats, and compromises throughout the U.S. Success at the state level has always been dependent on grassroots advocacy by individual Fellows and ACS chapters, and this was true in 2015 as more chapters hosted legislative lobby days, and Fellows continued to take action through the Surgery State Legislative Action Center (SSLAC)—a grassroots advocacy tool that the College and 13 other national surgical specialty societies share—and SurgeonsVoice Action Alerts. In those instances where it was necessary to take action on more pressing legislation, numerous resources were used. These online resources make it possible for surgeons to contact their state legislators by e-mail with a targeted, pre-drafted message. In 2015, more than 1,700 such messages were sent to state legislators, most focused on liability reform, obesity treatment, and ambulatory surgical center (ASC) taxes.

State legislation is tracked using an online search service provided by Congressional Quarterly called CQ StateTrack to identify and monitor bills on an array of health care and surgery-specific topics. In 2015, more than 2,400 bills were reviewed with approximately 500 actively identified as issues related to surgery. These bills covered a range of issues, including medical liability reform, out-of-network billing, trauma/injury prevention, tanning bed restrictions, the Uniform Emergency Volunteer Health Practitioner Act (UEVHPA), coverage for bariatric surgery, and ASC taxes and regulations.

Coverage for bariatric surgery

Last fall, the ACS State Affairs team began working to have bariatric surgery included as an essential health benefit (EHB) in plans offered through health insurance exchanges authorized by the Affordable Care Act. Currently, 28 states do not require health plans to offer bariatric surgery coverage, and about half of them have their own state-based exchanges. The initial legislative push was on states with their own exchanges, including Arkansas, Colorado, Connecticut, Kentucky, Minnesota, Oregon, Utah, and Washington, as well as the District of Columbia.

The College submitted letters to state policymakers inquiring about the lack of coverage and the rationale for not including coverage for bariatric surgery. The letters also extended an offer to help make bariatric surgery a covered service, either through legislative action or through the selection process for the EHB plan. These letters were sent to a diverse group of
Efforts to gain coverage for bariatric surgery will remain an ongoing activity over the next few years. States are gearing up to select the next essential health benefit plan, which creates an opportunity to influence the outcome.

Leaders in each state, including the governor, director of the state exchange, insurance commissioner, speaker of the House, president of the Senate, and leadership in the Republican and Democratic parties.

Four states—Arkansas, California, Louisiana, and Mississippi—considered bills requiring coverage for obesity treatment services, including bariatric surgery. The Arkansas bill would have covered only state/public employees; this bill, along with the Mississippi and California bills, died in committee.

In Louisiana a bill, S.B. 173, was introduced that would have expanded access to bariatric surgery. Although it passed in the Senate, it failed to advance out of the Louisiana House Committee on Insurance. The bill, introduced by Sen. David Heitmeier, OD (D), would have required group health plans to cover bariatric surgery, physician office visits, health and behavior assessments, nutrition education, patient self-management education training, and therapeutic exercises. The Louisiana Chapter of the ACS played an important role in getting the bill introduced and intends to work with the legislature to advance S.B. 173 in 2016.

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Emergency volunteers
The UEVHPA, created by the Uniform Law Commission, a nonpartisan commission of lawyers established in 1892 and endorsed by the College in 2009, permits licensed physicians and other professionals to enter a state and practice their profession without medical board clearance in the event of a declared emergency. To date, 14 states and the District of Columbia have enacted the UEVHPA.

In 2014, the focus of the UEVHPA centered largely on southeastern states because they are most likely to experience the brunt of severe hurricanes. Initial conversations on the introduction of the model bill were held with chapter leaders/executive directors and commissioners of the Uniform Law Commission (some of whom are state legislators) in Alabama, Florida, Georgia, Mississippi, North Carolina, and South Carolina. Alabama and North Carolina have statutes that policymakers within those states believe provide similar protections as the UEVHPA, so they were removed from the list, leaving Florida, Georgia, Mississippi, and South Carolina as targets for 2015. In addition, Pennsylvania considered a bill in 2014 that remained active for 2015.

In Florida, political drama and strategic concerns derailed UEVHPA efforts for 2015. In 2016, an emphasis on how the UEVHPA will serve as an important component of disaster preparedness within the Florida emergency management program will be used to help get the bill introduced.

The Georgia bill was introduced near the end of the legislative session and will serve as placeholder legislation for the 2016 legislative session. The Georgia Society of the ACS made this development possible and is working to facilitate passage next year.

The UEVHPA was introduced in Mississippi, and Hugh A. Gamble II, MD, FACS, a former ACS Governor, championed the bill. Similar to Alabama and North Carolina, some officials expressed their belief that Mississippi already has a process in place similar to the one in UEVHPA. The bill stalled as a result.

At press time, it was unclear whether the UEVHPA in Pennsylvania would make it out of the Senate Veterans Affairs Committee, where it sat for months as part of a larger emergency medical services/disaster preparedness bill; there was hope the entire bill would pass earlier in the session.

Delays in identifying a surgeon champion in South Carolina slowed efforts to introduce the UEVHPA and provided an opportunity for further investigation into the need for this legislation.

Liability reform
Indiana surgeons played a key role in ensuring the defeat of two legislative attempts to weaken the state’s medical liability system in 2015. The Senate voted down S.B. 55, which would have increased the threshold for filing a liability claim against a physician
without first going through the state’s medical review panel. The bill would have raised the threshold for direct filing to $50,000 from $15,000. In the House, H.B. 1043 stalled in the Judiciary Committee. That bill would have increased the caps on medical liability claims. More specifically, the bill would have raised the cap on total damage awards to $1.65 million from $1.25 million and would have increased the maximum potential liability of a qualified health care provider for an occurrence of liability to $400,000 from $250,000 or $300,000 in some circumstances. Surgeons used the annual Indiana Chapter Day at the Capitol to discuss the bill with lawmakers, in addition to responding to Action Alerts issued by the ACS. 

Illinois surgeons helped stop legislation, S.B. 1700, that would have removed protections provided to physicians and hospitals under the Medical Studies Act. Current protections are in place to exclude peer review, research, and medical studies from use as evidence in medical liability cases. S.B. 1700 would have severely diminished the ability of health care providers to share information, effectively shutting down the peer review process. Illinois courts have consistently recognized the importance of the Medical Studies Act in maintaining the peer review committee process and have ruled that they should not be made available to plaintiff attorneys. S.B. 1700 stalled in the Senate Judiciary Committee after more than 70 surgeons contacted their senators to voice opposition to the bill. 

Missouri Gov. Jay Nixon (D) signed S.B. 239, legislation that reinstates limits on noneconomic damages in medical liability cases and creates a statutory cause of action for damages against health care providers. It also reinstates caps of $400,000 for personal injury cases and $700,000 for catastrophic personal injury or wrongful death lawsuits. The limits will increase by 1.7 percent each year.

Toward the end of the session, legislation (A. 285) passed out of the New York Assembly that would have quadrupled the statute of limitations for medical, dental, or podiatric liability to include a discovery of injury rule. This provision would have allowed the current 2.5 year statute of limitations to run from the date a patient discovers (or should have discovered) an injury was caused by malpractice. The effects of this expansion would have had significant financial implications for New York Fellows. A. 285 and similar legislation failed to advance in the Senate, after more than 100 Fellows answered the call to action and sent letters of opposition to their state legislators, ensuring the defeat of this legislation. 

The Florida 4th District Court of Appeals on July 6 ruled that a 2003 law that caps noneconomic damages for pain and suffering in personal injury cases is unconstitutional. Florida's Supreme Court ruled last year that caps on noneconomic damages for wrongful death cases were unconstitutional, and the appeals court cited this ruling in its 14-page decision. The court ruled that “caps are unconstitutional not only in wrongful death actions, but also in personal injury suits as they violate equal protection.” In the case resulting in the judgments, a jury originally awarded the plaintiff $4.7 million, of which $4 million was in noneconomic damages. After a circuit judge applied the caps from the 2003 law, the noneconomic damages were reduced by $2 million. The appeals court ordered the trial court to reinstate the total amount of the damages, although they may still be limited under the doctrine of sovereign immunity. 

Out-of-network providers

Early this year, the California Insurance Commissioner issued emergency regulations to increase patient access to provider networks. Insurers have considerably narrowed their provider networks and offered insurance products with no out-of-network benefits.* These emergency regulations require plans to do the following:

Numerous states introduced legislation to repeal, change, or institute a universal motorcycle helmet law.

- Ensure an adequate number of primary care physicians are available to accept new patients to accommodate enrollment growth
- Ensure an adequate number of primary care providers and specialists have admitting and practice privileges at network hospitals
- Account for the frequency and type of treatment needed to provide mental health and substance abuse care
- Adhere to and monitor new appointment wait time standards
- Report information about the networks and changes to the networks to the Department of Insurance on an ongoing basis
- Provide accurate provider network directories to the department and make them available both to policyholders and the public, so that individuals who are shopping for health insurance have access to this information as well
- Make arrangements to provide out-of-network care at in-network prices when too few in-network care providers are available
- Inform patients that an out-of-network medical provider will participate in the non-emergency procedure or care, before the care is provided, so that the patient can decline the participation of the out-of-network provider if they choose

**New Jersey** legislators sought a compromise to legislation (S.B. 20/A. 4444) intended to reform various aspects of the state’s health care delivery system by increasing transparency in pricing for services by limiting billing for out-of-network costs.

The current legislation is stalled in committee until a version is developed that is acceptable to legislative leadership, Gov. Chris Christie (R), and key health care stakeholders. The New Jersey Chapter of the ACS and the ACS State Affairs team are actively monitoring this legislation and will provide updates via action alerts if there is any movement.

**Cancer**

An **Ohio** law that took effect March 23 restricts the use of tanning beds by minors. More specifically, H.B. 131 requires parental consent for youth ages 18 and younger to use tanning beds; for individuals younger than 16 years old, a parent must be present.

**New Hampshire** Gov. Maggie Hassan (D) signed legislation, H.B. 136, on June 2 that prohibits individuals ages 18 and younger from using tanning facilities. However, the new law allows health care professionals to approve their use for medical reasons. Until passage of this law, state law banned individuals younger than 14 years old from using a tanning bed without physician approval, and parental permission was required for teenagers younger than age 18. The law took effect August 2. A total of 12 states and the District of Columbia now ban the use of tanning beds by individuals younger than 18 years old.

Effective June 1, **Michigan** began mandating mammography service providers to notify patients when their mammograms demonstrate the existence of dense breast tissue. The law defines “dense breast tissue” as “heterogeneously or extremely dense breast tissue as defined in nationally recognized guidelines or systems for breast imaging reporting of mammography screening including, but not limited to, the breast imaging reporting and data system established by the American College of Radiology.” The law also allows the Department of Community Health to update the definition, if necessary.

**Trauma**

S.B. 93 in **Texas**, legislation that would have curtailed the state’s Driver Responsibility Program, stalled during this year’s legislative session. S.B. 93 passed in the Senate; however, the House failed to act on the bill before the session ended. The Driver Responsibility Program provides funding for the state trauma system by imposing surcharges on drivers who receive traffic...
violations. The legislation would have removed the provision that suspends drivers’ licenses for individuals who fail to pay the fine, which would have led to a significant decrease in funding for trauma care in the state. The ACS opposed the bill and will continue working to avert efforts to cut trauma funding in Texas when the legislature reconvenes in 2017.

H.B. 261 was introduced in the Ohio House of Representatives. This bill would create an Ohio Trauma Board and make changes to the state’s trauma system. The board, which would be administered by the Ohio Department of Health, would comprise 19 members appointed by the Governor, Speaker of the House, and Senate President. The board would be responsible for operating the state trauma registry, seeking and distributing grants, and developing a statewide system for improving the quality of trauma care and rehabilitation.

The legislation also would add new designation standards, such as participation in statewide and regional injury prevention activities and submission of more timely data to the registry. In addition, the bill would require the Ohio Department of Health to hire an executive director and chief medical director. At press time, H.B. 261 was awaiting action in the Health and Aging Committee. The Ohio Chapter of the ACS and the Ohio Committee on Trauma are advocating for passage of this bill.

Motorcycle helmet laws
Numerous states introduced legislation to repeal, change, or institute a universal motorcycle helmet law. Following is a roundup of the bills, all of which failed in their respective statehouses.

- **Iowa:** H.F. 267 would have required persons operating a motorcycle and their passengers to wear helmets.

- **Nebraska:** L.B. 31 would have repealed the state’s mandatory helmet law.

- **New Mexico:** S.B. 308 would have created a validation sticker to exempt motorcycle operators and their passengers who are older than 18 years of age from wearing a helmet.

- **Washington:** S.B. 5198 would have removed the mandatory helmet requirement for individuals older than 18 years of age.

- **West Virginia:** S.B. 356 would have exempted individuals from wearing a helmet who are both older than age 21 and have a health insurance plan with at least $10,000 in medical benefits for injuries incurred as a result of an accident while operating a motorcycle.

- **Tennessee:** H.B. 700/S.B. 925, bills to repeal Tennessee’s universal helmet law, would have exempted motorcycle operators and passengers older than 21 years of age from the requirement to wear a helmet if they have health insurance coverage through a carrier other than TennCare and would have changed a violation of the helmet law into a secondary offense.

Scope of practice
The Arkansas Senate Committee on Public Health, Welfare and Labor in February voted down S.B. 78, legislation that would have removed the physician supervision requirement for certified registered nurse anesthetists and permitted them to practice independently. The ACS and other physician groups in the state opposed the bill.

California surgeons helped to successfully block S.B. 622, a bill that would have allowed optometrists to significantly expand their scope of practice. More specifically, the legislation would have authorized optometrists to perform scalpel and laser eye operations, administer immunizations, and perform or order laboratory and diagnostic imaging tests, all with minimal training. California surgeons and the California Medical Association argued that this legislation would place patients at risk of significant harm because optometrists lack the education, training, and experience to safely provide these types of services. The College and ACS California
Chapters sent nearly 900 opposition letters to lawmakers via the SSLAC.

**Medical licensure, ASCs, and cosmetic surgery**

The Federation of State Medical Boards developed the Interstate Medical Licensure Compact in response to concerns regarding the long wait times for physicians to attain medical licenses in states outside of their primary practice location, along with increased demand for physician services due to the Affordable Care Act and interest in the expansion of telemedicine services. In 2015, a total of 11 states enacted legislation ensuring the compact would be created, making it easier for physicians to obtain licenses to practice in multiple states.

To be eligible for expedited licensure, physicians must fulfill the following requirements:

- Possess a full and unrestricted license to practice medicine in a compact state
- Possess specialty certification or be in possession of a time-unlimited specialty certificate
- Have no disciplinary actions related to controlled substances
- Have no disciplinary actions on any state medical license
- Must not be under investigation by any licensing or law enforcement agency
- Have passed the U.S. Medical Licensing Examination or Comprehensive Osteopathic Medical Licensing Examination within three attempts
- Have successfully completed a graduate medical education program

Physicians who are ineligible for the expedited licensure process could still seek licenses in those states where they want to practice using traditional licensure processes. The federation has created a website for physicians seeking further information about the compact.†

**Connecticut** legislators passed a budget in early June that included a 6 percent tax on the gross receipts of ASCs. However, when lawmakers reconvened for a special session June 30, they amended the tax. The new version of the bill excludes the first $1 million in gross receipts from taxation, as well as any ASC revenue that is subject to the state’s hospital tax. The ACS Connecticut Chapter engaged more than 90 Fellows to take action against this legislation using the SSLAC.

The ACS joined a coalition of 12 other physician associations to oppose a proposed section of the **Maine** state budget that would have established a tax on all cosmetic surgery. The coalition argued this plan would have made it extremely difficult to establish a legislative difference between elective and medically necessary cosmetic surgery, thereby creating a discriminatory health policy. The tax was removed from the final budget.

Looking ahead
Chapters and surgeons can expect interesting legislative sessions next year. With 2016 being an election year, many legislators will try to advance bills that will make them more electable and not create much in the way of controversy. At times like this, public health issues can gain prominence, as can legislation to help key health care constituencies.

One issue likely to gain prominence is the recording of operations. Wisconsin’s legislature considered a bill in 2015 that would have required the option of recording a procedure if the patient requested it, including covering exits/entrances to the operating room to date and time stamp when staff entered or left the room. The health care community objected to the bill because it provided no legal protections from discovery in medical liability claims.

Out-of-network legislation designed to restrict balance billing and unanticipated billing will become more common. While California and New Jersey considered bills in 2015 to address some of the related concerns, activity in this area will likely increase as insurers continue to narrow their networks. The National Association of Insurance Commissioners will be releasing an updated version of a model act dealing with health benefit plan network access and adequacy, which also is likely to generate some buzz in state legislatures.

How can surgeons engage in the state legislative process in 2016? Following are some suggestions:

• There is no time like the present for Fellows to begin developing relationships with their legislators. A relatively quiet session can be the best time for these meetings to occur because the focus is shifted from advocacy to relationship building. The ins and outs of grassroots advocacy are found in the ACS guide “Surgeons as Advocates: A SurgeonsVoice Handbook for Advocacy,” available at http://surgeonsvoice.org/content.aspx?page=toolkit.

• Participate in a state chapter lobby day. In 2016, 18 states will host lobby days, including Alabama, Alaska, California (Northern, Southern, and San Diego), Connecticut, Florida, Georgia, Indiana, Kansas, Louisiana, Metro Chicago, New York (Brooklyn-Long Island and New York Chapter), Ohio, Oregon, Pennsylvania (Metro Philadelphia, Keystone, and Southwest), Tennessee, Texas (North and South), Virginia, and Wisconsin.

• Become a State Councilor in the SurgeonsVoice program. State Councilors are the boots-on-the-ground grassroots activists for the entire program. State Councilors monitor current bills in their state legislatures, inform the College of current issues, and act as key contacts for their state (see Figure 1, page 26).

• Send letters to state legislators through the SSLAC. Action Alerts will let Fellows know when letters are needed as part of a grassroots initiative. Action Alerts are e-mailed to Fellows and posted to SurgeonsVoice, Facebook, and Twitter (see Figure 2, page 26). Follow the College on Facebook and Twitter to stay current on what is going on in legislatures around the country.

• Attend the ACS 2016 Leadership & Advocacy Summit April 9–12 at the JW Marriott in Washington, DC. The annual summit offers volunteer leaders and advocates comprehensive and specialized educational sessions focused on effective surgeon leadership, as well as interactive advocacy training useful in federal and state grassroots advocacy and coordinated visits to congressional offices.

The State Affairs Staff is available to provide expert guidance on all matters related to state legislative issues, activities, and initiatives. Fellows interested in getting involved can contact the state team at state_affairs@facs.org.

Acknowledgement
Tara Leystra Ackerman, State Affairs Associate, ACS Division of Advocacy and Health Policy, contributed to this article.
Dr. Timothy Miller: A career in service to military, patients, veterans

by Matthew Fox

Timothy A. Miller, MD, FACS, a recently retired plastic and reconstructive surgeon, and professor emeritus and former chief, division of plastic surgery, University of California-Los Angeles (UCLA), finished his career with many notable accomplishments, including a Bronze Star for his service in the Vietnam War, directorship of the American Board of Plastic Surgery, and authoring a number of fiction and nonfiction books, among other achievements. But there is one role of which Dr. Miller, a Fellow of the American College of Surgeons since 1976, is particularly proud—cofounder, chief reconstructive surgeon, and executive director for Operation Mend. Founded in 2007, Operation Mend is a program that provides reconstructive surgery services as well as other medical and psychological counseling services at no cost to severely wounded and disfigured veterans of the recent conflicts in Afghanistan and Iraq.

“I’m wrapping up my practice,” Dr. Miller said, “and to end in this way, doing this type of surgery, has been an honor and a privilege.”

Vietnam and establishing a career

Working with Operation Mend held particular significance because of Dr. Miller’s early years of service in the U.S. Army at the Brooke Army Medical Center’s Burn Center, Fort Sam Houston, San Antonio, TX, and, some months later, in the Vietnam War. After completing medical school at UCLA and a surgical internship at Vanderbilt University Medical Center, Nashville, TN, Dr. Miller joined the Army and was assigned to the Brooke Army burn unit. It was an exceptionally educational experience, he said, noting that although he had no training beyond a surgical internship, he “learned a tremendous amount by taking care of burns from the other surgeons in the faculty, all of whom were board-certified general surgeons.”
“My initial focus, of course, was if they didn’t have a nose. I wanted to build a nose that looked just like a nose. And as they were reconstructed, their personalities changed. In their initial consultations, most of them were quiet, sometimes extremely withdrawn. But after the surgeries, their confidence began to reappear.”

—Dr. Miller

Soon afterward, Dr. Miller was called into service in Vietnam. The conflict was in its early stages, with fewer than 20,000 U.S. troops in the war zone, but medical and surgical services were already needed.

“I went with Special Forces, who were in need of physicians,” he said. “We went to villages that were in the middle of nowhere. I would take care of small, and sometimes larger, medical or surgical issues. I was young at the time, and being in a war was a valuable experience. Before, at Brooke, I was taking care of burn patients in a controlled setting. This was a war, and that changes your point of view.”

That new perspective would stay with Dr. Miller after he returned home and began building his career. He completed a general and thoracic surgery residency at UCLA, and then pursued a fellowship in plastic and reconstructive surgery at the University of Pittsburgh, PA. He returned to UCLA, where he would teach and practice plastic surgery for 42 years. Through this time, Dr. Miller remained involved with veterans’ health care and surgery, including being named chief of plastic surgery at the Veterans Affairs (VA) West Los Angeles Medical Center, one of the largest VA hospitals in the U.S.

Experiences in Operation Mend
When Dr. Miller was offered a chance to perform the facial reconstruction on a U.S. Marine who would become the first patient served by Operation Mend, he didn’t hesitate. Ronald A. Katz, a member of the Ronald Reagan UCLA Medical Center board and executive committee, saw a television program that described the massive burns and scarring of the Marine, and it compelled him to act. “[Mr. Katz] called the dean of UCLA Medical School, and the dean called me and asked if I would be interested in operating on this young man. I said, ‘How about tomorrow?’” Dr. Miller recalled.

The immediacy of his response was drawn from the connection he felt to these veterans. “I knew what it was like to be in the military, I knew what it was like to be in a war and to be shot at. I could relate to their experiences,” he added.

Operation Mend started with that first case in 2007 and became a formal program through a partnership between UCLA, the VA Greater Los Angeles Healthcare System, and Brooke Army Medical Center. The program is supported entirely by private donations. “I gave presentations to potential donors almost every two week when we began,” Dr. Miller recalled.

The veterans on whom Dr. Miller operated were all severely burned, in almost all cases by roadside bombs—improvised explosive devices [IEDs] triggered to detonate by cell phones, wires, or lasers. Some patients had also lost hands and sustained significant burn deformities, but the commonality in his patients was severe scarring of the face, which often included a missing nose or ear or an absent lip. The magnitude of their injuries was such that the reconstruction process required an average of 15 operations, often spread over a period as long as two years. And the number of operations was growing.

“I asked for help from Chris Crisera [MD, FACS], a superb plastic surgeon, to help with a number of patients,” Dr. Miller said. “Soon after, because the hands were often exposed and injured, I asked Kodi Azari [MD, FACS], an excellent hand surgeon, to address these problems and to provide additional improvement so these men could return to a normal life after the war.” Drs. Crisera and Azari are now co-directors for Operation Mend.

Dr. Miller’s implicit purpose in these operations was to restore the appearance of the veterans, but, as time went on, he realized the procedures were having a profoundly significant mental effect as well. “My initial focus, of course, was if they didn’t have a nose, I wanted to build a nose that looked just like a nose,”
he explained. “And as they were reconstructed, their personalities changed. In their initial consultations, most of them were quiet, sometimes extremely withdrawn. But after the surgeries, their confidence began to reappear. A sense of humor appeared in men that didn’t at first talk. They could look in a mirror and see that there was a real improvement. Psychologically, that progression was very evident.”

He recalled the case of a U.S. Marine Corps Staff Sergeant who was badly wounded from a roadside bomb in Iraq. He wanted to be able to take his kids to a soccer game, but when he did, everyone stared. Perhaps the best compliment he offered to Dr. Miller after his reconstructive surgery was complete was, “I’d really like to thank you. You took the stares off me.” Dr. Miller conveys this story and others like it in his book, *The Surgical Reconstruction of War: Operation Mend*, released earlier this year and available on Amazon. “Certainly they still have scars, but their faces, I’m happy to say, have normal features,” Dr. Miller said.

Operation Mend provides the veterans not only with surgical and medical services, but, perhaps as importantly, with a sense of community. Dr. Miller is particularly attuned to the significance of a supportive network for returning veterans, injured or otherwise, because of some of the negative reactions and hostility he and other soldiers experienced when they returned from Vietnam.

“I’m so happy these young men and women were really accepted and welcomed,” he said. “Operation Mend was designed to care for them in a truly holistic fashion. We flew them to Los Angeles, we met them at the airport, we housed them, and we had families in the community who made contact with them when they were recovering.” As of October, 135 men and women from the U.S. Army, Marine Corps, Navy, and Air Force had been treated through the program.

More information on Operation Mend can be found at the program’s website, operationmend.ucla.edu.

A lasting connection

After performing his final Operation Mend case in July, Dr. Miller decided it was time to retire from practice. He and his wife, Mia, are contemplating a move to Sun Valley, ID, where he plans to work on writing his third novel about this experience and to fish. Although retirement represents a less demanding lifestyle, “It’s difficult to transition away from being a surgeon for so many years,” Dr. Miller said.

The reluctance to leave surgery behind is understandable, though, considering Dr. Miller’s connection to Operation Mend. His work with the program bridged his service in the military, his skill as a plastic and reconstructive surgeon, and his dedication to wounded veterans into work that is a fitting capstone to a long and accomplished career. “These soldiers had been through a tremendous amount, and the fact that I had the experience of being in war helped a lot. This was an opportunity to give back to these guys for what they’ve done,” Dr. Miller said. “It was the most satisfying effort of my entire career, and the most important accomplishment I ever made.” ♦
Executive Director’s annual report

by David B. Hoyt, MD, FACS
Each year, the *Bulletin* publishes an update on the major activities carried out by the American College of Surgeons (ACS). This report focuses on October 2014–October 2015, pointing to our accomplishments and to the areas in which we are striving to better meet the needs of surgeons and their patients.

**Advocacy and Health Policy**

The most significant health policy and advocacy development of this period occurred April 16, when President Barack Obama signed H.R. 2, *The Medicare Access and CHIP (Children’s Health Insurance Program) Reauthorization Act of 2015* (MACRA). This legislation repeals the **sustainable growth rate (SGR)** formula used to calculate Medicare physician reimbursement and ends 13 years of costly, short-term payment fixes. In addition, MACRA establishes an annual payment update of 0.5 percent for five years; seeks to establish a new Merit-based Incentive Payment System in 2019; and calls for the development, evaluation, and adoption of alternative payment models. The law also extends funding for CHIP through fiscal year (FY) 2017.

Furthermore, MACRA prevents the Centers for Medicare & Medicaid Services (CMS) from implementing a final rule that would have transitioned 10- and 90-day **global codes** to 0-day global codes beginning in 2017 and 2018, respectively. The College opposed this plan from the start, sending detailed comments asserting that CMS should postpone moving forward until the agency completed a comprehensive analysis of the effects on surgical patients and access to surgical care and until CMS had developed a methodology for transitioning to 0-day global codes.

Under MACRA, CMS will start collecting data in 2017 on the number and level of visits furnished in the global period and, beginning in 2019, will use this information to improve the accuracy of the valuation of surgical services. MACRA also allows 5 percent of the surgical payment to be withheld until information is reported at the end of the global period and grants authority to discontinue the reporting requirement if sufficient information can be derived from Qualified Clinical Data Registries (QCDRs), surgical logs, electronic health records (EHRs), or other sources.

CMS recently indicated it would begin enforcing a long-forgotten rule requiring physicians to certify that patients admitted to **critical access hospitals (CAHs)** can reasonably be expected to be discharged or transferred within 96 hours. Previously, CAHs had been operating under a similar but separate condition of participation that required patient stays to be less than 96 hours on average. CMS’ recent action will result in surgeons being unable to admit patients for procedures routinely performed in CAHs, thus forcing patients to travel further for treatment.

To address the issue, Rep. Adrian Smith (R-NE) and Sens. Pat Roberts (R-KS) and Jon Tester (D-MT) introduced the **Critical Access Hospital Relief Act** (H.R.169/S.258). This legislation, which the ACS has endorsed, would eliminate the certification requirement for admitting physicians and maintain the 96-hour average stay requirement.

The Affordable Care Act included a 10 percent incentive payment for major surgical procedures performed by general surgeons in **Health Professional Shortage Areas (HPSAs)**. This provision expires at the end of the year, and the College has sought to extend and improve it.

Following the release of an Institute of Medicine report on the financing and governance of the nation’s **graduate medical education (GME)** system, the House Energy and Commerce Committee sent a letter requesting responses to a series of questions on the topic. The College responded and offered a set of principles for GME reform, which can be summarized as follows:
The most significant health policy and advocacy development in this period occurred April 16, when President Barack Obama signed H.R. 2, MACRA. This legislation repeals the SGR formula used to calculate Medicare physician reimbursement and ends 13 years of costly, short-term payment fixes.

- GME should be supported as a public good.
- Surgical GME has unique needs.
- Reforms should focus on creating a system that produces a physician workforce that can optimally and consistently meet our nation’s medical needs.
- Because the practice of medicine is dynamic, the system should be nimble enough to adjust to the changing medical landscape.
- Accountability and transparency must be built into the system.
- Programs that produce high-quality graduates in an efficient manner and consistent with workforce needs should be rewarded through financial incentives or higher levels of support.

The Medicare and Medicaid EHR Incentive Program for the meaningful use (MU) of certified medical records has now entered a penalty-only phase. Unsuccessful or nonparticipation in the 2015 EHR program will result in a –3 percent penalty of Medicare Part B fee-for-service payments and will be applied in 2017.

The ACS commented on CMS’ proposed rule on Stage 3 of the MU program. CMS proposes that Stage 3 will be the final stage of the program and seeks to require all providers to report on the Stage 3 objectives and measures in calendar year (CY) 2018. The ACS response stressed the importance of flexibility for providers, reduced measure thresholds, and additional hardship exemptions.

In addition, CMS released a proposed rule on modifications to the MU program for 2015–2017, which seeks to modify MU Stages 1 and 2 by removing duplicative measures, reducing thresholds for measures that require patient action, and allowing all providers to comply with a 90-day reporting period in CY 2015.

The ACS continues to play a leadership role in surgical training. The special “Fix the Five” Committee on Residency Training continues to make progress. Discussions have centered on ensuring that residents achieve the requisite levels of knowledge and skills through definition of milestones, competency-based advancement, and use of the final year of training to prepare individuals for surgical practice.

A new Committee on the Future of Surgery Residency and Training was appointed this year to examine the ACS’ role in accrediting post-residency Fellowships and possible collaboration with the Accreditation Council for Graduate Medical Education.

During the academic year 2014–2015, the ACS Transition to Practice Program (TTP) was piloted at 11 sites. At present, 18 institutions have been approved to offer the TTP Program in 2015–2016. A special ACS TTP Program: Experiences from the Field, took place in April, with several TTP Directors and TTP Associates in attendance.

The Consortium of ACS-Accredited Education Institutes (ACS-AEIs) continues to advance the field of simulation-based surgical education and training, promote teamwork, and enhance patient safety. The ACS-AEIs will be showcased in 2015–2016, through a cross-country tour starting with the Methodist
A new Committee on the Future of Surgery Residency and Training was appointed this year to examine the ACS’ role in accrediting post-residency Fellowships and possible collaboration with the Accreditation Council for Graduate Medical Education.
certify patient education programs, resources, and materials; optimize resources through collaboration and sharing; train patient educators in interdisciplinary and interprofessional teams to deliver the best surgical care; credential and certify patient educators; and increase awareness of the positive impact of patient education on patient care outcomes and safety.

The ACS Committee to Enhance Peak Performance in Surgery through Recognition and Mitigation of the Impact of Fatigue has been engaged in the development of an online curriculum. A manuscript based on the activities of the committee is in development.

Continuous quality improvement (CQI)
The 10th annual ACS National Surgical Quality Improvement Program (ACS NSQIP®) National Conference took place in July in Chicago with more than 1,500 attendees from 676 medical institutions and 15 countries. Some of the nation’s top researchers, clinicians, and surgeons led lectures, panel discussions, and workshops on a range of topics aimed at reducing surgical complications, applying quality improvement techniques to surgical problems, and maximizing efficiency and resource utilization.

The Joint Commission and the National Quality Forum presented ACS NSQIP with the 2014 John M. Eisenberg Patient Safety and Quality Award for Innovation in Patient Safety and Quality at the National Level. The Eisenberg Awards recognize individuals and organizations who have significantly contributed to improving patient safety and health care quality.

The Coalition for Quality in Geriatric Surgery Project launched July 1 with funding from the John A. Hartford Foundation. The project has seven objectives: set standards, engage key stakeholders, develop meaningful measures, establish a verification program, educate providers and patients, pilot the program, and launch the Geriatric Surgery Quality Campaign.

The Children’s Surgery Verification Program continues to develop. The ACS Task Force for Children’s Surgery developed the first draft of the Pre-Review Questionnaire and Optimal Resource Standards from 2012 through 2014 with support from the Society of Pediatric Anesthesia and the American Pediatric Surgical Association. The pilot phase launched this spring and was completed within one month. The program is set to launch next spring.

More than 800 facilities participate in the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP). Over the course of a year, with 75 trained surgeon surveyors to support the verification effort, more than 325 site visits were completed.

The MBSAQIP’s Decreasing Readmissions through Opportunities Provided (DROP) project launched in March with more than 120 centers participating in this effort to decrease 30-day post-operative readmissions.

Review and revision of the second version of the MBSAQIP standards is under way, with an anticipated release in early 2016, and the MBSAQIP was again selected as a QCDR for PQRS in 2015.

The number of surgeons participating in the SSR continues to rise. Surgeons use the registry to fulfill PQRS and Maintenance of Certification. Furthermore, on June 15, a measures group was submitted to CMS for consideration during the open call for measures PQRS 2017 reporting period. If approved for PQRS 2017, this measures group, developed in alignment with the College’s quality manual, currently in development, includes eight newly developed, clinically relevant surgical measures, in addition to two applicable PQRS-approved measures.

The ACS, in conjunction with the Northwestern Patient Safety Education Program (PSEP) and the Armstrong Institute for Patient Safety and Quality, piloted a successful one-day “Surgeons Leading Quality” course October 4. The course featured national leaders in quality improvement who have assisted with other College courses and QI programs.
The CRP published the first edition of *Operative Standards for Cancer Surgery* in July 2015. Five disease site teams have been developed to research and write the second edition, targeted for completion in November 2016.

**Cancer Programs**

The Commission on Cancer (CoC) has accredited 1,532 programs in the U.S. and Puerto Rico; 402 cancer programs are due for surveys in 2015, and 33 new centers joined the *Accreditation Program* in 2014. Of the cancer programs the CoC surveyed in the first half of 2015, 21 received the Outstanding Achievement Award.

Approximately 75 percent of CoC-accredited cancer programs participate in the *Rapid Quality Reporting System (RQRS)*. The CoC Accreditation Committee recently voted to make RQRS participation a compliance standard in 2017.

A limited launch of the *Oncology Medical Home (OMH)* Accreditation program will take place in 20 locations. CoC leaders and staff participated in a summit sponsored by the Community Oncology Alliance at the end of October, which brought together payors, physicians, and other constituents to clarify the OMH needs of all groups and discuss payment options and incentives for medical oncology care.

Also in development is a *Rectal Cancer Accreditation* module. The Rectal Cancer Accreditation Steering Committee plans to identify six facilities for pilot surveys.

A cross-functional workgroup is evaluating *pediatric cancer standards* and developing an enhanced set of standards and pediatric performance measures with an eye toward providing more value to the existing pediatric program participants and adding new participants in this category.

Newly diagnosed cancer cases from 2013—including follow-up data for previous years—were submitted to the *National Cancer Data Base (NCDB)* in January 2015 and were used to update the quality reporting tools for end users throughout 1,500 CoC-accredited cancer programs in July.

The NCDB *Cancer Program Practice Profile Reports (CP²R)* has been expanded to include three new quality measures and one replacement quality measure. Two cervical, one non-small cell lung, and one rectal cancer measure were released in March. CP²R currently reports 15 quality measures across six sites. Five gynecological measures were released this fall, resulting in a total of 20 quality measures across seven disease sites. In addition, the Quality Integration Committee approved nine new NCDB quality metrics—three bladder, one pediatric, and five melanoma.

The NCDB is working to satisfy CMS’ requirements for becoming a QCDR in 2016. By becoming a QCDR, the NCDB would enable physicians at CoC-accredited hospitals to submit data to CMS and participate in the PQRS. Plans are in place to improve the data submission system used by 1,500 hospitals to submit data to the NCDB and RQRS.

A total of 102 *Cancer Liaison Program (CLP)* appointments and six State Chair appointments were processed this year. State Chair Outstanding Achievement Awards were presented at the State Chair Town Hall Meeting at Clinical Congress.

The *Advocacy Committee’s* focus this year has been on funding for survivorship care and delivery, reimbursement for patient navigation, clinical research, access to oncology drugs, National Institutes of Health (NIH) funding, and cancer quality measurement. With this committee’s support, the CoC hosted a second annual legislative briefing on Capitol Hill June 9.

One Voice Against Cancer (OVAC) Lobby Days took place June 8–9 in Washington, DC, with support from the CoC. The focus was on encouraging members of Congress to back OVAC’s request to increase funding for the NIH, the National Cancer Institute (NCI), and the Centers for Disease Control and Prevention. Other legislation that the CoC has supported this year includes the Breast Cancer Research Stamp Reauthorization Act of 2015, the Accelerating Biomedical Research Act, and the American Cures Act; the Advocacy Committee is monitoring the status of the 21st Century Cures Act.

The *Clinical Research Program (ACS CRP)* Education Committee sponsored four Panel Sessions and two
Meet-the-Expert Luncheons at this year’s Clinical Congress. The committee also has sponsored four surgical investigator meetings to promote Alliance clinical trials and membership. The CRP published the first edition of *Operative Standards for Cancer Surgery* in July 2015. Five disease site teams have been developed to research and write the second edition, targeted for completion in November 2016.

Data collection for three CRP studies funded by the Patient-Centered Outcomes Research Institute on post-treatment surveillance for lung, breast, and colorectal cancer was completed August 15. The data analysis will be completed by the three principal investigators at their institutions. In addition, several comparative effectiveness research studies using NCDB data will be submitted to the NCI Community Oncology Research Program through the ACS CRP Cancer Care Delivery Research Committee.

Final content for the *American Joint Committee on Cancer* 8th Edition of the *Cancer Staging System* has been submitted. The vision for the 8th Edition is to accommodate changes in cancer care to reflect current clinical practice and update the staging system based on the evidence available from the published literature, evidence-based analyses, and other sources that affect the diagnosis and treatment of cancer.

The National Accreditation Program for Breast Centers (NAPBC) accredits 640 U.S. breast centers. At press time, 31 new programs had been added in 2015, and 32 additional centers were pending survey. Reaccreditation rates for 2015–2016 remain at 99 percent. Approximately 20 percent of centers ask to be surveyed with their CoC program. One international center has NAPBC accreditation; plans for international expansion in 2016 include one Canadian breast center and five U.K. centers.

**Trauma Programs**

More than 2,020 Advanced Trauma Life Support® (ATLS®) Courses have been presented in 2015, training 32,620 students. The program was presented for the first time this year in Mongolia, Kenya, Jordan, and Estonia. The MyATLS app has been as downloaded 149,024 times in 179 countries.

ATLS is undergoing major revisions, including the following:

- A new mission, vision, and core goals focused on global education
- Strategic financial planning
- Review and overhaul of current program evaluations
- Update of U.S. site visit guidelines
- Introduction of mobile delivery mechanisms for education to launch with the 10th edition

The *Rural Trauma Team Development Course* (RTTDC) has been presented 102 times in 2015 to 1,692 students. The revised RTTDC program was scheduled for imminent release at press time, and the first course of the next edition will be presented at Vanderbilt University, Nashville, TN.

The *Disaster Management and Emergency Preparedness* Course was presented 12 times to 230 students in 2015. The new manual and course are scheduled for release in 2016.

The Advanced Surgical Skills for Exposure in Trauma (ASSET) Course has been presented 57 times in 2015 to 461 students. ASSET continues to grow substantially, and a new manual is projected to be released in March 2016. Meanwhile, the Advanced Trauma Operative Management (ATOM) Course has been presented 46 times in 2015 to 194 students.

Trauma center verification standards in the *Resources for Optimal Care of the Injured Patient*, published in 2014, took effect with visits scheduled on or after July 1, 2015. Ongoing performance improvement activities will result in decreased turnaround times for final reports.

The National Trauma Data Bank (NTDB®) research datasets for 2013 and 2014 admissions will soon be
The COT Membership Committee’s Mentoring for Excellence in Trauma Surgery (METS) program launched this year with the goal engaging young surgeons and acute care surgery fellows in COT activities and preparing them for future leadership roles.

available to approved researchers via the ACS website. The ACS continues to receive frequent requests from researchers to use NTDB records in their investigations. A bibliography of publications based on the NTDB is available on the ACS website. The ACS provided 279 individual data files to requesters in 2014.

A total of 340 hospitals participate in the Trauma Quality Improvement Program (TQIP). At press time, Adult TQIP had 313 participants; 68 hospitals were enrolled in Pediatric TQIP, and 10 hospitals were in the process of joining the program.

The ACS Committee on Trauma (COT) continues development of TQIP for Level III hospitals, including 200-plus hospitals enrolled in the pilot program. In the pilot year, TQIP will offer hospitals tailored online educational opportunities and reporting on data quality and outcomes. The Level III Pilot Project Team, with feedback from the trauma centers, will work to develop a robust Level III program over the next year.

The most recent TQIP benchmark report series was delivered in March 2015 for Adult TQIP and May 2015 for Pediatric TQIP, and reported on the outcomes of mortality; major complications; and major complications including death, pneumonia, and acute kidney injury. The well-received 2015 TQIP annual conference took place November 15–17 in Nashville.

More than 26 representatives from various constituencies participated in a Consensus Summit August 24–25 in Chicago. The discussion represented the viewpoints and concerns of systems, state and federal agencies, trauma centers, legislators, and so on. The achieved goal was to create convergence around standards that lead agencies could use in designating centers while developing their systems, resulting in a tool or broad template with metrics and processes.

Several COT leaders participated in the Hartford Consensus III meeting led by ACS Regent Lenworth M. Jacobs, Jr., MD, MPH, FACS. An outgrowth of this meeting, Strategies to Enhance Survival in Active Shooter and Intentional Mass Casualty Events: A Compendium, mailed with the September Bulletin. A press release was issued, and COT staff helped to coordinate a demo of the related Bleeding Control course at the Clinical Congress 2015.

The Injury Prevention and Control Committee offered statements on the following issues for the Board of Regents’ approval at Clinical Congress: Safety Belt Laws and Enforcement Position (revision), Non-traffic Vehicular-Related Injuries in Children (revision), and Geriatric Burn Position (new).

There is interest in encouraging trauma centers to discuss criteria for screening, intervention, and violence prevention and establishment of programs to address firearm injury. Because the community most at risk is gun owners themselves, the COT seeks to involve these individuals in a dialogue regarding sensible gun policy. The COT will reach out to different groups to talk about gun violence and to determine the ACS’ position on gun violence and the level of COT involvement going forward.

The COT Membership Committee’s Mentoring for Excellence in Trauma Surgery (METS) program launched this year with the goal of engaging young surgeons and acute care surgery fellows in COT activities and preparing them for future leadership roles. METS welcomed two liaisons from the Resident and Associate Society (RAS), one from the Young Fellows Association (YFA), and the first two participants in the Future Trauma Leaders program.

The International Injury Care Committee (I2C2) continues to focus on data, education, and standards for trauma systems and trauma centers. The Latin American region is making significant progress in adopting principles in Resources for Optimal Care of the Injured Patient in their region.

The Trauma Evaluation and Management course is disseminated at no charge throughout sub-Saharan Africa, and a similar arrangement will be piloted in
some Central American countries. Members of I2C2 are also working with the World Health Organization to establish a minimum trauma data set for use in low-income countries.

COT leadership continues to work with Margaret “Peggy” Knudson, MD, FACS, ACS Medical Director, Military Health System Strategic Partnership ACS (MHSSPACS), to ensure alignment between the COT’s military collaborations and the MHSSPACS projects as several areas are of mutual interest.

State COT chairs are being surveyed to determine advocacy areas of need at both the state and federal levels. Efforts are under way to develop briefing reports and updates that surgeons could use when they meet with their state legislators in their state offices. The Advocacy Committee also is interested in establishing collaborative relationships with other specialty societies.

**Member Services**

The ACS has 78,623 members: 64,890 Fellows (58,000 U.S., 1,364 Canadian, and 5,526 International); 2,327 Associate Fellows; 9,473 Residents; 1,664 Medical Students; and 269 Affiliate Members. Women comprise 13 percent of the membership.

This year, 1,679 surgeons were initiated into the ACS: 1,228 U.S., 34 Canadian, and 417 International. These Initiates included 354 women and 1,325 men. Class size continues to rise and is at its highest point since 2001.

To foster recruitment and retention of ACS members, Member Services led or coordinated the following initiatives:

- A Young Surgeons Marketing Campaign, Realize the Potential of Your Profession, which launched in January with the 100 Reasons to Join video

- A specialty-by-specialty recruitment campaign, which included Top 10 Benefits of Membership flyers for each specialty, specialty-specific Web pages, and targeted recruitment communications

- A new Bulletin column, “Your ACS Benefits”

- A survey of nonmember board-certified surgeons that will be analyzed to enhance member recruitment

- Continuation of the Show Your Pride campaign

- Availability of a downloadable Fellowship Pledge poster

The ACS has begun contacting members in an effort to reduce terminations of membership secondary to nonpayment of dues. Furthermore, targeted outreach is occurring with all member classes to ensure member retention during the critical transitions from Medical Student to Resident, Resident to Associate Fellow, and Associate Fellow to Fellow.

The ACS chapters continue to grow. This past year, international chapters were established in Jordan and Nigeria. A needs assessment is in progress to help revitalize the domestic chapters. Once chapter needs are determined, the ACS will work with each chapter to develop a customized strategic plan. In addition, an association management services pilot program has been launched to determine its usefulness to chapters. Planning and development of a Chapter Leader Training Program is scheduled to launch in 2016.

A new Medical Director, Girma Tefera, MD, FACS, and Program Administrator have been hired to run and revitalize Operation Giving Back (OGB). Primary initiatives under way include redesign of the OGB website and creation of an OGB Advisory Committee. Dr. Tefera also is reevaluating and reestablishing existing OGB partnerships and exploring new opportunities in developing countries, nongovernment organizations that are involved in global outreach, and the World Health Organization.

A survey is being conducted to assess member involvement and needs relative to volunteerism activities and to develop disaster management, international or domestic volunteerism opportunities, and advocacy rosters. New program areas, such as development of domestic volunteer opportunities, creation
A survey is being conducted to assess member involvement and needs relative to volunteerism activities and to develop disaster management, international or domestic volunteerism opportunities, and advocacy rosters.

of a humanitarian volunteer boot camp, and collaboration with the military in areas of mutual interest are priorities.

Activities carried out by the Board of Governors (B/G) workgroups include the following:

• Development of a statement on the aging surgeon

• Revision of the Chapter Guidebook, roll out of new webinars, and release of a Chapter Event Toolkit

• Publication of a quarterly newsletter, The Cutting Edge: News and Notes from the Board of Governors

To better engage the Advisory Councils, the B/G has been restructured to include pillars aligned with the Divisions of the College. Communications have been e-mailed from the Advisory Council Chairs to their specialty colleagues encouraging them to share information about the value of ACS membership and to the specialty program directors to encourage resident enrollment.

The Resident and Associate Society (RAS) offers a variety of opportunities for engagement. Recent activities include the following:

• Development of a strategy to support resident member recruitment among the surgical specialties

• Development of a Top Gun skills competition that will debut at Clinical Congress 2016

• Revision and expansion of the International Exchange Program

• Development of a Medical Student Guide to Surgery Residency

The Young Fellows Association (YFA) has been working to expand its member representation on College committees and Advisory Councils and has planned an annual meeting and Initiates Program. Other accomplishments are as follows:

• A total of 20 matches made through the annual Mentor Program

• Presentation of a Speed Mentoring Program at this year’s Clinical Congress

• Development of a Career Toolkit

• Presentation of the inaugural Young Fellow Advocacy Training at the Leadership & Advocacy Summit

The subcommittees of the International Relations Committee (IRC) have been working to improve the experience of international members and guest physicians. Notable activities in 2015 include the International Fellowship Subcommittee’s successful bid to provide three levels of membership fees corresponding to the World Bank’s high-middle-low income groupings. Other accomplishments are as follows:

• The Scholarships Subcommittee hosted 20 international scholars and travelers at Clinical Congress 2015.

• Two international scholars participated in the ACS NSQIP conference in July.

• The first international presentation of the ACS’ General Surgery Review Course took place in Beirut, Lebanon.

The Women in Surgery Committee (WiSC) has five active subcommittees working to increase engagement and opportunities for women members of the College. Specific activities are as follows:

• A Women’s Health Day at this year’s Clinical Congress
• Second year of a successful Mentor Program

• Nomination of a number of women surgeons for College awards

• Expansion of a podcast Leadership Series highlighting women surgeons in the College

• Plans for a Mary Edwards Walker Inspiring Women in Surgery Award

• Development of an ACS Statement on the Importance of Parental Leave

The Committee on Diversity Issues established an ACS online community with nearly 100 members. In addition to offering educational programming on diversity issues for the Clinical Congress, the committee developed a toolkit to educate and guide surgeons to successful interactions with diverse patient populations.

This year, the Central Judiciary Committee (CJC) reviewed 18 cases for disciplinary action. The CJC has recommended that 10 Fellows be charged with Bylaws violations. It has held four hearings involving personal appearances by Fellows, made three recommendations to the Board of Regents for disciplinary actions, and recommended that two Fellows have their full Fellowship privileges restored.

The Scholarships Committee manages scholarships and fellowships available to U.S. and Canadian members. Offerings include the Resident Research Scholarships, Faculty Research Fellowships, the Clowes Career Development Award, several NIH career development awards cosponsored with specialty societies, and numerous Health Policy Scholarships shared with partnering societies. This year marked the first offering of an ACS/American Society for Surgery of the Hand career development award.

The ACS manages the Society of Surgical Chairs, which now has 177 dues-paying members in the U.S. and Canada, an increase from 157 in 2010, when the ACS began managing it. The number of women chairs has increased to 13 in 2015 from four in 2010.

Since establishment of the MHSSPACS in 2014 (see Trauma Programs in this report for more information), three subcommittees have been established with the following goals:

• Education and Training Subcommittee to develop a standard, validated training curriculum for ACS-Accredited Centers of Excellence that includes both technical and team resource management instruction and contains the essential elements needed for a surgeon deployed to a military conflict, a disaster, or a humanitarian mission

• Quality Subcommittee to develop a consortium of military treatment facilities using ACS quality measurement and improvement tools

• Joint Trauma Systems Subcommittee to preserve the Joint Trauma System and its key elements under a central command that can be ready for future conflict

The partnership led an effort to create a new Excel- sior Society, which held its first meeting at Clinical Congress 2015, featuring a half-day program that included speakers from the U.S. Army, Navy, and Air Force.

More than 435 officers of the College, chapter officers, young surgeons and medical students participated in the spring Leadership & Advocacy Summit. The next Summit is scheduled for April 9–12, 2016, in Washington, DC.

Communications
This summer, the ACS issued public comments on physician rating systems for individual surgeons, questioning the usefulness of the information the websites provided because the surgeon ratings were based on administrative claims data rather than risk-adjusted clinical data. The ACS noted that “use of clinically validated data would have more fully taken into account the severity of the patient’s condition when assessing surgeon performance...
This summer, the ACS issued public comments on physician rating systems for individual surgeons, questioning the usefulness of the information the websites provided because the surgeon ratings were based on administrative claims data rather than risk-adjusted clinical data.

Without factoring in surgeons’ success rate with the more challenging patients, the potential for wrongly directing patients away from these surgeons certainly increases.”

As noted earlier, Strategies to Enhance Survival in Active Shooter and Intentional Mass Casualty Events: A Compendium mailed with the September Bulletin. This document is being distributed to a wide audience, including not only ACS Fellows and staff but also employees of federal agencies and other stakeholders interested in improving the public’s ability to respond at the scene of active shooter and mass casualty events. It was developed under the leadership of Dr. Jacobs and has been well-received.

Strategic planning for moving more content and driving readers to the Bulletin online is ongoing. Efforts are also under way to give readers an online experience comparable to reading the print version.

The Journal of the American College of Surgeons (JACS) recently received its 2014 impact factor rating from Thomson Reuters: 5.122 for articles published 2012 and 2013— an increase of 15 percent from the previous year. JACS now ranks eighth among 198 surgery journals list.

Several improvements have been made to the “My Profile” feature of the ACS website, including implementation of a dues notification message and a feature that allows members to select their preferred format for receiving JACS and the Bulletin: print or electronic. “Surgeons at work” photos have been added to several areas of the website. We continue to seek additional photos that showcase the diversity of ACS members.

The ACS marketing team assisted in the development of the “Straight from the Source” videos that highlight specific education programs and feature surgeon faculty and course participants talking about the importance and impact of the courses. The first video in the series was released this summer and focused on Selected Readings in General Surgery. Other videos in development include AEI, Surgical Education and Self-Assessment Program, and Surgeons as Leaders.

Plans are in place for a tour of AEIs to showcase innovations in surgery and to advance the case for skills training and simulation in the credentialing and privileging process. The first stop on the tour is slated for January 2016 in Houston, TX.

A series of intimate local networking events for young surgeons to meet with College leadership and discuss how the ACS can help them in their careers is under way. The first event took place in September in Sacramento, CA, followed by a meeting in Philadelphia, PA.

The communications team helped to develop the first ACS NSQIP Quality Brief, an e-newsletter targeted at the hospital C-suite, to build awareness of ACS NSQIP and its impact on improving quality and reducing health care costs. The first issue was released in March.

In 2014, the College launched Clinical Congress Daily Highlights, a digital newsletter to promote the scientific news featured at the conference. The newsletter was distributed every morning via e-mail with articles on key courses/seminars from the previous day and serves as a companion to the daily Clinical Congress News.


The College’s state-of-the-art online community platform, ACS Communities, became available to members in the summer of 2014. As of August 2015, the platform has grown to 109 communities covering a variety of member surgeon interest areas. Of these, 66 communities are open, meaning that any member of the College may join. Closed communities exist primarily to provide online work forums for ACS leadership groups. In the first year, more than 166,000 discussion posts were written, generating more than 1 million page views.
The ACS has also made considerable progress in growing its social media presence. The College now has approximately 22,400 followers on Twitter, 12,355 “Likes” on Facebook, 372,773 views on YouTube, 6,895 followers on LinkedIn, and 388 in circles on Google+.

**ACS Foundation**

The Foundation continues to focus on its four strategic objectives:

- **Promote unrestricted/discretionary use giving to the College.**

- **Secure philanthropic support that advances College priorities.** The 1913 Legacy Campaign was at the core of this effort and had three major objectives: identify opportunities for investment during the ACS Centennial period; engage an increased base of prospective donors to make a gift to support the Surgeon, the Profession, and the Societal Good; and develop infrastructure and strategies for long-term growth in the College’s philanthropy initiatives, especially planned and deferred giving. In addition, the Thomas R. Russell, MD, FACS, Scholarship Fund and Dr. Pon Community Surgeon awardees were announced, and the ACS Foundation launched the Gerald B. Healy, MD, FACS, Mentorship Fellowship initiative.

- **Build a basis for planned gifts that ensure the stability of future ACS programs and priorities.** The 1913 Legacy Campaign “moment of opportunity” had a positive impact on Mayne Heritage Society enrollment. In the approximate two-year time period of the campaign, the planned giving program acquired 18 new members and more than $400,000 in bequests.

- **Increase the engagement of Fellows as partners in philanthropy to ensure ACS financial vitality.** The Chapter Philanthropic Champion program completed its first full year in 2014 and has continued to develop and grow in 2015. This effort encourages “home-grown” philanthropic champions in each ACS chapter.

**Closing comments**

I conclude this report by thanking all of the ACS volunteers and staff for their dedication to improving the care of the surgical patient.

Dr. Jacobs deserves special recognition for his work on the Hartford Consensus and the compendium mentioned earlier in this report. This project has enabled the College, through the COT, to meet and collaborate with the White House, a range of government agencies, and emergency providers to make a real difference in the lives of patients who have been involved in mass casualty events.

I also want to thank ACS Past-President L. D. Britt, MD, MPH, DSc(Hon), FACS, FCCM, FRCSEng(Hon), FRCSEd(Hon), FWACS(Hon), FRCSEl(Hon), FCS(SA)(Hon), FRCSGlasg(Hon), and Adil Haider, MD, MPH, FACS, Chair and Vice-Chair, respectively, of the ACS Committee on Health Care Disparities, for establishing a collaborative relationship with the National Institute on Minority Health and Health Disparities (NIMHD). Given the College’s history with quality improvement programs and the NIMHD’s considerable research and scientific resources, we anticipate that this partnership will substantially expand access to surgical care for all Americans.

With regard to staff, I want to recognize Felix Niespodziewanski for his 26 years of service in ACS Convention and Meetings, and Marty Wojcik, for his many years with the ACS Foundation. Both of these individuals are retiring this year.

Through the hard work and commitment of people like these individuals, the ACS continues to lead the way in ensuring all Americans have access to high-quality surgical care. ♦
Successfully navigating the transition
to ICD-10 terminology

by Sarah Kurusz

The 10th revision of the International Classification of Diseases (ICD-10) took effect October 1 in the U.S. The change to ICD-10 allows you and your coders to capture more details about the health status of patients and sets the stage for improved patient care and public health surveillance across the country. As with any new government policy, law, standard, or code, questions are sure to arise. The American College of Surgeons (ACS) is taking steps to ease the transition to ICD-10 from ICD-9.

Glossary of terms
Besides the task of transitioning to ICD-10, surgeons and their staff should become familiar with new terminology to properly code with the expanded code set. Following is a useful glossary of ICD-10 terms to help ensure a smooth transition.

- **Alphabetic Index:** An alphabetical list of ICD-10-CM (Clinical Modification) terms and their corresponding codes, which helps to determine which section to refer to in the Tabular List. It does not always provide the full code. The Alphabetic Index consists of the following parts: the Index of Diseases and Injury, the Index of External Causes of Injury, the Table of Neoplasms, and the Table of Drugs and Chemicals.

- **Acute conditions:** Medical conditions characterized by sudden onset, severe change, and/or short duration.

- **Additional diagnosis:** The secondary diagnosis code used, if available, to provide a more complete picture of the primary diagnosis.

- **Bilateral:** For bilateral sites, the final character of the codes in the ICD-10-CM indicates laterality. An unspecified side code also is provided in instances where the side may be unidentified in the medical record. If no bilateral code is provided and the condition is bilateral, assign separate codes for both the left and right side.

- **Category:** The three-digit diagnosis code classifications that broadly define each condition (for example, 250 for diabetes mellitus).

- **Character “x”:** Used as a placeholder in ICD-10-CM in certain codes to allow for future expansion and to fill in empty characters when a code that is less than six characters in length requires a seventh character.

- **Chronic conditions:** Medical conditions characterized by long duration, frequent recurrence over a long period of time, and/or slow progression over time.

- **Combination codes:** Single codes used to classify any of the following: two diagnoses; a diagnosis with an associated secondary process (manifestation); or a diagnosis with an associated complication.

- **Conventions of ICD-10:** The general rules for use of the classification independent of guidelines. These conventions are incorporated within the Index and Tabular List of the ICD-10-CM as instructional notes. Possible conventions to include with codes include the following:
  - Notes: Extra information to define or clarify code choice.
  - Includes notes: This note appears immediately under a three-character code title to further define or give examples of the content of the category.
  - Not otherwise specified (NOS): This abbreviation is the equivalent of “unspecified.”
Clinical documentation specificity is one of the most important characteristics of the ICD-10-CM coding system. Additional details in clinical documentation provide more information, suggestions, guidance, and checklists—all of which coding professionals may use to select the codes that most accurately describe the procedures and services provided.

- **Excludes notes:** There are two types of excludes notes. A type 1 excludes (Excludes1) note means “not coded here.” An Excludes1 note indicates that the code excluded should never be used at the same time as the code above the Excludes1 note. An Excludes1 is used when two conditions cannot occur together, such as a congenital form versus an acquired form of the same condition. A type 2 excludes (Excludes2) note indicates “not included here.” An Excludes2 note indicates that the condition excluded is not associated with the condition represented by the code, but a patient may have both conditions at the same time. When an Excludes2 note appears under a code, it is acceptable to use both the code and the excluded code together when appropriate.

- **Documented:** Clinical documentation specificity is one of the most important characteristics of the ICD-10-CM coding system. Additional details in clinical documentation provide more information, suggestions, guidance, and checklists—all of which coding professionals may use to select the codes that most accurately describe the procedures and services provided.

- **GEM (General Equivalence Mapping):** This reference mapping attempts to include all valid relationships between the codes in the ICD-9-CM diagnosis classification and the ICD-10-CM diagnosis classification. It is a useful tool to convert data from ICD-9-CM to ICD-10-CM.

- **ICD:** A medical code set maintained by the World Health Organization (WHO). The primary purpose of this code set is to classify both causes of death or mortality and diseases or morbidity. The U.S. extension, known as ICD-CM, is maintained by the National Center for Health Statistics within the Centers for Disease Control and Prevention to more precisely define ICD use in the U.S. ICD-10 is represented with a letter in the first position and a number in the second, third, and fourth positions. The fourth character follows a decimal point. Possible code numbers range from A00.0 to Z99.9. The letter U is not used.

- **Index (to diseases):** The ICD-10-CM is divided into the Alphabetic Index described earlier and the Tabular List.

- **Manifestation codes:** Certain conditions have both an underlying etiology and multiple body system manifestations. For such conditions, the ICD-10-CM has a coding convention that requires the underlying condition be sequenced first followed by the manifestation. Wherever such a combination exists, there is a “use additional code” note at the etiology code, and a “code first” note at the manifestation code. These instructional notes indicate the proper sequencing order of the codes, etiology followed by manifestation.

- **Medical necessity:** Services or supplies that are proper and needed for the diagnosis or treatment of a medical condition; are provided for the diagnosis, direct care, and treatment of a medical condition; meet the standards of good medical...
practice in the local area; and are not mainly for the convenience of the patient or physician.

• **Morbidity:** Term refers to the disease rate or number of cases of a particular disease in a given age range, gender, occupation, or other relevant population-based grouping.

• **Principal diagnosis:** First-listed/primary diagnosis code. The code sequenced first on a medical record defines the primary reason for the encounter as determined at the end of the encounter.

• **Signs/symptoms:** Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider.

• **Sequelae:** A late effect is the residual effect (condition produced) after the acute phase of an illness or injury has terminated. There is no time limit on when a late effect code can be used. The residual may be apparent early, such as in cerebral infarction, or it may occur months or years later, such as that due to a previous injury.

• **Tabular List:** A chronological list of ICD-10-CM codes divided into chapters based on body system or condition. It is essential to use both the Alphabetic Index and Tabular List when locating and assigning a code. The Alphabetic Index does not always provide the full code. Selection of the full code, including laterality and any applicable seventh character, can only be done in the Tabular List. A dash (−) at the end of an alphabetic index entry indicates that additional characters are required. Even if a dash is not included at the Alphabetic Index entry, it is necessary to refer to the Tabular List to verify that no seventh character is required.4

**OTHER ICD-10 TRANSITION RESOURCES**

- ACS ICD-10 Coding: [www.facs.org/advocacy/practmanagement/icd10](www.facs.org/advocacy/practmanagement/icd10)
- CMS Road to 10: [www.roadto10.org/](www.roadto10.org/)

**REFERENCES**

Effective January 1, 2016, a new place of service (POS) code will go into effect for health care services provided in outpatient settings outside of the main hospital campus. As this new code is implemented, physicians will need to know whether their hospital location is considered “on” or “off campus” when submitting their professional claims to the Centers for Medicare & Medicaid Services (CMS).

On August 6, CMS created POS code 19, Off Campus-Outpatient Hospital, and revised the description of POS code 22 to On Campus-Outpatient Hospital (originally Outpatient Hospital), via a change request to the Medicare Claims Processing Manual. See Table 1 on this page for a description of each code from the POS Codes for Professional Claims Database.*

CMS defines “campus” as “the physical area immediately adjacent to the provider’s main building, other

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**TABLE 1. POS CODES AND DESCRIPTIONS**

<table>
<thead>
<tr>
<th>POS code</th>
<th>POS name</th>
<th>POS description</th>
</tr>
</thead>
<tbody>
<tr>
<td>19</td>
<td>Off Campus-Outpatient Hospital</td>
<td>A portion of an off-campus hospital provider-based department that provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. (Effective January 1, 2016.)</td>
</tr>
<tr>
<td>22</td>
<td>On Campus-Outpatient Hospital</td>
<td>A portion of a hospital’s main campus that provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. (Description change effective January 1, 2016.)</td>
</tr>
</tbody>
</table>

Source: Centers for Medicare & Medicaid Services

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In the 2015 Medicare physician fee schedule final rule, CMS stated its intention to create a new POS code for professional claims to collect better data on off-campus versus on-campus provider-based HOPDs.

RESOURCES

- Place of Service Codes for Professional Claims Database: www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html

areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual case basis by the CMS regional office to be part of the provider’s campus.†

This change stems from CMS’ desire to better understand the growing trend toward hospital acquisitions of physician offices and the treatment of these offices as off-campus, provider-based hospital outpatient departments (HOPDs) from a practice expense payment perspective. In the 2015 Medicare physician fee schedule final rule, CMS stated its intention to create a new POS code for professional claims to collect better data on off-campus versus on-campus provider-based HOPDs. The addition of POS code 19 is primarily for data collection purposes and, for the time being, will follow the same payment policies as the current POS code 22.†

Prospective comparative effectiveness trial for malignant bowel obstruction: SWOG S1316

by Robert S. Krouse, MD, FACS, and Y. Nancy You, MD, MHSc, FACS

Malignant bowel obstruction (MBO) is a relatively common problem in patients with advanced intra-abdominal cancers. It is most often seen in patients with ovarian and colorectal cancers, but it can also occur with many other types of cancer. MBO is rarely an emergent problem requiring immediate intervention, and surgical teams usually have time to consider optimal treatment approaches.

No defined algorithm of care has been created for most patients with MBO. Many patients who present with an MBO are surgical candidates, and for some, an operation may be deemed the best option. However, in many instances the patient care team may decide to avoid an operation.

The Prospective Comparative Effectiveness Trial for Malignant Bowel Obstruction trial (S1316) was developed to address this clinical conundrum. The study is funded in collaboration with the Agency for Healthcare Research and Quality (AHRQ R01 HS021491) and SWOG (formerly known as the Southwest Oncology Group) through the National Cancer Institute Community Oncology Research Program Research Base grant 5UG1CA189974-01 to provide evidence to identify which algorithm of care may be optimal for patients with MBO.

Study aims
The aim of S1316 is to assess the quality of life (QOL) outcome of “good days,” defined as the number of days alive and outside of the hospital within the first 91 days (13 weeks) after registration, for patients with MBO who receive surgical intervention in comparison with patients who undergo nonsurgical intervention. Research questions include:

• Are there differences in health-related QOL outcomes for patients with MBO who receive surgical intervention as compared with nonsurgical intervention?
• Are there clinical factors that predict better health-related QOL outcomes for patients with MBO who receive surgical or nonsurgical intervention?

Study approach
This study uses a mixed approach, meaning that a randomized arm will be augmented by an observational arm (see Figure 1, next page). Notably, all patients must be “randomizable”; that is, they all must be surgical candidates and there must be equipoise as determined by the surgical team for both surgical versus nonsurgical treatment. For surgery, the lead surgeon in the operating room (OR) makes the decision. For the nonsurgical arm, nonoperative approaches, such as the use of percutaneous endoscopic gastrostomy tubes, are allowed.

In this trial, the nonsurgical arm mandates a trial of a somatostatin analog because of existing evidence of its benefit for MBO and because no evidence exists that points to detriment if the patient should later require surgical intervention. Patients will be accrued either to the...
randomized arm or the non-randomized/observation arm after they are seen by a surgical team. For example, if the team believes the patient would benefit from a week of parenteral nutrition to make them eligible for the OR, the patient may be registered at that time (see Figure 1.)

Eligibility criteria
As a surgical trial, one of the most important criteria is that the patient must be a candidate for surgery, meaning that not only is the patient likely to survive an operation, but also that the team feels an operation is indicated. In addition, the team must agree that either treatment approach, operative or nonoperative, is reasonable. This agreement does not necessarily mean that the operating team is without bias, but rather that it is open to alternatives.

Patients requiring an emergency operation are not eligible to participate in this trial. Other eligibility criteria include the following:

- MBO due to intra-abdominal primary cancer with incurable disease
- Clinical evidence of a small bowel obstruction beyond the ligament of Treitz with supporting imaging evidence
- Zubrod performance status of 0–2 one week before admission
- The ability to complete questionnaires in English or Spanish

Patients will be contacted weekly for 13 weeks, and then monthly for up to one year.

Outcomes
The primary outcome is a composite measure of “good days,” defined previously. Multiple secondary endpoints will be measured, including the ability to eat (as measured by serial diet recalls), health-related QOL, morbidity and mortality, and survival.

Study status
This study was initially limited to a few sites, but to augment accrual, the study has been opened to other sites across the U.S. Potential sites must have dedicated surgical teams with interest in this issue, including multiple surgical specialties, such as gynecologic oncology, surgical oncology, colorectal surgery, and general/acute care surgery. The study is open on the National Cancer Institute Cancer Trials Support Unit, so not all sites are mandated to be SWOG.

If you are interested in having your health care center become a site for this important surgical study, e-mail S1316@swog.org.
The ACS Surgery Career Connection and Coding Hotline

by Connie Bura and Sarah Kurusz

This month’s column provides information on two valuable but little-known American College of Surgeons (ACS) benefits: the ACS Surgery Career Connection, a robust resource for members who are seeking a career change or looking to fill a position that launched September 1; and the ACS Coding Hotline, which provides members a consultation service to stay informed regarding changes in claims coding and billing rules.

ACS Surgery Career Connection
The new ACS Surgery Career Connection—where the member provides the expertise, and the College provides the connection—is one of the most effective ways to connect employers from across the country with qualified surgeons of all surgical specialties and at every career stage. Powered by YourMembership, a leading provider of job websites and career centers for professional organizations, the mobile-responsive platform makes accessing Surgery Career Connection effortless across all Internet-enabled devices.

With this platform, surgeons are able to post multiple resumes and cover letters or create a career profile that leads potential employers directly to them. When a resume is set as “public,” employers can access the candidate’s resume. When institutions, health systems, or practices are interested in recruiting a specific candidate, the employer completes a contact request form. If the candidate agrees, his or her contact information is released to the employer. If not, they reject the request, which keeps the identity of the candidate private.

With Surgery Career Connection Job Alerts, individuals seeking new career opportunities receive an e-mail every time a job that matches their desired interests and locations becomes available. Surgeons also have the option of searching the jobs database, which is equipped with robust filters to focus on the individual’s specific interests. Along with searching for jobs, surgeons have access to Surgery Career Connection career resources, including suggestions for compiling a curriculum vitae, interview guidelines, sample resumes, answers to frequently asked questions, and more.

Surgery Career Connection provides many benefits to employers by helping them recruit top surgeons for their institutions and practices. Employers have the option of including their open positions in a bimonthly e-mail sent to all ACS-registered job seekers, allowing them to reach both active and passive job seekers by putting open jobs directly in the in-boxes of qualified surgeons.

Aside from online exposure, employers have the opportunity to include their open positions in various ACS member e-mail newsletters that exclusively reach ACS members. Job posting opportunities are available to ACS members at discounted prices.

“The American College of Surgeons is a world-class organization whose members and Fellows are an integral part of the country’s health care delivery system,” said Tristan Jordan, senior vice-president, YourMembership Careers. “Surgery Career Connection is an innovative...
We encourage members to take the time to become familiar with Surgery Career Connection and the Coding Hotline so that these member benefits will become valued and trusted resources when users need them the most.

gateway that matches the right health care providers with the right surgical talent to help keep surgical facilities well-staffed, and surgeons’ careers moving along a professional path that meets their goals.”

For more information on how to start the journey toward enhancing your career or organization, visit the Surgery Career Connection at http://surgeonjobs.facs.org, or go to the ACS home page at facs.org and click the Jobs tab at the top of the page.

ACS Coding Hotline
Accurate coding may be one of the most important areas for surgical practice improvement. However, keeping up with the constant changes in claims coding can be time-consuming and costly. To help alleviate these concerns, the College has established a coding consultation service hotline. ACS members can call the ACS Coding Hotline for answers to questions related to the following code sets and coding issues:

• Current Procedural Terminology
• Healthcare Common Procedure Coding System Level II
• 10th revision of the International Classification of Diseases
• Evaluation and Management coding
• National Correct Coding Initiative edits
• Correct modifier usage
• Difficult-to-code operative reports

Confirmation of ACS membership is required to obtain hotline assistance, so be prepared to provide your Member ID number to the hotline staff. If you need your Member ID number, contact ms@facs.org. ACS Coding Hotline services are provided and measured in consultation units (CUs). One CU covers a period of up to 10 minutes. ACS members are provided with up to five free CUs each calendar year. Unused CUs cannot be rolled over to the next year; however, additional CUs can be purchased.

Answers to coding questions are provided verbally over the phone. If it is necessary to submit an operative note for review, it must be pre-coded. Submitted operative reports may require additional time for review. If the answer to your question is not readily available, it will be referred for research; it may take up to 10 business days for a response.

The hours of operation are 9:00 am–6:00 pm EST Monday–Friday. Calls are returned within 24 hours. To access a coding specialist, call the ACS Coding Hotline at 800-ACS-7911 (800-227-7911).

We encourage members to take the time to become familiar with Surgery Career Connection and the Coding Hotline so that these member benefits will become valued and trusted resources when users need them the most.
The high reliability journey: A look in the mirror with Oro 2.0

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

In the last two issues of the Bulletin, I have highlighted the Joint Commission’s Robust Process Improvement (RPI) methodology and how the RPI toolkit can be of benefit to surgeons and health care institutions. This last column in this particular series focuses on a new resource: Oro 2.0.

**Self-examination for improved reliability**

Created by the Joint Commission Center for Transforming Healthcare, Oro 2.0 is a Web-based application that is available to accredited health care institutions at no additional fee. The mission of the center is to help transform health care into a high-reliability industry where every patient receives excellent care, every time. Oro 2.0 is designed to help institutions on their journey to high reliability. It includes an assessment for hospital senior leaders and a resource library for all physicians and staff who work at the organization.

The assessment helps health care leaders plot where their institution is on their path to high reliability. It is meant to provoke an honest, in-depth conversation among senior leaders and create alignment. Senior leaders take the assessment individually and then come together as a group to take the assessment again, with the goal of reaching a consensus on their institutions’ strengths and weaknesses. Institutions that pilot tested the assessment indicate that the discussion is extremely valuable, as it allows the senior leadership team to align around the various aspects of high reliability—what they mean to their organization and where they need to focus their efforts.

The assessment helps leaders plot where their institution is on their path to high reliability.

**Leadership**
- Board
- CEO/senior management
- Physicians
- Quality strategy
- Quality measures
- Information technology

**Safety culture**
- Trust
- Accountability
- Identifying unsafe conditions
- Strengthening systems
- Assessment

**Performance improvement**
- Methods
- Training
- Spread

The assessment typically takes about two hours for the group to complete and to achieve consensus. It is recommended that a trained facilitator administer the assessment so that the senior team can focus on the discussion. The assessment discussion aims to:

- Engage leaders so they have a common understanding of where the organization is on its journey
- Provoke thinking and action around the organization’s
commitment to zero harm, a culture of safety, and approach to performance improvement

• Create alignment around a goal of zero harm and focus the direction by which the organization is moving to achieve that aim

Embracing the goal of high reliability
Joint Commission President Mark R. Chassin, MD, and the late Jerod Loeb, MD, began evaluating the attributes of high-reliability organizations such as members of the commercial aviation and nuclear power plant industries many years ago. Drs. Chassin and Loeb also studied the approaches used in manufacturing, and they analyzed the high-reliability characteristics of corporations such as General Electric and Toyota. With the knowledge The Joint Commission gained by surveying more than 20,000 programs and organizations, the high-reliability maturity model for health care was developed, culminating in an article published in 2013 in the Milbank Quarterly. More than 60 organizations were involved in piloting the assessment, which led to optimization of the questions and the Oro 2.0 application.

Why should surgeons support and champion this cause? First, because surgeons have an opportunity to observe firsthand situations that resulted in preventable harm to patients. The undesirable outcomes of these situations hurt patients and surgeons alike. Second, surgeons are becoming leaders in their organizations to a greater extent than we have seen in the past. Even if we are not leading from a formal position, we often have a great deal of influence in our organizations and, therefore, are in a prime position to recognize that taking on the aim of zero harm is in the best interests of everyone—patients, hospitals, and surgeons.

Embracing high-reliability science is an approach that can lead to dramatic improvements in patient outcomes, health care redesign, organizational effectiveness, and cost. It also can lead to dramatic improvements for the day-to-day work of an individual surgeon in terms of efficiency, empowerment, and the optimal care for all patients.

For more information about Oro 2.0, go to www.centerfortransforminghealthcare.org/oro.aspx. ♦

Disclaimer
The thoughts and opinions expressed in this column are solely those of Dr. Pellegrini and do not necessarily represent the official views of The Joint Commission or the American College of Surgeons.

The ability of Oro 2.0 to provide a snapshot of where an organization is on its journey across multiple components is one of the program’s key features, and it is critical to determining next steps.

Holiday Road,” a 1983 song written and performed by Lindsey Buckingham of Fleetwood Mac, was popularized by its heavy use in the National Lampoon Vacation movies starring Chevy Chase as Clark Griswold, a food additive designer from Chicago, IL. Throughout these movies, a common theme emerged concerning road trips and motor vehicle-related mishaps.

Dashing through the snow
The holidays in December are a prime time to hit the road for many Americans. According to the 2014 American Automobile Association (AAA) year-end holiday forecast, almost 99 million travelers were expected to be traveling by road for the holidays. That represents a 4 percent increase from previous years and the highest travel volume since these statistics started being recorded. More than 90 percent of all travelers will be celebrating the holidays with a road trip.*

In a December 2014 press release, the National Safety Council estimated that nearly 800 total fatalities from car crashes would occur during that holiday season. These estimates differ each year as the length of the holiday periods are dependent on the day of the week on which the holiday falls. It may be 1.25 days long if December 25 falls on a Wednesday; 3.25 days long if December 25 falls on a Friday, Saturday, Sunday, or Monday; or 4.25 days long if December 25 falls on a Tuesday or Thursday.†

With Christmas and New Year’s Day being exactly one week apart, the New Year’s period will be of identical duration for any given year. This year, the holidays land on a Friday, so the holiday periods will be 3.25 days in length.

To examine the occurrence of Christmas holiday road motor vehicle driver-related injuries in the National Trauma Data Bank® (NTDB®) research dataset for 2013, admissions medical records were searched for the 24-hour period using arrival date and time that occurred between 7:00 pm December 24 to 7:00 pm December 25, 2013. Records were then searched using the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnoses codes. Specifically searched were records that contained the following external cause of injury codes (E-code): E810–E819 (motor vehicle crashes) with a post decimal value of zero for driver of a car or three for driver of a motorcycle. A total of 1,090 records were found; 916 records contained a discharge status, including 623 patients discharged to home, 156 to acute care/rehab, and 66 sent to skilled nursing facilities; 71 died. Most of these patients (58.3 percent) were male, on average 42.4 years of age, had an average hospital length of stay of 7.5 days, an intensive care unit length of stay of 7.1 days, an average injury severity score of 15.8, and were on the ventilator for an average of 10 days. In all, 677 patients were tested for alcohol, and more than half (51.3 percent) tested positive. Of the 380 tested for illicit drugs, 41 percent tested positive. (See Figures 1 and 2, page 56.)

Celebrate safely
The holidays are a time to celebrate with family and friends, and statistics show that millions of Americans take to the road each year. The National Safety Council makes the following recommendations for safe travel:

- Buckle up every trip, every time—even when traveling short distances.
- Refrain from using electronic devices—including hands-free technology—behind the wheel.
- Secure children in size-appropriate restraints.
- Do not drink and drive, as impairment begins with the first

drink. If you do drink, designate a sober driver or take alternate transportation.

- Plan ahead and drive defensively, especially in bad weather.

- Never drive when you are tired—get plenty of sleep before your trip and plan regular stops.

To quote Clark Griswold, “Why aren’t we flying? Because getting there is half the fun.” This season, let’s get there safely when we take to the holiday road.

Throughout the year, we will be highlighting these data through brief reports that will be found monthly in the Bulletin. The NTDB Annual Report 2014 is available on the ACS website as a PDF file at www.facs.org/quality-programs/trauma/ntdb. In addition, information is available on our website about how to obtain NTDB data for more detailed study. If you are interested in submitting your trauma center’s data, contact Melanie L. Neal, Manager, NTDB, at mneal@facs.org. ♦

Acknowledgement
Statistical support for this article has been provided by Chrystal Caden-Price, Data Analyst, NTDB.
Courtney M. Townsend, Jr., MD, FACS, Robertson-Poth Distinguished Chair in General Surgery, department of surgery, University of Texas Medical Branch (UTMB), Galveston, was elected President-Elect of the American College of Surgeons (ACS) at the Annual Business Meeting of the Members October 7 in Chicago, IL. The First and Second Vice-Presidents-Elect also were elected.

Dr. Townsend’s first teaching position was as adjunct assistant professor of surgery, division of oncology, department of surgery, UCLA (1974–1976). He then served two years (1976–1978) in the U.S. Navy as staff surgeon and surgical director, intensive care unit, National Naval Medical Center, Bethesda, MD, before returning to UTMB as an associate professor, department of surgery, in 1978. In 1981, he was promoted to Robertson-Poth Associate Professor of Surgery, and in 1982 he was appointed director, surgical research laboratory, UTMB. From 1983 to 1995, he was the Robertson-Poth Professor, department of surgery, and from 1987 to 1995 he was interim director, UTMB Cancer Center. He assumed his current roles as professor of physicians assistant studies in 1989, as John Woods Harris Distinguished Chairman in 1995 (a post he held until 2013), as graduate faculty in the cell biology program in 2001, and as Robertson-Poth Distinguished Chair in General Surgery in 2009. An ACS Fellow since 1981, Dr. Townsend has served in many leadership roles in the organization, most recently as Secretary (2006–2015). Previously, he served as Chair of the ACS Board of Governors (B/G) (2004–2005), on the B/G Executive Committee (1999–2003), and as the Society for Surgery of the Alimentary Tract Governor (1986–1992). In addition, he served on several Commission on Cancer (CoC) committees, including the CoC Committee on Approvals (1989–1994), the CoC National Cancer Data Base Committee, and the National Cancer Data Base Governing Board (1989–1995). Furthermore, he served on the ACS Committee for the Forum on Fundamental Surgical Problems (1991–1994), the Committee on Papers (2000–2003), the Committee on Special Issues (1991–1994), the Member Services Liaison Committee (2003–2004), and the Nominating Committee of the Fellows (2000–2002). He currently serves on the Surgical Research and Education Committee, which he chaired (1998–2000). At the local level, Dr. Townsend has served on the Southern Texas District #1 Committee on Applicants (1996–1999) and as President of the South Texas Chapter of the ACS (1988–1989).

Dr. Townsend is past-director and chairman of the American Board of Surgery (2000–2006) and previously served on the Accreditation Council for Graduate Medical Education Residency Review Committee for Surgery (1994–1999). He has been a leader of...
numerous other professional organizations, including the following: American Pancreatic Association (president, 1992–1993); American Surgical Association (president, 2007–2008); Collegium Internationale Chirurgiae (board of trustees, 1992), James IV Association of Surgeons (board of directors, 1999–2002); Society of Surgical Oncology (executive council, 1994); Southern Surgical Association (secretary, 1998–2003; and president, 2004); Surgical Biology Club I (secretary, 1995–1997); and Texas Surgical Society (council member, 1997–1999). Dr. Townsend is an honorary member of the Society of Black Academic Surgeons and the Association of Women Surgeons (AWS) and is a recipient of the John P. McGovern Lifetime Achievement Award in Oslerian Medicine.

Dr. Townsend's research in gastrointestinal endocrinology and cancer has been supported through grants from the NIH and the American Cancer Society. He has authored or co-authored 416 articles in peer-reviewed publications, 123 articles in other publications, and 364 abstracts.

**Vice-Presidents-Elect**
The Vice-Presidents-Elect also were elected at the Annual Business Meeting. The First Vice-President-Elect is **Hilary Sanfey, MB, BCh, BAO, MCh, MA, MHPE, FACS, FRCSI, FRCS** , professor of surgery and vice-chair for educational affairs, department of surgery; and associate director, Academy for Scholarship and Education, Southern Illinois School of Medicine, Springfield.

Dr. Sanfey hails from Ireland and graduated from Trinity College Dublin School of Medicine in 1976. She trained in surgery at the Royal College of Surgeons in Ireland, Dublin; spent three years as a research fellow at Johns Hopkins University, Baltimore, MD; and worked as a consultant transplant surgeon at the Royal Infirmary of Edinburgh, Scotland, for four years before moving to the University of Virginia, Charlottesville, in 1996. She remained on the clinical faculty at the University of Virginia starting as an assistant professor of hepatobiliary surgery in 1991 and leaving in 2008 for Southern Illinois University, Springfield, as a professor of surgery. In 2009 she received a master’s degree in health professions education from the University of Illinois, Chicago. Dr. Sanfey recently spent three months as a specialist advisor in the postgraduate surgical training and education department of surgical affairs, Royal College of Surgeons in Ireland.

An ACS Fellow since 2001, Dr. Sanfey has been the ACS Liaison to the American Medical Association (AMA) Women Physicians Congress (2006–2008) and an ACS Governor (2006–2012). As a Governor, she chaired the B/G Committee on Chapters Subcommittee on Diversity (2009–2011) and the Nominating Committee (2010–2012). In addition, she served on the Executive Committee of the Committee on Medical Student Education (2005–2011) and as a liaison to the Program Committee. She presently serves as faculty for the ACS Residents as Teachers and Leaders Program and on the Executive Committee of the Scholarship Committee. She has been active on the Women in Surgery Committee since 2005 (Executive Committee, 2007–2013; Chair, 2009–2013).

Dr. Sanfey has held high-ranking positions in other prestigious surgical organizations as well, including the AWS.
[Dr. McCarthy] is the recipient of numerous professional awards, including the American Hospital Association Nova Award, and AWS Distinguished Member and Nina Starr Braunwald Awards.

(president, 2005–2006) and the U.S. Chapter of the International Surgical Society (president, 2013–2015). In addition, she has served on key committees of the Association of Program Directors in Surgery, the Association for Surgical Education, and the American Society of Transplant Surgeons.

Dr. Sanfey is on the editorial boards of the Association for Surgical Education, *Journal of the Royal Colleges of Edinburgh and Ireland*, and JACS. She is an accomplished surgical investigator and has contributed to nearly 100 peer-reviewed papers and 22 book chapters and has been a frequent guest lecturer and visiting professor at numerous international symposia and workshops.

She is the recipient of many awards in surgical education. In 2010, the AWS’ Outstanding Woman Resident Award was renamed the Hilary Sanfey Outstanding Resident Award, and in 2013 and 2014, respectively, Dr. Sanfey was honored with the AWS Olga Jonasson Distinguished Member Award and the Nina Starr Braunwald Award.

The Second Vice-President-Elect is Mary C. McCarthy, MD, FACS, Elizabeth Berry Gray Chair and Professor, department of surgery, Boonshoft School of Medicine, and adjunct graduate faculty, School of Engineering, Wright State University (WSU); and an acute care surgeon at Miami Valley Hospital, Dayton, OH. Other positions that Dr. McCarthy has held at WSU are as follows: professor of surgery (1994–present); associate professor of surgery (1991–1994); and associate graduate faculty member, school of nursing (1993–1998). Before moving to WSU, she held the following positions at Indiana University (IU) School of Medicine, Indianapolis: assistant professor of surgery (1983–1988), clinical assistant professor of surgery (1988–1989), and clinical associate professor (1989–1990).

An ACS Fellow since 1986, Dr. McCarthy has served in a number of leadership positions within the organization, including ACS Governor (1995–2001). As a Specialty Society Governor for the AWS, she served on the Nominating Committee (member, 1996–1997; Vice-Chair, 1997–1998); the Governors’ Committee on Chapter Activities (1995–2001), chairing the committee’s Subcommittee on Chapter Membership Recruitment, Retention, and Diversification (1998–2001); and Advisor to the Governors Committee on Chapter Activities Executive Committee (1995).

Dr. McCarthy presently serves on the ACS Advisory Council for General Surgery and the Committee on Trauma. She also has served on the *Surgical Education and Self-Assessment Program (SESAP)* Committee, including as Co-Chair for SESAP XII (1999); the Committee on Continuing Education (member, 1994–1999; Vice-Chair, 1995–1997); the Committee on Applicants for District 6 (present); and the Clinical Congress Abstract Selection Committee (2007–2009). While at IU, she was active in the Indiana Chapter, and she remains active in the Ohio Chapter, having served on the Executive Committee (1995–2001) and the Ohio COT (1991–present).

She is a past-president of the AWS (1990–1992) and has served in prominent positions in the Association for Surgical Education, Eastern Association for the Surgery of Trauma, Halsted Surgical Society, Midwest Surgical Association, Parkland Surgical Society, and Society of Critical Care Medicine.

Dr. McCarthy is the recipient of numerous professional awards, including the American Hospital Association Nova Award, and AWS Distinguished Member and Nina Starr Braunwald Awards. She is a prolific author of peer-reviewed publications, book chapters, and abstracts on trauma and critical care.
New members of the American College of Surgeons (ACS) Board of Regents (B/R) and the Executive Committee of the Board of Governors (B/G) were installed at Clinical Congress 2015 in Chicago, IL.

**Board of Regents**

The newly elected B/R Chair is Valerie W. Rusch, MD, FACS, vice-chair, clinical research, department of surgery, Miner Family Chair in Intrathoracic Cancers; attending surgeon, thoracic service, department of surgery, Memorial Sloan Kettering Cancer Center; and professor of surgery, Weill Cornell Medical College, New York, NY. Michael J. Zinner, MD, FACS, will serve as Vice-Chair of the B/R. Dr. Zinner is Moseley Professor of Surgery, Harvard Medical School; clinical director, Dana-Farber/Brigham and Women’s Hospital (BWH) Cancer Center; and surgeon-in-chief, BWH, Boston, MA.

New regents

In addition, the B/G elected four new Regents: James C. Denneny III, MD, FACS, FAAOA, is executive vice-president and chief executive officer, American Academy of Otolaryngology–Head and Neck Surgery, Alexandria, VA, and adjunct professor of clinical otolaryngology, department of otolaryngology–head and neck surgery, University of Missouri-Columbia. A Fellow of the College since 1991, Dr. Denneny has been an ACS Governor since 2009 and has served on the B/G Executive Committee since 2011. As Secretary of the B/G (2014–2015), he served on the Executive Compensation Committee and the B/R Finance Committee. He has been Chair of the B/G Advocacy and Health Policy Pillar since 2013, has been a member of the B/G Socioeconomic Committee since 2011, served on the B/G Ad Hoc Committee to Restructure the Governors Committees (2012–2013), and chaired the B/G Coalition Workgroup (2013–2014). Dr. Denneny also has served on the Advisory Council for Otolaryngology–Head and Neck Surgery (2009–2015), the Health Policy and Advocacy Group (2013–2014), and the Missouri Credentials Committee (2009–2015).

Timothy J. Eberlein, MD, FACS, is the Bixby Professor of Surgery and chair of surgery; Spencer T. and Ann W. Olin Distinguished Professor and director, The Alvin J. Siteman Cancer Center; and surgeon-in-chief, Barnes-Jewish Hospital, Washington University School of Medicine,
St. Louis, MO. Dr. Eberlein is Editor-in-Chief of the *Journal of the American College of Surgeons*. A Fellow since 1988, he has served on several ACS committees, most recently on the B/G (2004–2010). As a Governor, Dr. Eberlein served on the B/G Committee to Study the Fiscal Affairs of the College (2008–2010) and the Missouri Credentials Committee (2004–2010). He has served on the Commission on Cancer (1995–2005) and on the Commission on Cancer’s Committee on Education (2001–2007). He served on the Scientific Forum Committee (member, 1998–2004; and Vice-Chair, 2002–2004) and chaired the Surgical Research Committee (1996–2002). As Chair of the Research and Education Committee, Dr. Eberlein worked with Olga Jonasson, MD, FACS, then-Medical Director of the former Education and Surgical Services Department of the ACS, to establish the Clinical Trials Methods Course. Dr. Eberlein also served on the Program Committee (member, 2001–2002; and Liaison, 2003–2004).

**Linda G. Phillips, MD, FACS**, is the Truman G. Blocker, Jr., MD, Distinguished Professor and chief, department of surgery, division of plastic surgery; and professor, School of Medicine, University of Texas Medical Branch, Galveston. A Fellow of the ACS since 1988, Dr. Phillips has served on the ACS Committee on Surgical Education in Medical Schools (1993–2003); the Advisory Council for Plastic and Maxillofacial Surgery (member, 2000–2009; Chair, 2004–2008); the Program Committee (Liaison, 2003–2009); the Nominating Committee (member, 2006–2009; and Chair, 2009); and the Women in Surgery Committee (member, 2001–2007; and Consultant, 2007–2011). At the local level, she has served on the Council of the South Texas Chapter and continues to be a member of the Southern Texas District #1 Committee on Applicants. **Anton N. Sidawy, MD, MPH, FACS**, is Professor and Lewis B. Saltz Chair, department of surgery, George Washington University, Washington, DC. An ACS Fellow since 1987, Dr. Sidawy has served as an ACS Governor (2001–2007). In that role, he was an active member of the Governors’ Committee on Chapter Relations (member, 2001–2006; and Chair, 2006–2007). He also has served on the ACS Committee on Patient Safety and Quality Improvement (2006–2010). Dr. Sidawy has been active in the leadership of the Metropolitan Washington, DC, Chapter of the ACS, including as Secretary-Treasurer (1998–1999) and President (2000–2001) and has served on the Metropolitan Washington Credentials Committee (1995–2014), as well. In 2006, the Metropolitan Washington, DC, Chapter of the ACS presented the LaSalle D. Lefall, Jr., Award to Dr. Sidawy for “outstanding contributions to the profession of surgery and to the entire metropolitan Washington community.”

**Reelected Regents**

The following individuals were reelected to serve a second term as ACS Regents:

- **John L. D. Atkinson, MD, FACS**, professor of neurosurgery, department of neurological surgery, Mayo Clinic, Rochester, MN
- **Henri R. Ford, MD, MHA, FACS**, vice-president and surgeon-in-chief, Children’s Hospital of Los Angeles; and vice-chairman and vice-dean for medical education, Keck School of Medicine, University of Southern California, Los Angeles

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The following Regents have been reelected to serve a third term:

- **Leigh A. Neumayer, MD, FACS**, professor and chair, department of surgery, University of Arizona, and Margaret and Fenton Maynard Endowed Chair in Breast Cancer Research, University of Arizona College of Medicine, Tucson

- **Marshall Z. Schwartz, MD, FACS**, professor of surgery and pediatrics, Drexel University College of Medicine; adjunct professor of surgery and pediatrics, Temple University School of Medicine and Thomas Jefferson University; and surgeon-in-chief, St. Christopher’s Hospital for Children, Philadelphia

**B/G Executive Committee**

In addition, the B/G reelected **Fabrizio Michelassi, MD, FACS**, as Chair of its Executive Committee. Dr. Michelassi is the Lewis Atterbury Stimson Professor and Chairman, department of surgery, Weill Cornell Medical College, and surgeon-in-chief, New York-Presbyterian/Weill Cornell Medical Center, New York, NY. **Diana Farmer, MD, FACS**, a pediatric surgeon, the Pearl Stamps Stewart Professor of Surgery, and chair, department of surgery, University of California Davis Health System, Sacramento, has been elected Vice-Chair of the B/G; and **Steven C. Stain, MD, FACS**, Henry and Sally Schaffer Chair and Professor, department of surgery, Albany Medical College, NY, has been elected Secretary.

New members of the Board of Governors Executive Committee elected to an initial one-year term are as follows: **Daniel L. Dent, MD, FACS**, Distinguished Teaching Professor, general surgery residency program director, and professor of surgery, University of Texas Health Science Center, San Antonio; and **James W. Fleshman, Jr., MD, FACS, FASCRS**, Helen Buchanan and Stanley J. Seeger Professor and chair, department of surgery, Baylor University Medical Center, Dallas, TX. **Susan K. Mosier, MD, MBA, FACS**, was elected to the B/G Executive Committee for an initial two-year term. Dr. Mosier is an ophthalmologist who is presently serving as the Secretary of the Kansas Department of Health and Environment and the State Health Officer for Kansas, Topeka. **Francis D. Ferdinand, MD, FACS, FRCSed**, a cardiothoracic surgeon at Lankenau Medical Center, Wynnewood, PA, was elected to an initial two-year term. ♦
**Nominations for 2016 volunteerism and humanitarian awards due February 29**

The American College of Surgeons (ACS), in association with Pfizer, Inc., is accepting nominations for the 2016 Surgical Volunteerism Award(s) and Surgical Humanitarian Award. All nominations must be received by **February 29, 2016**.

**Volunteerism Awards**
The ACS/Pfizer Surgical Volunteerism Award—offered in four potential categories—recognizes surgeons who are committed to giving back to society by making significant contributions to surgical care through organized volunteer activities. The awards for domestic, international, and military outreach are intended for ACS Fellows in active surgical practice whose volunteer activities go above and beyond the usual professional commitments or for retired Fellows who have been involved in volunteerism in the course of active practice and into retirement. Resident Members and Associate Fellows of the College who have been involved in significant surgical volunteer activities as part of their postgraduate surgical training are eligible for the Resident award.

For the purposes of these awards, “volunteerism” is defined as professional work in which one’s time or talents are donated for charitable clinical, educational, or other worthwhile activities related to surgery. Volunteerism in this case does not refer to uncompensated care provided as a matter of necessity in most clinical practices. Instead, volunteerism should be characterized by prospective, planned surgical care to underserved patients with no anticipation of reimbursement or economic gain.

**Humanitarian Award**
The ACS/Pfizer Surgical Humanitarian Award recognizes an ACS Fellow whose career has been dedicated to ensuring the provision of surgical care to underserved populations without expectation of commensurate reimbursement. This award is intended for surgeons who have dedicated a significant portion of their surgical careers to full-time or near full-time humanitarian efforts rather than routine surgical practice. Examples include a career dedicated to missionary surgery, the founding and ongoing operations of a charitable organization dedicated to providing surgical care to the underserved, or a retirement characterized by surgical volunteer outreach. Having received compensation for this work does not preclude a nominee from consideration.
The ACS/Pfizer Surgical Humanitarian Award recognizes an ACS Fellow whose career has been dedicated to ensuring the provision of surgical care to underserved populations without expectation of commensurate reimbursement.

and, in fact, may be expected based on the extent of the professional obligation.

The ACS Board of Governors’ Surgical Volunteerism and Humanitarian Awards Workgroup will evaluate the nominations and forward their selections to the Board of Governors’ Executive Committee for final approval.

Nominations
The following conditions apply to the nominations process:

- Self-nominations are permissible but require at least one outside letter of support
- Re-nomination of previous nominees is acceptable but requires completion of a new application
- Re-nomination of previous nominees is acceptable but requires completion of a new application
- Demographic information about the nominee and nominator
- Details about the nominator’s relationship to the nominee, along with background information on the nominee’s career in surgery
- Completion of seven questions related to the nominee’s volunteerism or humanitarian work (2,500 characters maximum for each question) to include questions on the following: type of service provided, sustainability of programs, advocacy efforts, additional roles, and others

The nomination website will open January 4 for electronic submission and can be accessed through the Operation Giving Back (OGB) section of the ACS website at www.facs.org/ogb. For more information, contact the OGB at ogb@facs.org.

Dr. Lenworth Jacobs speaks at White House “Stop the Bleed” event

Lenworth M. Jacobs, Jr., MD, MPH, FACS, American College of Surgeons (ACS) Regent and Chairman of the Hartford Consensus, was among the featured speakers October 6 at a “Stop the Bleed” event at the White House, a campaign launched that day by the Obama Administration. The campaign will provide bystanders of emergency situations with the tools and knowledge to stop life-threatening bleeding. Working with the private sector and not-for-profit organizations, “Stop the Bleed” will put knowledge gained by first responders and the military into the hands of the public. This effort is intended to save lives by teaching the techniques of bleeding control as recommended by the Hartford Consensus and as taught in the Bleeding Control for the Injured Course developed by the ACS in partnership with the National Association of Emergency Medical Technicians. View the campaign’s Fact Sheet on the White House website at https://goo.gl/Bqhjoj.
In memoriam:

Dr. Thomas Krizek, leader in plastic surgery

by Mary H. McGrath, MD, MPH, FACS

Thomas J. Krizek, MD, MA, FACS, died on August 5 at his home in Whittier, NC, at age 83. A renowned plastic surgeon, teacher, friend, and leader, he was distinguished for his unmatched ability to stimulate intellectual curiosity and creative thinking in his students and colleagues. Playing a major role in the development of American plastic surgery, he left an indelible mark on the specialty and endures in the lives of those touched by his presence.

**Academic career**

Tom Krizek was born in Milwaukee, WI, in 1932 to Elizabeth and Chester Krizek and graduated from Marquette University and Marquette Medical School (now the Medical College of Wisconsin), Milwaukee. He entered residency in general surgery at Case Western Reserve University School of Medicine, Cleveland, OH, served two years of active duty in the U.S. Marine Corps, and completed training in 1964.

Inspired by plastic surgeons at Case Western, particularly Clifford L. Kiehn, MD, FACS, he then completed training in plastic surgery and entered practice as chief of plastic surgery at the Baltimore General Hospital in the Johns Hopkins University, Baltimore, MD, program. In 1968, he was recruited to Yale University School of Medicine, New Haven, CT, to develop a section of plastic surgery in the department of surgery. He also served as associate dean of the Yale School of Medicine after establishing the plastic surgery program in 1971.

After a decade at Yale, he was recruited to serve as professor and chief of plastic surgery at Columbia University Medical Center, New York, NY; the University of Southern California, Los Angeles; and then the University of Chicago, IL, where he subsequently served for four years as chairman of the department of surgery, as well as interim dean of the School of Medicine. Prior to his retirement, he made a final move to the University of South Florida, Tampa, where he was chief of plastic surgery and vice-chair, department of surgery.

“Tom Krizek was a wonderful human, great leader, and surgeon. He characterized the very best of Fellowship in American College of Surgeons. He publicly acknowledged his own alcoholism, and we both served on the Board of Governors' Committee on Physicians’ Health. We worked together to produce a wonderful training video titled Out of Control, which the ACS offered to educate our colleagues about alcoholism and drug addiction. He helped hundreds of our colleagues find and maintain sobriety and serve very happy and productive careers.”

—Gordon L. Hyde, MD, FACS, professor emeritus surgery, University of Kentucky, Lexington. Dr. Hyde is a retired vascular surgeon and lives in Naples, FL.
Dr. Krizek was a man of faith who widened the world of those around him; he was a dominant figure in plastic surgery who inspired intellectual integrity, responsibility, and joy in everyday practice.

Leading burn surgeon

Working with severely burned patients and with funding from several National Institutes of Health grants, Dr. Krizek contributed to the understanding of thermal and radiation burns, biologic dressings and topical agents, diagnosis and treatment of sepsis, and, together with Martin Robson, MD, FACS, established the concept of confirming surgical wound infections with quantitative bacterial counts. He was chairman of the Plastic Surgery Research Council in 1974 and national plastic surgery consultant for the Shriners Hospitals and the U.S. Food and Drug Administration.

Dr. Krizek was an influential leader in plastic surgery education, serving on the Accreditation Council for Graduate Medical Education Plastic Surgery Residency Review Committee and as director of both the American Board of Plastic Surgery and the American Board of Surgery. A Fellow of the American College of Surgeons (ACS) since 1968, he was deeply involved in this organization and sat on the Board of Regents (1988–1997), was Vice-Chair of the Board of Regents (1996–1997), and served as First Vice-President (1999–2000). He chaired the Central Judiciary Committee and was on the ACS Ethics Committee for 10 years, at which time he helped to write the College’s Code of Ethics. His plastic surgery colleagues recognized his leadership, and he was elected president of the American Association of Plastic Surgeons, president of the American Association for Hand Surgery, and chairman of the Plastic Surgery Program Directors.

Ethicist and humanitarian

Dr. Krizek had an abiding interest in the experience of the surgical resident and the life of the practicing surgeon, and he thought and wrote about surgical error, reporting adverse events, the surgeon’s role in palliative care, and the impaired physician. He relished challenging dogma, thinking beyond the surface, and stimulating others with provocative questions. He was a master teacher who engaged his students, brought vitality to the learning experience, and created an atmosphere of remarkable productivity.

His humor was clever and dry, and he delighted in the absurd. He was an eloquent speaker and left his audiences optimistic and brimming with ideas. He was the commencement speaker at eight medical school graduations and gave numerous keynote addresses, including the Ethics and Philosophy Lecture at the 2001 ACS Clinical Congress.

After retiring from the practice of surgery, Dr. Krizek continued his study of the human condition and earned a master’s degree in religious studies. He taught sports ethics and religious studies to a new generation of students who crowded into his classrooms, captivated by his style and humor. His intellectual energy and evident joy when engaging with others were legendary.

Dr. Krizek was a man of faith who widened the world of those around him; he was a dominant figure in plastic surgery who inspired intellectual integrity, responsibility, and joy in everyday practice.

He is survived by his wife Claudette Reid Krizek; three children: Thomas, Jr., Kelly Ann Criscuolo, and Mary Ellen Burgard; two step-children: Clifton Cannon and Timothy Cannon; and six grandchildren: Emily, Isaac, Lucas, Ethan, Dima, and Valentina. He is mourned by them and the numerous plastic surgeons whom he trained and celebrated.
Robert Hope succeeds Felix Niespodziewanski as Director of ACS Convention and Meetings

Robert “Bob” Hope, who joined the American College of Surgeons (ACS) staff in August, will succeed Felix Niespodziewanski as Director of Convention and Meetings when Mr. Niespodziewanski retires at the end of the year after 26 years at the College.

Before joining the College staff, Mr. Hope worked in a similar capacity for 17 years as the director of housing, registration, and travel services at the Radiological Society of North America (RSNA), Oak Brook, IL. RSNA hosts the world’s largest medical meeting, attended by more than 55,000 health care professionals. At RSNA, Mr. Hope was responsible for negotiating all travel and convention-related contracts and managing business relationships with vendors including hotels, airlines, registration and housing companies, travel agencies, event venues, tour operators, and convention bureaus.

Mr. Hope began working in the hospitality industry in the sales and convention service departments at the Fontainebleau Hilton Resort, Miami Beach, FL, following graduation from Florida International University, Miami, where he earned a bachelor’s degree in hotel and restaurant management. Early in his career, Mr. Hope held convention management positions at several Hilton and Hyatt properties in Georgia, Florida, Arizona, California, New York, and Illinois. Mr. Hope made Chicago, IL, his home when he became assistant director of convention services at Hilton Chicago, and then became director of convention services at Hyatt Regency Chicago.

Experience at work
Mr. Hope brings 35 years of executive management experience to ACS Convention and Meetings, having worked across all areas of meeting planning including strategic planning, contract negotiation, team leadership, operations, special events, and budget forecasting. Mr. Hope currently serves on the advisory boards for Marriott International and Fairmont Hotels.

“I look forward to working with all members of the College’s widely respected professional staff and making a significant contribution as we build upon the already successful meetings program at the ACS,” Mr. Hope said.

As part of the changes in the leadership of Convention and Meetings, Jackie Mitchell has been appointed to the Associate Director position. Ms. Mitchell has assisted in planning the Clinical Congress and other ACS events for 31 years.

Away from the office, Mr. Hope pursues his passion for golf, adventure, and travel with his family. He has traveled to four continents and more than 35 countries. Several years ago, he and his wife Kit backpacked on a six-month journey around the world.

Often asked about his favorite travel destination, Mr. Hope responds, “The next new place I’m going.” He says, “While the more exotic and different a destination’s culture is from what I am most familiar interests me most, I learn something from every place I experience and enjoy the new people I meet.” ♦
The 2016 Nominating Committee of the Board of Governors (NCBG) will select nominees for pending vacancies on the Board of Regents that will need to be filled at Clinical Congress 2016. The deadline for submitting nominations is **February 26, 2016.**

### Criteria

The NCBG uses the following criteria when reviewing candidates for potential nomination to the Board of Regents:

- **Loyal members of the College who have demonstrated outstanding integrity and medical statesmanship along with an unquestioned devotion to the highest principles of surgical practice.**

- **Demonstrated leadership qualities that might be reflected by service and active participation on ACS committees or in other components of the College.**

- **Recognition of the importance of representing all individuals who practice surgery.**

- **Practice location, surgical specialty, and academic or community practice.**

- **The College encourages consideration of women and other under-represented minorities.**

- **All surgical specialties will be considered, although special consideration will be given to general surgery and urology recommendations.**

- **Individuals who are no longer in active surgical practice should not be nominated for election or reelection to the Board of Regents.**

  All nominations must include a letter of recommendation, a personal statement detailing the candidate’s ACS service, and the name of one reference. In addition, entities such as surgical specialty societies, ACS advisory councils, and ACS chapters must provide a description of their selection process and a list of all applicants reviewed. Any attempt to contact members of the NCBG by a candidate or on behalf of a candidate will be viewed in a negative manner and may result in disqualification of the candidate. Applications submitted without the requested information will not be considered.

### Further details

Nominations may be submitted to officerandbrnominations@facs.org. If you have any questions, contact Betty Sanders, Staff Liaison for the NCBG, at 312-202-5360 or bsanders@facs.org.

For information only, the current members of the Board of Regents who will be considered for reelection are (all MD, FACS) Margaret M. Dunn, James W. Gigantelli, and Michael J. Zinner. ♦
The 2016 Nominating Committee of the Fellows (NCF) will select nominees for the three Officer-Elect positions of the American College of Surgeons (ACS): President-Elect, First Vice-President-Elect, and Second Vice-President-Elect. These positions will be filled at the Annual Business Meeting of the Members at Clinical Congress 2016. The deadline for submitting nominations is February 26, 2016.

**Criteria**
The NCF will use the following criteria when considering potential candidates:

- Nominees must be loyal members of the College who have demonstrated outstanding integrity and medical statesmanship, along with an unquestioned devotion to the highest principles of surgical practice.

- Nominees must have demonstrated leadership qualities that might be reflected by service and active participation on ACS committees or in other components of the College.

- Members of the Nominating Committee recognize the importance of achieving representation of all who practice surgery.

- The College encourages consideration of women and other under-represented minorities.

All nominations must include a letter of recommendation, a current curriculum vitae, and the name of one individual who can serve as a reference. Nominees for President-Elect also should provide a personal statement detailing service to the ACS.

**Further details**
In addition, nominating entities, such as surgical special societies, ACS advisory councils, and ACS chapters, must provide a description of their selection process and a list of all applicants reviewed. Applications submitted without the requested information will not be considered.

Nominations may be submitted to officerandbrnominations@facs.org. Any attempt to contact members of the NCF by a candidate or on behalf of a candidate will be viewed negatively and may result in disqualification. If you have questions, contact Betty Sanders, staff liaison for the NCF at 312-202-5360 or bsanders@facs.org.
Dr. Haile Debas examines future of global surgery in JAMA

In “The Emergence and Future of Global Surgery in the United States,” published in the September 2015 issue of the Journal of the American Medical Association (JAMA), Haile T. Debas, MD, FACS, examines the need for an integrated response in the U.S. to global surgery. U.S. academic institutions and surgical associations, including the American College of Surgeons, should drive the global effort, he says.

Dr. Debas is Maurice Galante Distinguished Professor of Surgery Emeritus, University of California, San Francisco (UCSF), and a gastrointestinal surgeon who chaired the UCSF department of surgery from 1987 to 2003. He also is the founding director of the University of California Global Health Institute and was instrumental in the creation of the Consortium of Universities for Global Health, serving as the founding chair of its board of directors (2009–2012). In addition, Dr. Debas is a volume editor of Essential Surgery, Disease Control Priorities, Third edition, published by the World Bank Group.

Referring to global surgery as an indispensable component of world health, Dr. Debas notes that approximately 18 percent of the total global burden of disease is surgical and that 1.4 million deaths could be averted annually with basic surgical procedures. Renewed efforts for global surgical care should focus on the formation of a consortium for global surgery, with the involvement of stakeholder organizations, students, and residents, he says.

The consortium would develop working groups in governance and organization, education and training, and clinical implementation of trauma and essential surgical services, as well as research in low- and middle-income countries as defined by the World Health Organization.

View the article online at http://archsurg.jamanetwork.com/article.aspx?articleid=2389263.
Dr. Eric Whitacre appointed co-chair of NQF MAP Clinician Workgroup

Eric B. Whitacre, MD, FACS, a breast surgeon in Tucson, AZ, was recently appointed co-chair of the National Quality Forum’s (NQF’s) convened Measure Applications Partnership (MAP) Clinician Workgroup. Dr. Whitacre has served on this panel for more than two years. The workgroup provides input to the U.S. Department of Health and Human Services (HHS) on matters related to the selection and coordination of clinician performance measurement programs and public reporting.

NQF was chosen by HHS to fulfill a statutory requirement to convene multi-stakeholder groups to identify performance measures, public reporting, and other applications, as well as to facilitate alignment of public- and private-sector performance measurement efforts. Learn more about the MAP at www.qualityforum.org/map/.

Surgical Outcomes Club installs officers at October annual meeting

Karl Y. Bilimoria, MD, MS, FACS, director of the Surgical Outcomes and Quality Improvement Center and vice-chair for quality, Northwestern University Feinberg School of Medicine, Chicago, IL, was installed as president of the Surgical Outcomes Club (SOC) at the group’s 11th Annual Meeting and Scientific Session October 4 in Chicago, IL. Dr. Bilimoria has been elected to serve a two-year term.

The SOC was launched at the 2005 American College of Surgeons Clinical Congress by surgeons and scientists pursuing advances in health services and surgical outcomes research. Attendees at this year’s meeting focused on safety improvements and changing surgical culture. Keynote speaker Jane Holl, MD, MPH, director, Center for Health and Medicine, Institute for Public Health and Medicine, Feinberg School of Medicine, spoke on Leveraging the Clinical Enterprise as a Health Care Quality and Safety Research Laboratory.

In addition, the SOC board of directors elected Amir Ghaferi, MD, MS, FACS, assistant professor of surgery; chief, division of Veterans Administration; and director, bariatric surgery, University of Michigan Health Systems, Ann Arbor, to be secretary and president-elect. Also installed at the meeting were the following four board members elected by SOC members: Rachel Kelz, MD, MSCE, FACS, associate program director, general surgery program, department of surgery, Hospital of the University of Pennsylvania, Philadelphia; Angie Smith, MD, MSCR, assistant professor, urology, University of North Carolina School of Medicine at Chapel Hill; Luke Selby, MD, Memorial Sloan Kettering Cancer Center, New York, NY; and Joel S. Weissman, PhD, deputy director and chief scientific officer, Center for Surgery and Public Health, Brigham and Women’s Hospital, Boston, MA.

Meeting presentations are available on the SOC website at www.surgicaloutcomesclub.com/scientific-sessions.

Dr. Bilimoria
Georgia Society of the ACS: [From left] Drs. Mabry, Warshaw, and Senkowski at the annual chapter meeting held in August.

Chapter news

by Donna Tieberg

Michigan Chapter hosts 62nd Annual Meeting in Grand Rapids
The Michigan Chapter of the American College of Surgeons (ACS) hosted its 62nd Annual Meeting and 65th Annual Surgical Resident Competition May 13–15 at the Amway Grand Plaza Hotel, Grand Rapids. Chapter President Kurt A. Kralovich, MD, FACS, led the meeting along with Program Chair Wayne E. Vanderkolk, MD, FACS.

In conjunction with the chapter meeting, the Michigan Committee on Trauma hosted its 65th Annual Keyport Trauma Symposium on May 13. Of special note among the nine different Resident Competition awards presented at the Michigan annual meeting is the Coller Award, named for the late Frederick Coller, MD, FACS, past-chair of surgery at the University of Michigan, Ann Arbor, and the first President of the Michigan Chapter of the ACS. Dr. Coller also was President of the ACS (1949–1950), and the Frederick A. Coller Society was named for him. Dr. Coller was recognized for his surgical skills, dedication to improving general surgery residency training programs in Michigan, and efforts to enhance and expand postgraduate surgical education. This year’s Coller Award was presented to Priya H. Dedhia, MD, PhD, second-year surgery resident at the University of Michigan. The next Michigan Chapter meeting is scheduled for May 18–20, 2016, at Mission Point Resort, Mackinac Island.

Georgia Chapter adds new “Day of Trauma” to annual meeting
The Georgia Society of the ACS hosted its annual meeting August 28–30 at the Grand Hyatt Buckhead in Atlanta. The meeting began with a dinner hosted by Chapter President Christopher K. Senkowski, MD, FACS. In attendance at the dinner were special guests Andrew L. Warshaw, MD, FACS, FRCS(Ed)(Hon), Immediate Past-President of the ACS; Charles D. Mabry, MD, FACS, Chair, ACS Health Policy Advisory Council; and Donna Tieberg,
ACS Chapter Services Manager. During the dinner meeting, the speakers reviewed the chapter’s accomplishments in the last year.

A new component of the annual meeting was a Day of Trauma, which began with meetings for trauma medical directors and managers and continued with the M. Gage Ochsner Resident Paper Competition with presentations by eight different residents.

In addition, Dr. Warshaw gave a presentation titled How the ACS Is Leading Our Profession, in which he described the College’s international growth and referred to the College’s history of setting standards for quality surgical care.

A special bariatric track was offered for the first time at this year’s meeting. Teresa Fraker, Program Administrator, ACS Metabolic and Bariatric Surgery Accreditation Quality Improvement Program, described the program and participated in the panel discussion.

Dr. Mabry offered a lively presentation titled For Whom Do We Work? on the challenges of employment contracts and how ACS benchmarking resources and the Surgeon Specific Registry can assist members.

Concurrent sessions took place during the lunch hour. Attendees could choose to participate in one of the following: a Program Director Panel presentation for students; a Commission on Cancer luncheon featuring former ACS Governor George M. Fuhrman, MD, FACS, of the Atlanta Medical Center, on Interesting Observations in the Management of Ductal Carcinoma in Situ of the Breast; or a political action committee luncheon with State Rep. Katie Dempsey (R), who spoke on the passage of recent health care legislation. Representative Dempsey, who was honored with a plaque for her contributions to the state, asked those present to encourage others to join the surgical profession to fill the local need for surgeons in Georgia.

The meeting ended with a dinner and Surgical Olympics. Surgical Olympics competitors were timed in different skills activities, including robotic surgery.

Social media use a focus at Kansas Chapter meeting
The Kansas Chapter of the ACS hosted its annual meeting at the DoubleTree Hotel, Overland Park. Prior to the meeting, Chapter President Pamela J. Steinle, MD, FACS, hosted an informal dinner meeting attended by Chapter Councilors; Chapter Administrator Denise Lantz; Jay L. Grosfeld, MD, FACS, then First Vice-President of the ACS; ACS Governor Tyler G. Hughes, MD, FACS; and Ms. Tieberg.

Two themes of this year’s Kansas Chapter meeting were disorders of the esophagus and the use of social media. Presenters described the benefits of social media use for surgeons, with Dr. Hughes offering a presentation titled Kansas ACS Communities, and Sean J. Langenfeld, MD, FACS, assistant professor of surgery, University of Nebraska College of Medicine, Omaha, speaking on Social Media for the Surgeon. Dr. Grosfeld provided an update on College activities, and Scott Coates, MD, FACS, presented the ACS Foundation update.

The second half of the day focused on resident/student paper presentations and Surgical Jeopardy. E. Patricia Hill, MD, a fourth-year general surgery resident at the University of Kansas School of Medicine, Wichita, received a $250 award for her winning submission in the resident paper competition,
Arkansas Chapter meets in state capital, plans for future activities

The Arkansas Chapter of the ACS hosted its annual meeting October 17 in Little Rock at the Jackson T. Stephens Spine and Neurosciences Institute, University of Arkansas Medical Center. Approximately 60 chapter members and surgery residents participated in the meeting, along with seven vendors.

Chapter President Patrick A. Dolan III, MD, FACS, welcomed meeting attendees and moderated throughout the day. Included in the day’s activities were Resident Trauma Case and Poster Presentations. Richard H. Turnage, MD, FACS, member of the Arkansas Program Planning Committee, also offered an engaging presentation on Public Reporting of Surgical Outcomes: Codman to Consumer Reports.

Before the annual meeting, chapter members and guests met at the historic Capital Hotel in downtown Little Rock for a reception. At this event, Charles D. Mabry, MD, FACS, Chair of the ACS Health Policy Advisory Council, gave a brief report on College activities, and ACS Governor Lee A. Forestiere, MD, FACS, described the efforts of the College’s Governors’ Chapter Activities Domestic Workgroup. Dr. Forestiere asked attendees to offer suggestions on how to encourage more surgeon participation in the chapter. Ideas shared included the possibility of attending a football game as a chapter meeting social event, adding more family activities, partnering with other organizations, creating a memorial educational society that would provide keynote speakers for the meeting, and encouraging more chapter resident participation by adding a Surgical Jeopardy competition to the annual meeting.

In attendance was Ms. Tieberg, who described the ACS Resident and Associate Society Jeopardy Kit pilot program, adding that the competition creates excitement within local surgical programs participating in the competition and is also enjoyed by the audience.

Metro Philadelphia Chapter offers 7th Mock Oral Boards

The Metropolitan Philadelphia Chapter of the ACS offered the 7th annual Mock Oral Boards examination September 19. The event took place at the Annenberg Center for Medical Education, Lankenau Medical Center, Wynnewood, PA. A total of 57 residents, fellows, and recent medical school graduates were quizzed by 59 surgeon faculty volunteers from nine teaching institutions located across the Philadelphia area. Both examinees and examiners deemed the event successful.

Egypt Chapter hosts annual meeting and Middle East conference

The fourth annual meeting of the Egypt Chapter of the ACS took place April 29–May 1 in Cairo at the Sonesta Hotel in conjunction with the first Region 17 Middle East and Mediterranean Conference of ACS chapters. Representatives of the Lebanon, Jordan, and United Arab Emirates (UAE) Chapters of the ACS attended the regional conference.

In addition, the conference planning committee, which included M. Sherif Omar, MB, BCh, FACS, President of the Egypt Chapter; Mohey E. R. Elbanna, MB, BCh, FACS,
Secretary/Treasurer of the Egypt Chapter; and Alaa Eldin Ismail, MD, FACS, ACS Governor for Egypt, invited surgeons from the African Foundation of Breast Cancer to join the regional meeting where a workshop on breast cancer management was held. Dr. Omar is founder of the African Foundation of Breast Cancer.

Dr. Warshaw attended the meetings in Cairo as a special guest. Drs. Warshaw and Ismail hosted a gathering of Chapter Council members from Lebanon, Jordan, and UAE. Fellows from Sudan who are interested in forming an ACS chapter also attended the meeting. Councilors from Region 17 discussed coordinating local chapters’ efforts and standardizing surgical education and training in the region.

The chapter meeting also signified the first time nurses participated in a surgeons’ conference in Egypt. Nursing staff and students engaged with one another during the meeting, with the participation of an unprecedented number of medical students. The Egypt Chapter reports increased interest in ACS membership among young surgeons in the country and plans to start offering a General Surgery Review Course or additional Fundamentals of Surgery courses.

Chapter Speed Networking in action at Clinical Congress 2015

More than 100 Clinical Congress attendees participated in the Chapter Speed Networking and Reception hosted by the ACS Governors of the Chapter Activities Domestic and International Workgroups at this year’s conference. Attending the event were international and domestic chapter council members, chapter staff/administrators, and Governors of the College. The event featured 15-minute table talks. Each table was moderated by one or two Fellows and young surgeon volunteers or College staff, and the talks centered on different topics of interest to chapters, including engaging young surgeons, the Chapter Annual Meeting Toolkit, the Chapter Partner Program, medical student recruitment, social media/networking for chapters, state/grassroots advocacy, creating a mentoring program, best practices for archiving chapter documents and materials, and an introduction to Operation Giving Back. Both workgroups plan to repeat this successful event next year, introducing additional table topics.
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 covering research and activities from the ACS Clinical Congress 2015, which took place October 4–8 in Chicago, IL. To access the news items in their entirety, visit the online ACS Newsroom at www.facs.org/media/acs-in-the-news.

Risk calculator does not alter surgeons’ choice to operate
Medscape, October 15, 2015
“The surgical risk calculator, developed by the American College of Surgeons National Surgical Quality Improvement Program [ACS NSQIP®], has a ‘high degree of predictive ability,’ according to study investigator Greg Sacks, MD, a surgery resident from the University of California, Los Angeles, and a research fellow at the Robert Wood Johnson Clinical Scholars Program.”

Helmet use reduces odds of head injuries in cyclists by 58%
Yahoo! News, October 12, 2015
“Urban cycling is a growing trend, but not all new cyclists are choosing to wear a helmet on their journeys. A recent American study may help convince the reluctant as it shows that this indispensable accessory can help save lives and prevent head and face injuries…Their study was presented October 8 during the 2015 Clinical Congress of the American College of Surgeons.”

Intermountain saves $2.5 million with blood-tracking initiative
FierceHealthIT, October 8, 2015
“An initiative at Salt Lake City-based Intermountain Healthcare to reduce blood transfusions helped the 22-hospital system cut costs by $2.5 million over two years while significantly reducing hospital-acquired infections and mortality, according to research being presented this week at the 2015 Clinical Congress of the American College of Surgeons.”

Surgeon’s experience tied to success of thyroid removal: Study
US News & World Report, October 8, 2015
“Patients who undergo thyroid removal may be less likely to suffer complications if their surgeon performs many such surgeries each year, a new study says…. The study was scheduled for presentation Wednesday at the annual meeting of the American College of Surgeons in Chicago.”

Colonoscopy findings fade quickly from memory
US News & World Report, October 8, 2015
“The percentage of patients who remembered the date of their last colonoscopy to within one month was 94 percent after two months, 42 percent after one year, 30 percent after two years, and 28 percent after four years, according to the study presented this week at the annual meeting of the American College of Surgeons (ACS) in Chicago.”

Surgery may raise survival with advanced melanoma: Study
US News & World Report, October 8, 2015
“According to the study, nearly one in four patients had surgery to remove the mass from their abdomen. Patients who underwent the surgery lived more than twice as long as those who received drug treatment alone—18 months versus seven months, on average, the researchers reported.

The study was to be presented Thursday at the annual meeting of the American College of Surgeons (ACS) in Chicago.”
Apply by February 1 for 2016 Scholarships for Heller School Executive Leadership Program

The American College of Surgeons (ACS) is offering scholarships to subsidize attendance and participation in the 2016 Executive Leadership Program in Health Policy and Management June 12–18 at the Heller School for Social Policy and Management at Brandeis University, Waltham, MA.

The award of $8,000 will apply to the cost of tuition, travel, housing, and subsistence during the period of the course and the post-course follow-up period. The closing date for receipt of all application materials is February 1, 2016.

The College will fully fund two scholarships reserved for general surgeons. In addition, several surgical specialty societies have partnered with the ACS to cosponsor a scholarship for members in good standing of both the College and their societies to attend this intensive program. Participating societies supporting scholarships are listed in the sidebar.

All applicants will be notified of the outcome of the selection process by March 31, 2016.

Direct questions to the ACS Scholarships Administrator at Kearly@facs.org or 312-202-5281. Requirements for these scholarships are posted on the ACS website at facs.org/member-services/scholarships/health-policy.


SOCIETIES CO-SPONSORING A SCHOLARSHIP WITH THE ACS

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

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**Calendar of events**

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

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**DECEMBER**

*Massachusetts Chapter*

**December 5**

Boston, MA

Contact: Crystal Beatrice, cbeatrice@prri.com, www.mcacs.org

*New Jersey Chapter*

**December 5**

Iselin, NJ

Contact: Andrea Donelan, njsurgeons@aol.com, www.nj-acs.org

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**JANUARY 2016**

*Louisiana Chapter*

**January 15–16**

New Orleans, LA

Contact: Janna Pecquet, janna@laacs.org, www.laacs.org

*Southern California Chapter*

**January 15–17**

Santa Barbara, CA

Contact: James Dowden, jdowden@prodigy.net, www.socalsurgeons.org

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**MARCH**

*Alberta Chapter*

**March 15**

Calgary, AB

Contact: John Barry Kortbeek, john.kortbeek@albertahealthservices.ca

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**FEBRUARY**

*Montana and Wyoming Chapter & Idaho Chapters*

**February 5–7**

Sun Valley, ID

Contact: Cyan R. Sportsman, csportsman@msurgical.com

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*Puerto Rico Chapter*

**February 18–20**

San Juan, PR

Contact: Aixa Velez-Silva, acspuertoricochapter@gmail.com, www.acspuertoricochapter.org

*North Texas Chapter*

**February 19–20**

Dallas, TX

Contact: Carrie Steffen, carrie@steffenmanagement.com, www.ntexas.org

*South Texas Chapter*

**February 25–27**

San Antonio, TX

Contact: Janna Pecquet, janna@southtexasacs.org, www.southtexasacs.org

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*North Dakota Chapter & South Dakota Chapter*

**April 22–23**

Watertown, SD

Contact: Terry Marks, tmarks@sdsm.org

*Indiana Chapter*

**April 22–24**

French Lick, IN

Contact: Carolyn Downing, cdowling@ismanet.org, www.infacs.org

*Northern California Chapter*

**April 29–30**

Berkeley, CA

Contact: Christina McDevitt, nccacs@att.net, www.nccacs.org

*Metropolitan Washington DC Chapter & Virginia Chapter*

**April 30**

Washington, DC

Contact: Norma Smalls, drnormasmalls@gmail.com, www.dcfacs.org, www.virginiaacs.org

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**FUTURE CLINICAL CONGRESSES**

**2016**

October 16–20

Washington, DC

**2017**

October 22–26

San Diego, CA

**2018**

October 21–25

Boston, MA