What’s next?
The future of Medicare physician payment in the post-SGR era
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Women have practiced surgery since the profession’s inception and have played a role in the American College of Surgeons (ACS) since its founding. Nonetheless, women have been and continue to be underrepresented in surgery, and, unfortunately, there are signs that fewer women will be entering the surgical workforce in the coming years as the number of women medical school graduates slowly declines. In 2005, 49.5 percent of medical school graduates were women,* but in 2014, less than 47.5 percent of medical school graduates were women.† Furthermore, only 21.3 percent of all surgeons in the U.S. are women.‡

The reasons women have traditionally chosen to work in health care professions other than surgery are myriad. The personal experiences of women surgeons of all ages, specialties, and backgrounds are presented in a new book, *Being a Woman Surgeon*, edited by Preeti R. John, MB, BS, MPH, FACS, acting director, surgical intensive care unit, Baltimore VA (Veterans Affairs) Medical Center, and clinical assistant professor, University of Maryland Medical Center, Baltimore. In all, 60 women surgeons describe in essays, poems, and interviews how they have dealt with the challenges, joys, frustrations, and rewards of being a woman in surgery. Their stories range from the humorous to the heart-breaking and make for inspiring reading.

**Blazing the trails**

Many women leaders of the ACS have contributed to this book, including Kathryn D. Anderson, MD, FACS, our first woman President; Patricia J. Numann, MD, FACS, the second woman ACS Presi-

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In all, 60 women surgeons describe in essays, poems, and interviews how they have dealt with the challenges, joys, frustrations, and rewards of being a woman in surgery.

dent and the founder of the Association of Women Surgeons; Barbara Lee Bass, MD, FACS, Past-Regent and recipient of the College’s highest honor, the Distinguished Service Award (DSA); and Julie Ann Freischlag, MD, FACS, the first woman to chair the ACS Board of Regents.

Other surgeons who contributed to this compendium also were the first women to assume leadership positions within their institutions. Dr. Freischlag, for example, was the first woman to head the department of surgery at The Johns Hopkins Hospital, Baltimore, and Mary Maniscalco-Theberge, MD, FACS, is the first and only woman to have served as chief of the department of surgery at Walter Reed Army Medical Center, Washington, DC.

Challenges

As the authors note, surgical training and practice are challenging for all of us, but some of these difficulties are compounded by gender. Starting a family, for instance, creates specific obstacles for women in surgery simply because of the fact that they are the child bearers. As a result, women surgeons have had to give more thought to whether and when to have children. Indeed, some authors indicate that they were asked why they should be accepted into a residency program or on staff at a hospital when they would probably leave to have children and thereby deny those opportunities to a man who, it was presumed, would be more likely to continue working regardless of whether he chose to have children.

Several authors opted not to have children. Many of the women who did decide to raise a family continued to operate until moments before their babies were born, both due to their dedication to their patients and in an effort to overcome any misconceptions about their commitment to balancing their professional and personal lives. They tell stories of reaching over their bellies to operate and going directly from the operating room to the labor room.

Once the babies arrive, new challenges emerge. Even since the American Board of Surgery passed rules that residents were required to work only 48 clinical weeks per year—46 in instances involving maternity leave—surgical residency during a child’s infancy can be grueling. On the other hand, it can also make for some rather memorable anecdotes. For example, one author describes using her breast pump when the intercom went off announcing a code blue on the surgical floor.

Many women in the book also recount their encounters with sexism, ranging from the subtle to the blatant. One woman tells of the time a male surgeon refused to shake hands with her at a surgical meeting. Others recall hearing male colleagues make sexist remarks in the hallways or hanging pictures of naked women in the rooms where residents would rest when on call in the hospital. More recent examples are subtler, such as physicians who only refer women patients to women surgeons, exclusion from certain meetings or events, being passed over for promotions, and so on.

Some gender stereotypes, on the hand, actually seem to have worked in favor of these women surgeons. Many of their patients say that women surgeons are better communicators and more empathetic than their male counterparts.
EXECUTIVE DIRECTOR’S REPORT

Mentors and role models
In any event, most of the authors gladly note that the days of overt gender bias in surgery are largely over, and even those surgeons who have faced discrimination or harassment in the workforce prefer to focus on the positive aspects of their careers. In fact, most of the authors point to many men surgeons who were willing to give women an opportunity to train at their institutions and who fostered the professional development of all of their trainees—regardless of gender. Some of the men surgeons cited for their willingness to help women surgeons pursue a surgical career include ACS DSA recipient John R. Davis, MD, FACS, at the University of Vermont, Burlington; Philip Donahue, MD, FACS, at Cook County Hospital, Chicago, IL; Ralph DePalma, MD, FACS, at the VA in Reno, NV; ACS Past-President Claude H. Organ, Jr., MD, FACS, at the University of California-East Bay; ACS Past-President C. Barber Mueller, at State University of New York, Upstate Medical University, Syracuse; Keith D. Lillemoe, MD, FACS, at Johns Hopkins and Massachusetts General Hospital, Boston; and ACS Past-Secretary Courtney Townsend, Jr., at Johns Hopkins.

All of us, men and women alike, would attribute at least some of our success in this demanding profession to these and other surgeons who mentored us—who saw something in us as medical students or residents that indicated we had the potential to provide quality care to surgical patients. One author recalls with great enthusiasm the time when, as a medical student doing her surgical rotation, her mentor, Karen Deveney, MD, FACS, Past-Secretary, ACS Board of Governors, allowed the student to sew in the mesh during an inguinal hernia repair. That, of course, was the moment she got hooked on surgery.

A calling and a passion
Most surgeons, including the women who share their stories in this collection, say that they didn’t choose surgery so much as it chose them. They knew from the first time they witnessed an operation that they wanted to be surgeons. They got a rush from being in the OR, from the intensity of the work, from being able to bring almost immediate relief to critically ill and injured patients. As one author writes, “There is only one requirement to be a truly great surgeon—passion. You have to love it with your heart and soul.”

Anyone who agrees with that statement—male or female—will surely enjoy reading Being a Woman Surgeon, and hopefully, this book will make its way into the hands of medical students and encourage more women to pursue a surgical career. We need them now more than ever. ♦

If you have comments or suggestions about this or other issues, please send them to Dr. Hoyt at lookingforward@facs.org.
What’s next?
The future of Medicare physician payment in the post-SGR era

by Matthew R. Coffron, MA
President Barack Obama signed legislation this spring that fulfilled one of the American College of Surgeons’ (ACS) foremost and longest running legislative goals—reform of the Medicare physician payment system, including permanent repeal of the broken sustainable growth rate (SGR) formula. The SGR, first enacted as part of the 1997 Balanced Budget Act, set unrealistic, aggregate spending targets in the Medicare physician fee schedule. As a result, each year since 2001, the Centers for Medicare & Medicaid Services (CMS) fee schedule mandated payment cuts for surgeons and other physicians.

These projected cuts were largely averted through annual (or sometimes more frequent) legislative patches commonly referred to as temporary “doc fixes.” In all, Congress enacted 17 temporary fixes, ranging in duration from one month to two years, at a cost of approximately $169.5 billion. These last-minute patches stopped the cuts but caused a great deal of uncertainty for physicians because of the fixes’ transitory nature. These short-term patches also made it more difficult to pass permanent, meaningful reforms that would incentivize the provision of high-quality care.

The recently enacted Medicare Access and Children’s Health Insurance Program (CHIP) Reauthorization Act (MACRA), Public Law No. 114-10, is the culmination of a multi-year effort by the physician community, patients, and lawmakers to advocate for meaningful reform and ensure ongoing access to care. The ACS played an especially influential role in garnering lawmakers’ support.

Legislators appreciated the fact that the ACS’ efforts went beyond calling for repeal and included the development of an SGR replacement proposal, known as the Value-Based Update (VBU). As a result, the College was invited to testify before the three key congressional committees with jurisdiction over the Medicare program—the Senate Committee on Finance, the House Committee on Energy and Commerce, and the House Committee on Ways and Means—while Congress developed the proposal in 2012 and 2013. The ACS remained active in negotiations on the finer points of the law throughout the entire legislative process as Congress sought to make meaningful improvements.

The law also includes a two-year extension of CHIP, entitlement reforms, and other provisions, several of which will affect surgeons.

**Physician payment under MACRA**

The new law takes a number of important steps to improve the Medicare physician payment system. The result of a bipartisan political compromise, the legislation was written with the goal of maintaining a balance between restoring stability to Medicare physician payments and realigning incentives to better facilitate physician-driven quality improvement efforts.

Perhaps the most significant change in the new law is the immediate and permanent repeal of the SGR, which had been a major goal of the College and the larger physician community. According to an estimate from the Congressional Budget Office (CBO), the cost of simply repealing the SGR and freezing payment levels for 10 years to put Medicare physician payments back on level ground would have cost $137.4 billion. This new law does not freeze payments, however. Repeal is followed by modest annual updates through 2019 in an effort to provide physicians with a period of stability as a new fee-for-service payment system is implemented. During this time, new payment models also will be proposed and developed by specialty societies and other interested parties. In addition, physicians will become eligible for lump-sum incentive payments and additional updates in the future.

Early versions of the legislation did not include updates and would have been roughly equivalent to a 10-year payment freeze; in 2013, however, the House Committee on Ways and Means modified the bill to
include the payment updates, largely in response to concerns raised by the College. In addition to the positive updates, the new law calls upon the Medicare Payment Advisory Commission (MedPAC) to study the effects of payment levels on the quality and efficiency of care and on Medicare patients’ access to physician services. The study will make recommendations for future payment updates to ensure adequate access to care for Medicare beneficiaries and will be an important tool in advocating for payment increases that keep pace with the growing cost of health care.

**Merit-based Incentive Payment System**
Beginning in 2019, annual physician payment adjustments for fee-for-service Medicare will be provided through a new Merit-based Incentive Payment System (MIPS). In the MIPS, existing CMS quality programs—including the Physician Quality Reporting System (PQRS), the value-based modifier (VBM), and the electronic health record (EHR) meaningful use program—are combined and streamlined to reduce the administrative burden on providers. Rather than requiring physicians to participate or face the penalties associated with each program, individual providers will now receive a score that takes into account their performance in all three programs, in addition to their individual efforts to improve patient care. Payments will be adjusted up or down based on this combined assessment.

Of note, the current potential penalties associated with PQRS, the VBM, and EHR meaningful use will grow to 8 percent of payments by 2018, before they are phased out. Under the new system, the maximum payment reduction will be 4 percent in 2019, increasing until it reaches 9 percent in 2022. In addition, the new system will provide opportunities for significant positive updates, which could, in certain cases, be more than three times the maximum negative update.

Physicians will receive a MIPS composite score of 0–100 that is based on performance in four categories: quality, resource use, meaningful use of EHRs, and clinical practice improvement activities (CPIA). The first three categories are derived from and measured through the existing programs, with enhancements made to improve their value (such as soliciting new quality measures, improving risk adjustment, and implementing a new system of attribution that will allow surgeons to designate their specific role in caring for a patient). The fourth category, CPIA, is designed to give credit to health care professionals who are working to improve their clinical practice or preparing to participate in the alternative payment models (APMs) described later in this article.

A physician’s score will be compared with a performance threshold set annually by the Secretary of the U.S. Department of Health and Human Services and based on either the median or mean score from a previous period. Physicians with scores below the threshold will receive a negative adjustment, and those with scores higher than the benchmark will receive a positive adjustment. Negative adjustments are capped at −4 percent in 2019. Physicians with scores in the bottom quartile below the threshold will receive the maximum penalty. Those with higher scores but still below the benchmark will face progressively smaller negative updates or no payment adjustment if their scores are equal to the threshold. The maximum penalty grows to −5 percent in 2020, −7 percent in 2021, and −9 percent in 2022 and future years. Physicians who attain scores above the threshold will receive positive updates calculated on the same percentages used for downside risk. However, if fewer physicians receive scores above the threshold than below, the positive updates can be increased to as much as three times the negative updates to maintain budget neutrality. For example, if three times as many physicians score below the threshold than score above it in the first year of implementation, the maximum update for the highest composite scores would be +12 percent. Conversely, if more physicians have high scores than low scores, updates will be reduced to ensure budget neutrality.

One significant victory that resulted from the College’s ongoing participation in the development of
In the MIPS, existing CMS quality programs—including the PQRS, the VBM, and the EHR meaningful use program—are combined and streamlined to reduce the administrative burden on providers.

MACRA was inclusion of an additional incentive payment. This provision calls for setting aside additional funding so that even if 100 percent of physicians score above the threshold and, therefore, nobody receives a negative update, the top achievers will still receive recognition through a positive update. A total of $500 million per year is being allocated to this fund and will be distributed to either the top 75 percent of physicians who score above the threshold, or those with scores that fall in the top three quartiles above the threshold. The maximum additional update under this section is 10 percent, but that amount could be lower if large numbers of physicians score above the threshold.

MACRA also provides $100 million over five years to be distributed to quality improvement organizations, regional extension centers, and other entities that provide technical assistance to small and rural practices. Preference for the technical assistance program goes to those practices in health professional shortage areas or to practices with low composite scores. The goal is to help these practices improve performance in MIPS or transition into APMs.

APMs

Although the new law preserves traditional fee-for-service Medicare physician reimbursement, it takes a number of steps, including the provision of payment incentives, to encourage development of and participation in alternative payment models.

The law states that to qualify for incentives and other benefits, physicians must participate in APMs that base payment on quality measures, such as those included in MIPS; use certified EHR technology (although those who meet certain criteria are exempt from meaningful use requirements); and include an element of financial risk with the potential for monetary loss.

Recognizing that APM options are nonexistent in many areas of the country or are unavailable for physicians in certain specialties, the law prioritizes development of new specialty-focused models, models for small practices of 15 or fewer physicians, models developed in conjunction with private payors, statewide payment models, or Medicaid-based options. The goal is to encourage specialty societies and other stakeholders to develop new and innovative payment models. The law’s language is broad enough that it may leave the door open for creation of a model based on the College’s Clinical Affinity Group (CAG) concept from the VBU, in which providers are grouped together based on the patients or conditions they treat, not their specialty designation.

Physicians who receive a high enough proportion of payments (either from Medicare alone or through a combination of Medicare and other payors) through qualified APMs will be exempted from the MIPS program, including EHR meaningful use mandates and many of its reporting requirements. Furthermore, they will receive a 5 percent lump-sum incentive payment to offset the risk and initial cost associated with transitioning to such a system. This incentive will be in effect from 2019 through 2024. Those physicians who strive to meet this participation threshold but fall short may be exempted from the MIPS program; however, they will be ineligible for the 5 percent incentive.

In addition, physicians who participate in an APM at any level and are in the MIPS program will automatically receive at least 50 percent of the total possible score on the CPIA portion of the composite score, allowing them to earn higher updates.

Under the new system, increasing incentives will be available to physicians to encourage movement to APMs over time. Along with the 5 percent incentive and exemption from the MIPS program requirements, starting in 2026, the current conversion factor will be split in two. The fee-for-service conversion factor will grow at a modest rate of 0.25 percent annually, whereas qualified APM participants will be paid for items and services using a separate qualifying APM conversion factor that will increase by 0.75 percent annually. Although both of these growth factors are small (and likely to be reconsidered before 2026), the difference will inevitably lead to an increasing pressure to participate in APMs.
Moving forward

Repealing the SGR was an important victory for the College and all Medicare physicians; however, passage of MACRA was only the first step. For the new quality-focused payment system to work, the College and other physician organizations will need to be active partners in the development of new quality measures, APMs, CPIAs, and so on. The College will continue to work with CMS and, if necessary, Congress to make the current quality programs more practical for surgeons. It is important to remember that these programs and the associated penalties remain in effect through the end of 2018 and will form the core of MIPS.

The College will seek out all opportunities to share its expertise and century of experience in quality improvement with policymakers as MIPS is developed and will actively explore APMs to ensure that relevant models for surgical practice are in place. ACS staff will provide additional guidance to Fellows to ensure that they are ready to perform under the new system.

College scores a victory on global codes

In November 2014, CMS finalized a policy that would have transitioned all 10- and 90-day global codes to 0-day global codes. Independent analysis showed that this would have resulted in a cut in reimbursement to surgeons for most procedures. A coalition of surgical groups led by the ACS advocated strongly for Congress to prevent CMS from moving forward with its plan. The College’s efforts were successful, and instead of eliminating 10- and 90-day codes, CMS will instead collect data on the number and level of visits furnished during the global period and use these data to improve the accuracy of the valuation of surgical services. The September issue of the Bulletin will include an in-depth story on this issue.

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A flow chart graphic on Medicare payment/quality programs is available at www.facs.org/advocacy/quality/medicare-programs.
The American Board of Surgery Maintenance of Certification Program: The first 10 years

by Mark A. Malangoni, MD, FACS, and Christine D. Shiffer, MBA

The American Board of Surgery (ABS) Maintenance of Certification (MOC) Program has now been in place for 10 years. This article looks back at the basis and rationale for establishing the MOC program, explains the current requirements, and discusses possible future directions for the program.

The beginning
Following the release of the Flexner Report on medical education in 1910, medical leaders in the U.S. realized that more needed to be done to ensure qualified physicians were providing care to patients. Board certification officially began in 1916 with the incorporation of the American Board of Ophthalmology, initiating a movement to establish a defined standard for the knowledge and skills of physicians in a discrete area of medicine.

In 1937, the ABS was founded by the leading surgical organizations of the time, including the American Surgical Association and the American College of
In 1937, the ABS was founded by the leading surgical organizations of the time, including the American Surgical Association and the ACS.

Purposes of the ABS

1. To conduct examinations of acceptable candidates who seek certification or maintenance of certification by the board
2. To issue certificates to all candidates meeting the board’s requirements and satisfactorily completing its prescribed examinations
3. To improve and broaden the opportunities for the graduate education and training of surgeons


Surgeons (ACS). The leaders of these organizations realized that surgery had evolved into a full-time specialty and recognized the need to differentiate between formally trained surgeons and physicians in general practice. This concept was developed with the intention of both protecting the public and improving the specialty. The Advisory Board for Medical Specialties was formed in 1933 as the umbrella organization for all certifying boards, becoming the American Board of Medical Specialties (ABMS) in 1970. Today, certification by an ABMS member board is recognized as the standard for allopathic physicians who practice in the U.S.

As set forth in its mission statement, “The American Board of Surgery serves the public and the specialty of surgery by providing leadership in surgical education and practice, by promoting excellence through rigorous evaluation and examination, and by promoting the highest standards for professionalism, lifelong learning, and the continuous certification of surgeons in practice.” The purposes of the ABS are highlighted in the sidebar on this page.

Initial certification

ABS certification is based upon a process of education, evaluation, and assessment. Accredited training, broad operative experience, and high ethical standards have always been core requirements of ABS certification. As specialties in addition to general surgery have been established within the ABS, certification processes have been developed using these requirements as a framework. These specialties include pediatric surgery, vascular surgery, hand surgery, surgical critical care, and complex general surgical oncology. Today, through its board of directors, component boards, and advisory councils, the ABS includes representation from 39 different surgical societies, as well as three members elected at large and one public member. Setting standards for board certification is a privilege of self-regulation that the American public has bestowed on the medical and surgical professions.

Recertification takes hold

In its first three decades, ABS certification, once achieved, was valid for a surgeon’s entire professional career. In the 1970s, however, the ABS Board of Directors recognized that surgical practice was evolving rapidly and determined that it was important for diplomates to demonstrate to the public that they were remaining current with changes in medical knowledge and patient care. The ABS became the
second medical board to require its diplomates to recertify by passing an examination once every 10 years. This change took effect in January 1976. Initially, ABS diplomates were required to take a proctored written examination administered at regional sites. Since 2005, these examinations have been given in a computerized format and are offered at hundreds of testing centers across the country, thus eliminating a potential day of travel and associated expenses for many surgeons. To gain admittance to the recertification exam, diplomates needed to have a full and unrestricted medical license, hospital privileges in surgery, and letters of support from the chief of surgery and chair of credentialing at the institutions where they practice.

In further recognition of the need to remain current in practice, in 2000 the ABS adopted a requirement for diplomates to demonstrate that they had completed 100 credit hours (60 Category I and 40 Category II) of continuing medical education (CME) in the two years prior to applying to take the recertification exam. Although this requirement has been modified during the last 15 years, the basic principle for its implementation remains relevant.

Advent of MOC
In 2005, the ABMS introduced standards for MOC, which were the end result of a multi-year planning process based on the six competencies developed jointly by the Accreditation Council for Graduate Medical Education and the ABMS. These competencies were consolidated to form the four parts of MOC: (1) professional standing, (2) lifelong learning and self-assessment, (3) cognitive expertise, and (4) evaluation of performance in practice.

At that time, many ABMS boards did not have any requirement for recertification or were in the very early stages of development. With the establishment of MOC, ABMS member boards acknowledged that board certification needed to become a more continuous process. Ongoing training and professional development were seen as key in addressing the gap between the rapid pace of advances in medicine and the more than 15 years on average it took for these important advances in care to be incorporated into practice.

The ABMS MOC effort was initially led by former ACS Regent and Past-Interim Director of the College, David L. Nahrwold, MD, FACS, a general surgeon and ABS diplomate. Dr. Nahrwold recognized that for board certification to remain relevant and for medicine to continue to enjoy the privilege of self-regulation, the certification process had to evolve beyond initial certification, or even once-in-10-years recertification. Boards and their diplomates had to demonstrate to the public and their colleagues an enduring commitment to maintaining the standards of the profession, participating in lifelong education, possessing medical knowledge relevant to their specialty, and improving practice performance.

All surgeons who certified or recertified after July 2005 became enrolled in the ABS MOC Program. At present, 95 percent of ABS diplomates with time-limited certificates are enrolled in ABS MOC. Once enrolled, MOC applies to all certificates a surgeon may hold.

Current requirements
While the ABMS established general standards for MOC that all ABMS member boards must meet, each board is responsible for developing its own MOC requirements within the ABMS framework. The current requirements of the ABS MOC Program are outlined in the table on page 18. In crafting these requirements, the ABS Board of Directors has sought to provide enough flexibility that surgeons can meet them in a way best suited to their individual practice environment.

The ABS MOC Program requirements are organized in identical three-year reporting cycles, running from January 1 to December 31. Toward the end of each three-year cycle, diplomates are required to submit information through the ABS website, www.absurgery.org, regarding how they are meeting MOC requirements. This information must be submitted by March 1 (two months after the end of the cycle). Diplomates also must pass a secure MOC
ABS MOC REQUIREMENTS

Every three years, ABS diplomates submit information on:

<table>
<thead>
<tr>
<th>Category</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional standing</td>
<td>Full and unrestricted medical license; hospital or surgical center privileges; contact information for chief of surgery and chair of credentialing where most work is performed.</td>
</tr>
<tr>
<td>CME activity</td>
<td>90 hours of Category I CME relevant to your practice over a three-year cycle, with at least 60 of the 90 credit hours including self-assessment (written or electronic question-and-answer exercise). A score of 75% or higher must be achieved on the self-assessment activity; however, no minimum number of questions is required and repeated attempts are allowed. In addition, the ABS will waive 60 hours of CME with self-assessment for passing a certifying or MOC exam given by the ABS or another ABMS board.</td>
</tr>
<tr>
<td>Practice assessment</td>
<td>Participation in a local, regional, or national outcomes registry or quality assessment program. Surgeons are asked to describe how they are meeting this requirement; no data is collected.</td>
</tr>
</tbody>
</table>

Every 10 years, diplomates must successfully complete:

<table>
<thead>
<tr>
<th>Category</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>MOC examination in the specialty</td>
<td>Surgeons are eligible to apply for an MOC exam starting three years before their certificate’s expiration. A full exam application is required, including a 12-month operative log (case numbers only), reference forms, and CME documentation. Diplomates must be in compliance with MOC to apply. For surgeons who hold multiple ABS certificates, this requirement is the only one that must be met for each certificate. Once the exam is passed, the surgeon receives a new certificate with an expiration date 10 years from the previous certificate’s expiration.</td>
</tr>
</tbody>
</table>

Relevance of ABS MOC

Surgeons practice in a variety of settings, each with its own characteristics. The ABS MOC Program is designed to be practice-relevant, allowing each surgeon to satisfy the requirements by completing CME and participating in a practice assessment activity in a way that best applies to his or her unique situation. Specific CME activities required by state medical licensing boards are considered practice-related and also may be used toward the CME requirement.

If a surgeon’s hospital participates in the ACS National Surgical Quality Improvement Program, Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program, Trauma Quality Improvement Program, or other registries that track patient outcomes, this activity will satisfy the practice assessment requirement. Participation in a state surgical collaborative, such as the Surgical Clinical Outcomes Assessment Program in Washington State or the Michigan Surgical Quality Collaborative, also meets this requirement. The ACS Surgeon Specific Registry is another option for fulfilling this mandate.

Other surgeons may comply with the practice assessment requirement through their institution by enrolling in the Multi-Specialty Portfolio Approval Program sponsored by the ABMS or by participating in a local hospital-based quality improvement activity. In addition, some diplomates have developed performance assessment activities within their own practices by focusing on a specific area of practice, defining measures and goals, tracking outcomes, making changes, and then reassessing to gauge improvement. Regardless of which pathway is chosen, the diplomate must only attest to his exam every 10 years; however, the exam may be taken up to three years before certificate expiration.
or her participation. The board does not collect, review, or otherwise scrutinize an individual’s specific results.

The ABS recognizes that practice improvement is a multifaceted process. Simply showing up for a CME course or entering cases into a registry is unlikely to improve care on its own. Rather, surgeons should use self-assessment opportunities to demonstrate that new knowledge or skills have been acquired, and practice assessment activities to view and analyze their individual results. More importantly, these results should be used to develop an action plan for improvement. There is good evidence that active participation in a national or state registry can improve quality of care, often through the identification of best practices.¹,⁴

**Future of ABS MOC**

ABS MOC is a surgeon-defined national standard that formally documents many of the activities surgeons already do to stay current in their field. Participating in the ABS MOC Program demonstrates a surgeon’s commitment to remain up to date in his or her specialty and to strive for improved outcomes and patient care.

Just like changes in medical practice, MOC will evolve over time to reflect new standards and best practices. The measurement tools available will undoubtedly improve in the coming years. The ABS Board of Directors is focused on making ABS MOC a more useful and meaningful process for surgeons without adding to the administrative burden surgeons already face.

ABS leaders are looking at innovative programs under development at other ABMS boards and organizations involved in quality improvement. However, we know that any requirements we establish will affect approximately 30,000 surgeons across the U.S. who practice in a wide range of practice environments. We are listening to feedback from our diplomates and affiliated societies and will take it into account as we continue to develop ABS MOC, while at the same time staying mindful of our duty to the public and our privilege of self-regulation.

Participation in ABS MOC demonstrates to both patients and peers that you are making a dedicated effort to improve the care you provide. As we move into the next decade of MOC, the ABS appreciates your involvement and welcomes your input. Suggestions, comments, and questions may be sent to moc@absurgery.org. ♦

**REFERENCES**

The Hartford Consensus III: Implementation of Bleeding Control

by Lenworth M. Jacobs, Jr., MD, MPH, FACS,
and the Joint Committee to Create a National Policy to Enhance Survivability from Intentional Mass-Casualty and Active Shooter Events
Editor’s note: The Joint Committee to Create a National Policy to Enhance Survivability from Intentional Mass-Casualty and Active Shooter Events developed the following call to action at its April 14 meeting in Hartford, CT. This committee meeting, chaired by American College of Surgeons (ACS) Regent Lenworth M. Jacobs, Jr., MD, MPH, FACS, focused on implementation of strategies for effective hemorrhage control. The deliberations of the group yielded the Hartford Consensus III document. This report was presented at a White House roundtable forum on April 29, which included representatives from 35 medical and surgical, nursing, law enforcement, fire, emergency medical services (EMS), and other stakeholder organizations (see pages 22 and 24 for lists of participating organizations and agencies). The participants unanimously endorsed the principles set forth in the Hartford Consensus III. The following is the Hartford Consensus III, edited to conform with Bulletin style.

Our nation’s threat from intentional mass-casualty events remains elevated. Enhancing public resilience to all such potential hazards has been identified as a priority for domestic preparedness. Recent events have shown that, despite the lessons learned from more than 6,800 U.S. combat fatalities over the last 13 years, opportunities exist to improve the control of external hemorrhage in the civilian sector.* These opportunities exist in the form of interventions that should be performed by bystanders known as immediate responders and professional first responders, such as law enforcement officers, emergency medical technicians (EMTs), paramedics, and firefighters (EMS/fire/rescue), at the scene of the incident.

The Joint Committee to Create a National Policy to Enhance Survivability from Intentional Mass-Casualty and Active Shooter Events was founded by the ACS. The committee met twice in 2013, making specific recommendations and issuing a call to action. The deliberations of the committee have become known as the Hartford Consensus. A third meeting was convened on April 14. This Hartford Consensus III meeting focused on implementation strategies for effective hemorrhage control.

The overarching principle of the Hartford Consensus is that in intentional mass-casualty and active shooter events, no one should die from uncontrolled bleeding. An acronym to summarize the necessary response is THREAT:

- Threat suppression
- Hemorrhage control
- Rapid Extrication to safety
- Assessment by medical providers
- Transport to definitive care

The Hartford Consensus calls for a seamless, integrated response system that includes the public, law enforcement, EMS/fire/rescue, and definitive care to employ the THREAT response in a comprehensive and expeditious manner.

Three levels of responders

There are different levels of responders in an intentional mass-casualty or active shooter event:

- Immediate responders: The individuals who are present at the scene who can immediately control bleeding with their hands and equipment that may be available
- Professional first responders: Prehospital responders at the scene who have the appropriate equipment and training
- Trauma professionals: Health care professionals in hospitals with all of the necessary equipment and skill to provide definitive care

Immediate responders

One goal of the Hartford Consensus III is to empower the public to provide emergency care. During intentional mass-casualty events, those present at the point

THE HARTFORD CONSENSUS III: IMPLEMENTATION OF BLEEDING CONTROL

JOINT COMMITTEE TO CREATE A NATIONAL POLICY TO ENHANCE SURVIVABILITY FROM INTENTIONAL MASS-CASUALTY AND ACTIVE SHOOTER EVENTS

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of wounding have often proven invaluable in responding to the initial hemorrhage control needs of the wounded. Traditionally thought of as “bystanders,” these immediate responders should not be considered passive observers and can provide effective lifesaving first-line treatment.

Immediate responders contribute to a victim’s survival by performing critical external hemorrhage control at the point of wounding and prior to the arrival of traditional first responders. Immediate responders contribute to what is the critical step in eliminating preventable prehospital death: the control of external hemorrhage.

The Hartford Consensus III recognizes the vital role that immediate responders play in responding to mass-casualty events. They make major contributions to improving survival from these incidents. However, the Hartford Consensus III does not advocate that members of the public enter areas of direct threat or imminent danger.

Good Samaritan laws have been effective in empowering the public to become involved in the immediate response to a victim of cardiac arrest or choking by the initiation of cardiopulmonary resuscitation and the Heimlich maneuver, respectively. The Hartford Consensus recommends that these legal protections be extended to include the provision of bleeding control.

Professional first responders
Professional first responders include law enforcement and EMS/fire/rescue. As indicated by THREAT, law enforcement must suppress the source of wounding if the shooter is still active and then, because they are usually the initial first responders on the scene, must act to control external hemorrhage. Victims with life-threatening external bleeding must be treated immediately at the point of wounding. All responders should be educated and have the necessary equipment to provide effective external hemorrhage control. Continued emphasis must be on the integration of the immediate responders, law enforcement, and EMS/fire/rescue to optimize rapid patient assessment, treatment, and transport to definitive care at the nearest appropriate hospital.

Building educational capabilities
Education in hemorrhage control can take many forms and should be offered using various modalities. Established education programs for individuals, communities, and professional responders can be modified to include effective external hemorrhage control techniques. The Bleeding Control for the Injured (B-Con) course offered by the National Association of Emergency Medical Technicians is an example of a newly created program that is appropriate for training individuals who have little or no medical background. Other methods such as public service announcements, slogans, advertising, and entertainment media should be used to convey the message that bleeding control is a responsibility of the public and is within their capabilities.

The public needs to be empowered to engage in lifesaving actions. This training should be included as part of preparing for situations involving other
potential hazards, including everyday events that may produce trauma and hemorrhage. For professional first responders, more advanced courses may offer additional options to control life-threatening external hemorrhage. All formal training should have specific objectives and train to competency. For professional responders, the training must be efficient and cost-effective. Ultimately, integrated training exercises must be conducted that include all levels of responders.

Specific educational content for immediate responders should include:

- Actions to ensure personal safety
- Appropriate interactions with law enforcement, EMS/fire/rescue, and medical personnel
- How to identify bleeding as a threat to life
- Use of hands to apply direct pressure
- Proper use of safe and effective hemostatic dressings
- Proper use of effective tourniquets

For professional first responders, educational content should include:

- Actions to ensure personal safety
- Coordination and integration of all responders
- Communication among all responders
- Appropriate interactions with immediate responders
- Application of THREAT principles
- Proper use of direct pressure
- Proper use of safe and effective hemostatic dressings
- Proper use of effective tourniquets

Use of improvised tourniquets as a last resort

It is appropriate to use existing national organizations to widely disseminate the principles embodied in these education initiatives.
Building equipment capabilities
Immediate responders need to recognize that applying pressure to a bleeding vessel is the appropriate first action to take and that their hands are a first-line resource. In most cases, control of external hemorrhage can be accomplished by applying direct pressure on the bleeding vessel.

Hemostatic dressings and tourniquets may be needed to effectively stop bleeding. For this reason, the Hartford Consensus recommends that all police officers and any concerned citizens carry a hemostatic dressing, a tourniquet, and gloves. This guideline should also apply to all EMS/fire/rescue personnel. Ground and air medical transport vehicles should carry multiple dressings and tourniquets based upon local need. In addition, bleeding control bags should be accessible in public places as determined by a local needs assessment. Potential sites for bleeding control bags include shopping malls, museums, hospitals, schools, theaters, sports venues, transportation centers (such as airports, bus depots, and train stations), and facilities with limited or delayed access. All hemostatic dressings and tourniquets must be clinically effective as documented by valid scientific data. The Tactical Combat Casualty Care guidelines for the U.S. military contain objective evidence to support the safety and efficacy of the various options for tourniquets and hemostatic dressings.

Contents of the bleeding control bags should include the following:

- Pressure bandages
- Safe and effective hemostatic dressings
- Effective tourniquets
- Personal protective gloves

Placement of bleeding control bags should be as follows:

- Next to all automatic external defibrillators based on local need
- Immediately recognizable visually or via a Web application
- Secure but accessible locations
- Able to be used within three minutes

Building resources for bleeding control programs
Procurement of equipment and training for bleeding control requires action at the federal, state, and local levels, as well as in the private sector. Tourniquet and hemostatic dressing procurement should reflect either the evidence and experience that the U.S. military has gained in the last 13 years of war or scientific evidence that becomes available. Federal agencies should make elimination of preventable death from hemorrhage a priority issue that will influence funding. At the
state and local levels, government should interact with the private sector to identify potential risks at public venues and workplaces. It is also important to note that municipalities can engage in fundraising activities at the local level to procure equipment. Professional organizations should set standards that encourage education, equipment, and training for immediate responders, which should be offered as a measure of public safety. Volunteers can be a resource to provide the training.

Considerations for the development and sustainability of bleeding control programs include the following:

• Using clear and concise messaging that bleeding control is an issue for public and private sectors

• Engaging the private sector, including businesses and trade associations

• Appealing to philanthropic organizations

• Applying for grant funding from government and private agencies

• Involving professional, community, social, and faith-based organizations

Conclusion
The most significant preventable cause of death in the prehospital environment is external hemorrhage. As demonstrated by guidelines enacted by the military, widespread bleeding control is critical to saving lives. Our nation has a history of learning hard lessons from wartime experiences; the case for hemorrhage control is no different. The Hartford Consensus directs that all responders have the education and necessary equipment for hemorrhage control and strongly endorses civilian bystanders to act as immediate responders. Immediate responders represent a foundational element of the ability of the U.S. to respond to these events and are a critical component of our ability to build national resilience. Immediate responders must be empowered to act, to intervene, and to assist.

We are a nation of people who respond to others in need. It is no longer sufficient to “see something, say something.” Immediate responders must now “see something, do something.”

Author’s note
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Profiles in surgical research:

Dorry L. Segev, MD, PhD, FACS

by Juliet E. Emamaullee, MD, PhD, and Gail E. Besner, MD, FACS

The third interviewee in this series is Dorry L. Segev, MD, PhD, FACS, a transplant surgeon at Johns Hopkins University. Dr. Segev is an internationally recognized expert in the area of organ allocation and has been instrumental in driving transplant policy at the local, regional, and national levels.

Dr. Segev is associate vice-chair for research and director, Epidemiology Research Group in Organ Transplantation, and associate professor of surgery and epidemiology, Johns Hopkins University, Baltimore, MD. He completed his undergraduate degree at Rice University, Houston, TX, and his medical degree at Johns Hopkins. He stayed at Johns Hopkins for both his general surgery residency and abdominal organ transplant fellowship. He has been on faculty at Johns Hopkins since 2006 and pursued a master of health science in biostatistics and a PhD in clinical investigation as a junior faculty member at that institution. He has published more than 250 papers in leading journals, including the \textit{Journal of the American Medical Association (JAMA)}, \textit{New England Journal of Medicine (NEJM)}, and \textit{The Lancet}. He has received many prestigious awards, including the Jacobson Promising Investigator Award (JPIA) in 2009.

Dr. Segev was interviewed in April 2015 by Juliet Emamaullee, MD, PhD, a transplant surgery fellow at the University of Alberta, Edmonton, and the Resident and Associate Society of the American College of Surgeons representative to the Surgical Research Committee.
During my fellowship, it occurred to me that I could use all of this quantitative analytical training that I had received as a computer scientist and apply it to the clinical and policy questions we had in transplantation.

Did you always know that you wanted to be a physician?

In high school, I was doing freelance computer programming, and I was writing software programs, including medical office software. However, I did not have much of a connection with the field of medicine. I went to Rice University, where I studied computer science, electrical engineering, and music. I am actually the first person in my family to have completed my undergraduate studies in the U.S. I was born in Israel, and we moved to the U.S. when I was young, when my parents were doing their graduate studies. I am the first physician in my family.

I enrolled at Rice with the intention of being a computer programmer. My focus was software development, algorithms, and artificial intelligence. Computer science is kind of a lonely endeavor. You spend all of your time sitting in front of a computer, struggling with the computer, not really interacting with others. It was studying music that helped me find that human connection, and it connected me to the Rice student volunteer program. I created a program where we went to the children’s center to present music I was writing to hospitalized children. I enjoyed the relationship between the medical providers and their patients. Having a direct impact on a patient’s life was a very strong draw for me. When the time came to decide what I wanted to do after graduation, I decided to apply to medical school. Fortunately, Hopkins seemed to like “weirdos” like me with unusual backgrounds.

When did you decide on surgery as a specialty?

For me, everything about medical school was new and challenging and interesting. I realized early on that I wanted to become a surgeon because it seemed like the most intense, definitive form of disease management, and it was very hands-on. I had spent hours typing on a computer, and I spent most of my childhood playing the piano, so working with my hands was very natural, and surgical technique came very naturally to me.

How were you introduced to research?

My interest in research started in the basic science lab of Martha A. Zeiger, MD, FACS, an endocrine surgeon at Hopkins who, at the time, was studying microsatellite polymerase chain reaction techniques to improve diagnosis of thyroid tumors. [Dr. Zeiger is professor of surgery, oncology, cellular and molecular medicine; associate vice-chair of surgery development; and associate dean for postdoctoral affairs at Johns Hopkins University School of Medicine.] The thought that we could have a direct impact on patient care through science was very appealing. Through this experience, I started to engage in the duality of coming into work and immediately being able to affect somebody’s life, but then also spending time doing research that could have an effect on patient care, clinical decision making, and policy. The thought that I could combine clinical practice and research as components of the same job was very exciting.

Part of the surgical residency at Hopkins involved spending some time in the lab, so I went up to Massachusetts General Hospital, Boston, and spent three years in the lab of Patricia K. Donahoe, MD, FACS. [Dr. Donahoe is director, pediatric surgery research laboratories, and chief emerita, pediatric surgery service, Massachusetts General Hospital; and Marshall K. Bartles Professor of Surgery, Harvard Medical School, Boston.] At that time, I wanted to be a pediatric surgeon, since I had been so inspired by the children I previously saw as a volunteer. Dr. Donahoe had a very strong, celebrated basic science lab, and I learned in those three years how to ask scientific questions, how to apply for grants, and how to connect the science we were doing to clinical care.

During my fellowship, it occurred to me that I could use all of this quantitative analytical training that I had received as a computer scientist and apply it to the clinical and policy questions we had in transplantation. From there, my interest and passion for outcomes research grew.
It sounds like Dr. Donahoe was an amazing mentor. What impact has mentorship had on your career thus far?

I had several really strong role models for clinician-scientists, including Dr. Zeiger as a medical student, Dr. Donahoe as a resident, and Robert A. Montgomery, MD, PhD, FACS, our division chief, as a fellow. [Dr. Montgomery is the Margery K. and Thomas Pozefsky Endowed Professor in Kidney Transplantation; chief, division of transplantation; and director, comprehensive transplant center, Johns Hopkins Hospital; and professor of surgery, Johns Hopkins University.]

Dr. Zeiger introduced me to science that can impact care, Dr. Donahoe taught me how to think scientifically, and Dr. Montgomery helped me put together the entire picture. He helped me see that I could use the skills I developed as a computer scientist and apply them to important clinical questions. He encouraged me to pursue further formal graduate training in order to really bring something new to our division and our field. We talked about a career for me that would bring a new way of looking at large data sets and mathematical modeling that could connect these ideas into policy and the patient care decisions we make every day. Ultimately, I completed my research training as a faculty member on a National Institutes of Health (NIH) K award. I obtained a master’s degree in biostatistics, which was a very technically demanding pursuit that required a strong background in mathematics, and a PhD in clinical investigation, which taught me epidemiology, study design, and how to work with big data. I also learned how this kind of research can affect policy.

Did anyone think you were crazy to pursue all that additional training, given the time and energy involved?

Absolutely—[and] maybe they still do. Honestly, Dr. Montgomery and my wife were the only ones who didn’t think I was crazy to do it. For everyone else, it was out of the ordinary. First of all, the paradigm was that surgeons who do research do basic science research and have a lab that, if you are lucky, is funded by the NIH. You work on understanding the biology underlying disease processes that you operate on. That was the Holy Grail of surgical research. When I was a resident, outcomes research was something you did in Excel, on your laptop, in the middle of the night while you were waiting for a case. It wasn’t something that people pursued seriously. I don’t think that people in our field were even aware of the power that we have in unleashing these big data or the potential role in driving important policy and clinical paradigms.

To conduct true quality outcomes research, is it necessary to collaborate with someone like you who has a strong mathematical and statistical background? That’s obviously a big asset.

I see a surgeon’s involvement in clinical research manifesting in one of two possibilities. You can “play in the orchestra,” which means you are a collaborative member. You have an important question from the trenches, you are smart enough to understand what is happening in the analytical approach, you have access to the patients, and you collaborate and synergize with people that have the skills to do the research part. But, if you are going to be a “soloist” and really drive the field, then I think you need formal training. Imagine a surgeon who knows the field, knows clinical practice, and also knows the nuances of the analytical tools that are available to us. When you make decisions about study design, you are making them based on a strong knowledge of what’s important and what’s not important. When you interpret variables from a cohort study, registry, or other big data, you understand the clinical nuances of those variables, and you are aware of the different scientific questions involved. You can ask questions that other people might have thought were impossible to answer, or never even thought to ask, because you are aware of these tools and how to use them, as well as their respective strengths and limitations.
A lot of clinicians are skeptical of outcomes research because some of what has been published is of lesser quality.

Certainly a lot of lower-quality outcomes research has been published, but the bar is being raised. When you think about studies that have affected national policy and clinical practice, they are published in high-impact journals that are read by physicians in other fields, payors, and policymakers. That research has to be very high quality.

You have been doing research as an independent investigator for nearly a decade. Have you experienced any major obstacles or setbacks along the way?

Every day there is a setback or challenging moment. Trying to balance the life of a surgeon, family member, researcher, teacher, and director of a large group is a daily challenge. The current funding environment is incredibly tough, to the point where you need to be writing 10 to 20 grants a year just to keep a research group above water. So, I spend a great deal of my time writing grants. This process can be interesting but at times incredibly frustrating. One of the most innovative things I helped develop to increase live donor kidney transplantation in this country—kidney exchange—has been developed essentially without NIH funding.

In fact, let’s take it further than that. My colleagues and I laugh at the irony that almost every JAMA, NEJM, and Lancet paper we have ever written has been unfunded, which means the most exciting, innovating, and highest-impact work that I have done has not been fundable, and yet, these are the studies that are changing our field. The projects that are fundable are focused on incremental advances and somewhat “safe,” but the ideas that will shake up our field are not incremental advances. They are aimed at huge paradigm shifts that are nearly impossible to fund, not just because of the priorities of federal funding agencies, but because of the funding timeline of at least two years between writing a grant and getting the money to do the work. Also, it is very disheartening that the current hospital environment judges surgeons based on RVUs [relative value units] and the revenue we generate for the hospital, rather than the quality of the research or our generalizable impact. It is frustrating to see my mentees struggle to find protected time to be successful in their own research endeavors. I would say that every day is a challenge.

With the funding environment the way it is today, are funding agencies being pressured to avoid risks because they have so little money to give? This puts pressure on the investigator to strategically ask for funds. It is such a chess game at some level. Would you agree?

I think that even historically fundable research has always been that which proposes incremental advances. We often say that by the time the grant is funded, you have already completed half the work. If I think of a really exciting idea, and I start designing and doing the study and writing the paper, the paper will likely be published in a
high-impact journal long before the grant has even made it through peer review.

**During my research training, we were fortunate to have private donor money that we would target toward our most innovative projects. Have you experienced anything similar given the overwhelming success of your program?**

I am lucky to have been continuously NIH funded since day one. I personally have three R01 grants that fund my research and a mid-career mentoring grant, which pays a good part of my salary to mentor junior faculty and residents. Certainly philanthropy plays a big role in seeding innovative projects or bridging gaps in funding, but that has not been a major source of funding for me. We have also been fortunate to have funding from the National Kidney Foundation, American Geriatrics Society, American Society of Nephrology, Doris Duke Charitable Foundation, and the American Society of Transplant Surgeons. Sometimes society grants help fund projects that may not be well-suited for federal funding.

**How has the JPIA helped you resolve these issues?**

For me, this award came right at that tipping point, exactly that point in my career where I had already received some early career development awards, demonstrating that there was promise in the research we were doing and the ideas that I had. However, I had not received a big award yet and was at a point where I was struggling to prove to my institution and my colleagues that the work I was doing had potential. As a result of this award, I was able to convince my institution to keep supporting my time and effort to “shoot for the stars.” I believe that it was a direct result of the JPIA that I was able to do what I needed to do, publish some *JAMA/NEMJ* papers early in my career, and get the NIH funding that I currently have.

**The paired donor exchange program was a monumental breakthrough. What do you consider your biggest accomplishment?**

I think my greatest accomplishment has been building the Epidemiology Research Group in Organ Transplantation, which I founded and currently direct. This is a group of unbelievably talented surgeons, physicians, epidemiologists, statisticians, mathematicians, and computer scientists who have dedicated themselves to helping us answer questions in organ transplantation. It has created an environment where we are asking important, potentially high-impact questions on a daily basis.

When I started on the faculty in 2006, this arrangement did not exist at Johns Hopkins or really anywhere else [to my knowledge]. I wanted to not only be answering these questions myself, I wanted a team of people where ideas were flowing freely, and we all held each other to a very high standard of study design and analytical robustness, poised to answer important questions as they came about.

Through this research group, we have been able to pass legislation aimed at improving health care research. We wrote and helped pass the Human Immunodeficiency Virus (HIV) Organ Policy Equity Act, which opens the door for HIV-positive kidneys to be transplanted, and we wrote and helped pass the Charlie W. Norwood Living Organ Donation Act, which made national paired donor kidney exchange possible. We demonstrated and quantified the comparative effectiveness of a protocol by which incompatible patients can undergo transplantation through desensitization, supporting its widespread use, coverage by insurance providers, and acceptance by regulatory agencies. We have also informed and studied various policies in organ allocation in this country. We use what we know from being actively involved in the field of organ transplantation as care providers and surgeons to identify the questions that seem most relevant to...
our field and our patients and to address these issues using the most appropriate methodology. And we train the next generation of surgeons, physicians, epidemiologists, statisticians, mathematicians, and computer scientists along the way, which is probably the most rewarding part of it all.

It is fortuitous that you are geographically so close to Washington, given the amount of policy work you do.

Yes, it is our proximity to Washington, DC, that got me interested in policy to begin with. As a junior faculty member, I did what is called a “nonresidential policy fellowship,” in which I spent time on Capitol Hill and learned how bills are written and how policy develops in real time. This experience helped me through several congressional policy efforts that we have taken on. We also do a lot of work with the Organ Procurement and Transplantation Network; the field of transplantation is mostly overseen outside of congressional law, so there are a lot of opportunities for people from the transplant community to influence organ allocation and policy decisions in the [U.S].

How have you applied the excellent mentorship you have received to your role as a mentor to other surgical investigators?

I would not be where I am today were it not for the influential and key people that I encountered in medical school, residency, and fellowship. I ended up with a career that somehow evolved to be perfectly suited to my unusual background and clinical interests. It is very different from the vision I had for my future when I was in medical school. These mentors helped me put the pieces together and link my various interests in a way that would help me unite my clinical interests with what I could do to advance the field.

Mentors have a much broader scope of vision than [young physicians] do when we are just entering the field. What I now find most interesting, fun, and gratifying is being able to corrupt (I think some people call it “mentor”) young people in our field. I like to show them why I find transplantation to be so exciting, foster their excitement of learning and moving the field forward, and introduce surgeons to robust epidemiology and statistical methods, as well as introduce statisticians to the field of transplantation.

In my training so far, the best mentors always seem to have an infectious enthusiasm and are truly altruistic—they just want you to be successful without any personal benefit. Have you experienced that?

Definitely, and from both sides, as mentee and mentor. The successes of which I am most proud today involve the accomplishments of my mentees. When I apply for a grant, it gets funded or doesn’t get funded. Of course, I need to get funded so my research group can stay alive, but there is not nearly the same level of excitement that I get when my mentees receive their first career development award, publish their first JAMA paper, or have their first really inspiring success.

What do you think are the greatest challenges facing surgeon-scientists starting their careers now?

For surgeon-scientists endeavoring to develop a serious clinical research career, I think the biggest challenge is finding protected time, resources, and the opportunity for dedicated, focused, formal training. This paradigm has never really existed for clinical research. You finish
your residency and fellowship, you get hired to operate, and you take on a big caseload. Years go by, and you lack the opportunity to truly obtain research training. I believe that clinicians need formal training to have the mental tools necessary to perform quality research and subsequently be noticed by their institutions, funding agencies, and everyone else. With formal training, the red carpet seems to be rolled out. Without formal research training, they lack the so-called validity factor, and without that, it can be very hard to get your foot in the door.

What advice would you give trainees who are interested in this career path?

My advice is to find a good mentor, find a supportive environment where there is an opportunity to really focus on research without worrying about generating thousands of RVUs, and to seek formal training at every potential opportunity.

As part of the surgical community, what can we do to facilitate the growth of research?

We need to establish environments where researchers are respected, protected, and nurtured, rather than driven further and further into the culture of generating RVUs.

Have you struggled to find balance between your clinical duties, research activities, and personal life?

One of my greatest challenges has been cutting back on my clinical efforts. As surgeons, we love to operate, we love challenging cases; as transplant surgeons, we love operating in the middle of the night. Forcing myself to reduce the time devoted to clinical care to pursue the formal training that I needed and to increase the protected time that I needed to develop into a scientist was difficult. Now that it has all come together nicely, I feel like I have the balance for me. Today, my career is ideally suited to my passions. I still spend time training residents and fellows in the operating room and providing care to my patients, but I also have enough time and support to accomplish quality research goals.

You have so many responsibilities, and yet you have a number of hobbies. How do you find time to do it all?

My wife and I met at the American Lindy Hop Championships as competitors and, subsequently, performed as winners together. We then founded a dance studio in Baltimore. We still teach dance in Baltimore and around the world and greatly enjoy pursuing the “rennaissance” interests that we have together. Incidentally, we also collaborate academically, but that’s a story for another day.

We have frequent music parties at our house that we call “house jams” that give me an opportunity to stay connected with playing the piano, guitar, and singing—things I studied before I ever went to medical school. I also try to take time when I travel for academic conferences to stay connected with my camera and my decades-long love for hiking and nature photography. I feel very strongly that nurturing both my scientific/technical side as well as my artistic side has allowed me to remain sane and balanced. I love to corrupt others by introducing them to dance and music and the arts, in the same way that I have enjoyed introducing people to epidemiology, biostatistics, and transplantation.

♦
Achieving Your Personal Best: Improvement Based on Evidence

The Best Surgical Education. All in One Place.
Dear Colleagues,

It is my pleasure to invite you to attend the American College of Surgeons (ACS) Clinical Congress, October 4–8, 2015, in Chicago, IL. The ACS Clinical Congress remains the premier annual surgical meeting and provides a broad range of outstanding education and training opportunities for surgeons, surgery residents, medical students, and members of surgical teams. Cutting-edge surgical research, hands-on learning opportunities, timely discourse on the most relevant surgical topics, and unparalleled peer access have long been hallmarks of Clinical Congress.

“Achieving Your Personal Best: Improvement Based on Evidence” was selected as the Clinical Congress 2015 theme by ACS President, Andrew L. Warshaw, MD, FACS, FRCSEd(Hon). The Program Committee, chaired by Valerie W. Rusch, MD, FACS, along with the ACS Division of Education under the leadership of Ajit K. Sachdeva, MD, FACS, FRCSC, have developed another outstanding Scientific Program. Efforts continue to be made to further enhance the educational program of the Clinical Congress to most effectively address evolving education and training needs in an ever-changing environment. Cutting-edge education and training methods along with state-of-the-art technology are used to achieve the best outcomes.

The 2015 Scientific Program has been arranged in key thematic tracks, covering both clinical and nonclinical topics, and should be of interest to surgeons from across various specialties. More than 120 Panel Sessions will cover the wide range of topics in these areas, and an exciting series of Named Lectures will be delivered by world-renowned experts in their respective fields. Didactic/Experiential and Surgical Skills Courses will emphasize advanced knowledge and skill acquisition through focused, applied learning techniques.

The Scientific Forum will offer surgical research presentations delivered in either podium or poster formats, with special recognition of resident and developing researcher presentations. Video-Based Education Sessions will showcase surgical procedures and current practices. Meet-the-Expert Luncheons and Town Hall Meetings on topics of interest allow for a more intimate learning experience in smaller settings.

Continuing Medical Education Credit is available for the majority of these learning opportunities, and most Panels, Courses, and Video-Based Education Sessions will also offer Self-Assessment Credit. Attendees will be able to obtain Levels of Verification following their participation in Postgraduate Courses. Sessions and courses covering the topics of patient safety, ethics, trauma/critical care, palliative care, and pain management may satisfy specific regulatory mandates.

In addition to the education and training opportunities offered, the ACS Clinical Congress is an excellent venue for networking with colleagues. On behalf of the American College of Surgeons, I look forward to welcoming you to Chicago for Clinical Congress.

With best regards,

Mark C. Weissler, MD, FACS
Chair, ACS Board of Regents
What's New in 2015?

• Clinical Congress 2015 will be held at McCormick Place in Chicago, IL.
• The Hilton Chicago will be the headquarters hotel.
• An improved mobile app will be available for planning and scheduling your Clinical Congress itinerary.
• The Scientific Forum abstract program is the “umbrella program” that now encompasses the programs formerly known as the Paper Sessions and Surgical Forum, as well as the Scientific Posters. All accepted abstracts submitted for an oral presentation will be featured in the Scientific Forum sessions.
• Self-Assessment Credit will be offered for most Courses, Panel Sessions, and Video-Based Education Sessions.
• The ACS Theatre will showcase select ACS programs from the Quality, Advocacy, Education, and Member Services areas midday Monday, Tuesday, and Wednesday in the exhibit hall. Presentations will be up to 30 minutes in length.

Didactic/Experiential Courses (DEC)*
New This Year
• A Primer in Clinical Trials Design and Methodology
• Fundamental Use of Surgical Energy (FUSE)
• Practical Communication Skills for Difficult Patient Encounters

Back by Popular Demand
• 2015 Introduction to CPT, ICD-10-CM, and Evaluation and Management Coding (Basic Coding Workshop)
• Annual Update in Surgical Critical Care
• Emergency General Surgery Update
• General Surgery Review Course
• Managing Common Anorectal Complaints
• Mastering General Surgery Coding (Advanced Coding Workshop)
• Measure Twice, Cut Once! Optimizing Surgical Systems of Care
• MOC Review: Essentials for Surgical Specialties
• Improving Patient Safety and Team Performance in Your OR: The Non-Technical Skills for Surgeons (NOTSS) System
• Surgical Education: Principles and Practice
• Trauma Update
• Vascular Surgery for General Surgeons

Surgical Skills Courses (SSC)*
New This Year
• Bariatric Surgery: Managing Complications Skills and Strategies
• Oncoplastic Breast Reconstructive Surgery
• Rib Plating
• Endovascular Skills for Hemorrhage Control
• Performing Total Mesorectal Excision (TME)
• Palliative Surgical Care

Back by Popular Demand
• Advanced Skills Training for Rural Surgeons: Laparoscopic Bile Duct Exploration and Facial Lacerations
• Advanced Colonoscopy Skills Course: New Interventions and Frontiers
• Laparoscopic Inguinal and Ventral Hernia Repair
• Minimally Invasive Laparoscopic Colorectal Surgery
• Surgical Endoscopy: Advancing Minimally Invasive Surgery and Retooling Our Workforce

Video-Based Education Offerings
Subject-Oriented Symposia
• Robotic Surgery
• Icons in Surgery
• Revisional Foregut: Which Is Best?
• ACS Video Atlas Showcase (Liver Volume)

Specialty-Specific Panel Sessions
• 10 Hot Topics in Critical Care
• Thoracic Aortic Disease Management: From the Aortic Valve to the Bifurcation
• Pelvic Organ Prolapse: Multidisciplinary Strategies for Care
• Managing the Unexpected Adrenal Mass
• Modern Management of the Mangled Extremity
• Challenging Trauma Cases: Lessons from the Experts
• New Horizons in Skull-Based Surgery
• Enhanced Recovery Protocols for GI Surgery: The SMART Approach
• Women’s Health Day Offerings:
  – Cardiovascular Disease: It’s Not Just about Men
  – Gynecology for the Nongynecologic Surgeon
  – Managing Pelvic Floor Disorders
  – The Surgeon’s Role in Treating Endocrine and Metabolic Disorders
  – What’s New in Body Contouring and Reconstructive Surgery

Nonclinical Panel Sessions Offer Learning and Insights into Other Aspects of Surgical Life
• The College’s Clinical Scholars 2015
• The Surgeon and Emotional Intelligence: It’s Real and Relevant
• Do I Need to Operate on That in the Middle of the Night?
• Managing Stress and Preventing Burnout: Strategies and Wellness Habits for Surgeons
• Tissue Engineering: What’s New?
• The College’s International Scholars and Outreach Programs
• The Role of Telemedicine in Surgical Outreach Programs
• You’re Not Alone: The Emotional Impact of Adverse Events
• Challenging Emergency Surgery Cases: Lessons from the Experts
• Research Training during Residency: Time for a Reality Check?
• Surgical Team Building: The Role of Interprofessional Education in Developing a Highly Functioning Care Team

Town Hall Meetings
• How Do We Credential Surgeons in the Use of New Technology?
• Finding Awe in Your Work
• Development of a Rural Track in Residency
• Enhanced Reimbursement for “Premium” Surgery

Cancellation of Sessions
The American College of Surgeons reserves the right to cancel any of the scientific sessions listed in this Program Planner. The information in this Program Planner is preliminary. Check the College’s website for updates.
Purpose
The Clinical Congress is a scientific and educational meeting that shall be held at the time and place of the Annual Business Meeting of Members, and shall include the Convocation (Bylaws, American College of Surgeons [ACS], Article VIII, Section 3).

The purpose of the Clinical Congress is to keep ACS Members and interested non-Fellow physicians abreast of the current status of the art and science of surgery. To accomplish its purpose, the Clinical Congress offers a highly diversified program of continuing education in all specialties of surgery and in important fields of science, socioeconomics, and medical education. It holds the preeminent place among all College activities designed to raise the standards of surgical practice and improve the care of the surgical patient.

The entire program presented at this meeting includes physicians drawn from various specialties. The sessions are designed to present a variety of viewpoints on matters of particular interest to those for whom the session is primarily intended and to stress the need for understanding and cooperation among the specialties.

Goal
The Clinical Congress is designed to provide individuals with a wide range of learning opportunities, activities, and experiences that will match their educational and professional development needs.

Objectives
By the conclusion of Clinical Congress, participants should be able to:
• Apply new knowledge and ideas to improve their surgical practice;
• Adapt concepts and quality measures in support of research advancements; and
• Enhance the quality of patient care.

Accreditation
The American College of Surgeons is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

Continuing Medical Education (CME) Credit
The American College of Surgeons designates this live activity for a maximum of 47.5* AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

* A maximum of 28.5 AMA PRA Category 1 Credits™ is available for sessions Monday through Thursday, including evening Video-Based Education sessions. A maximum of 19 credits is available for Postgraduate Courses held on Saturday and Sunday, as well as Meet-the-Expert Luncheons held throughout the week.

Self-Assessment Credit
Self-Assessment Credit will be available for most Panel Sessions, Didactic/Experiential Courses, Surgical Skills Courses, and Video-Based Education sessions. The process of earning Self-Assessment Credit is voluntary and is not a prerequisite to claiming CME credit. Self-Assessment Credit counts toward American Board of Surgery Maintenance of Certification (MOC) Part 2. Participants are strongly encouraged to complete their self-assessment posttest as soon after attendance as possible with a final deadline of December 1, 2015.

Claiming CME Credit
On-site claiming of credit for nonticketed sessions (NL, PS, SF, and VE) will be available at the My CME booth and kiosks located at McCormick Place, October 5–8, 2015. Physicians are responsible for claiming CME credit for Clinical Congress. Claims for CME credit for this event will be accepted until December 1, 2015.

Credit to Address Regulatory Mandates
Some state licensing boards and other regulatory organizations have established specific content requirements for CME credit. Examples include: Ethics (E), Patient Safety (PS), Pain Management (PM), and Palliative Care (PA). Trauma-Critical Care (T) credit is also required of surgeons working in the trauma field. The CME Certificate now includes specific content credit designations where applicable, indicated after each session title using the abbreviations listed above. Please check with your state or local medical board, hospital, or organization to verify that this content meets the criteria for your specific requirements.

Scientific Poster Presentations and Technical Exhibits
The Scientific Poster Presentations is a forum of more than 300 posters showcasing timely, innovative information and findings on original scientific research, surgical procedures, practices, and approaches.

The Scientific Poster Presentations will be located at McCormick Place, Hall F2. Hours are 9:00 am to 4:30 pm, Monday through Wednesday. The Technical Exhibits comprise more than 200 companies displaying their products and services. The exhibition provides an excellent opportunity to explore the surgical marketplace by comparing products firsthand and planning purchases.

The Technical Exhibits hours are 9:00 am to 4:30 pm, Monday through Wednesday. The exhibits are located in McCormick Place West, Hall F2.

Friends of Bill W.
Friends of Bill W. will meet 7:00 to 8:30 pm, Monday, October 5, through Wednesday, October 7, at the Hilton Chicago Hotel.

Clinical Congress News
The official newspaper of the annual meeting, the Clinical Congress News, will be distributed at the Hilton Chicago Hotel and McCormick Place each morning during Clinical Congress.

Clinical Congress e-News
Daily electronic updates will be available via e-mail.
### SATURDAY, OCTOBER 3

<table>
<thead>
<tr>
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<th>Title</th>
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<tbody>
<tr>
<td>8:00-3:30</td>
<td>DEC01</td>
<td>Review of the Essentials of Vascular Surgery</td>
<td>VAS</td>
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<tr>
<td>8:00-5:30</td>
<td>SSC04</td>
<td>Advanced Skills Training for Rural Surgeons: Laparoscopic Bile Duct Exploration and Facial Lacerations</td>
<td>GEN-PLA-TRA</td>
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<tr>
<td>9:00-11:15</td>
<td>DEC03</td>
<td>Fundamental Use of Surgical Energy (FUSE)</td>
<td>GEN</td>
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<tr>
<td>10:00-5:55</td>
<td>SSC03</td>
<td>Oncoplastic Breast Reconstructive Surgery</td>
<td>GEN-ONC</td>
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<tr>
<td>11:00-4:00</td>
<td>SSC01</td>
<td>Bariatric Surgery: Managing Complications—Skills and Strategies</td>
<td>GEN</td>
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### SUNDAY, OCTOBER 4

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<tr>
<td>8:00-3:30</td>
<td>DEC04</td>
<td>Trauma Update 2015</td>
<td>TRA</td>
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<tr>
<td>8:00-5:30</td>
<td>SSC04</td>
<td>Surgical Endoscopy: Advancing Minimally Invasive Surgery and Retooling Our Workforce</td>
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<tr>
<td>8:30-4:00</td>
<td>DEC05</td>
<td>E/M Coding, Profitable Practice Operations, and Strategy: 2015 Basic Coding Workshop</td>
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<td>8:30-4:00</td>
<td>DEC06</td>
<td>Surgical Education: Principles and Practice</td>
<td>EDU</td>
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<tr>
<td>8:30-5:15</td>
<td>SSC05</td>
<td>Practical Applications of Ultrasonography in the ICU (ECHO)</td>
<td>EDU-TRA</td>
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<td>9:00-2:15</td>
<td>SSC06</td>
<td>Rib Plating</td>
<td>GEN-TRA</td>
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<td>9:00-4:30</td>
<td>DEC07</td>
<td>Measure Twice, Cut Once! Optimizing Surgical Systems of Care</td>
<td>EDU-INFO</td>
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<tr>
<td>11:30-4:00</td>
<td>SI01</td>
<td>Medical Student Program, Session I</td>
<td>RES/MED</td>
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<tr>
<td>11:30-3:00</td>
<td>SI02</td>
<td>Focus on RAS-ACS</td>
<td>RES/MED</td>
<td></td>
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<td>3:00-5:00</td>
<td>SI03</td>
<td>RAS Symposium—Social Media: Threat to Professionalism and Privacy, or Essential for Current Surgical Practice?</td>
<td>RES/MED</td>
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<tr>
<td>6:00-8:00</td>
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<td>Convocation</td>
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### MONDAY, OCTOBER 5

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<tr>
<td>8:00-9:30</td>
<td>NL01</td>
<td>Opening Ceremony/Martin Memorial Lecture Sponsored by the American Urological Association</td>
<td>URO</td>
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<tr>
<td>9:45-10:45</td>
<td>NL02</td>
<td>John H. Gibbon, Jr., Lecture</td>
<td>CTS</td>
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<tr>
<td>9:45-11:15</td>
<td>PS100</td>
<td>Frailty Indices as Indicators of Risk in Surgery for the Geriatric Patient</td>
<td>GER-GEN-ETH</td>
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<tr>
<td>9:45-11:15</td>
<td>PS101</td>
<td>Metabolic Surgery: Understanding a Surgical Solution to an Epidemic</td>
<td>BTR-GEN</td>
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<tr>
<td>9:45-11:15</td>
<td>PS102</td>
<td>Entrustable Professional Activities and Milestones: New Strategies for Surgical Teaching in the Operating Room</td>
<td>EDU-RES/MED</td>
<td></td>
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<tr>
<td>9:45-11:15</td>
<td>PS103</td>
<td>Novel Treatments for GERD</td>
<td>CTS-GEN-RUS</td>
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<tr>
<td>9:45-11:15</td>
<td>PS104</td>
<td>Lower GI Bleeding: Diagnostic Workup and Evidence-Based Interventions</td>
<td>CRS-GEN-TRA</td>
<td></td>
</tr>
<tr>
<td>9:45-11:15</td>
<td>PS105</td>
<td>Lumps and Bumps: Current Management of Soft Tissue Sarcomas</td>
<td>ONC-ORT</td>
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<tr>
<td>9:45-11:15</td>
<td>SF01</td>
<td>Neurological Surgery</td>
<td>NEU</td>
<td></td>
</tr>
<tr>
<td>9:45-11:15</td>
<td>SF02</td>
<td>Pediatric Surgery I</td>
<td>PED</td>
<td></td>
</tr>
<tr>
<td>9:45-11:15</td>
<td>SF03</td>
<td>Transplantation and Tissue Engineering I</td>
<td>BTR</td>
<td></td>
</tr>
<tr>
<td>9:45-11:15</td>
<td>SF04</td>
<td>Bariatric/Foregut I</td>
<td>BTR</td>
<td></td>
</tr>
<tr>
<td>9:45-11:15</td>
<td>VE01</td>
<td>Cardiothoracic Surgery</td>
<td>CTS</td>
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</tr>
<tr>
<td>9:45-11:15</td>
<td>VE02</td>
<td>Colon and Rectal Surgery</td>
<td>CRS</td>
<td></td>
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<tr>
<td>9:45-11:15</td>
<td>VE03</td>
<td>General Surgery I</td>
<td>GEN</td>
<td></td>
</tr>
<tr>
<td>9:45-11:00</td>
<td>VE04</td>
<td>Subject-Oriented Symposium I: Atlas Showcase (Liver Volume)</td>
<td>GEN</td>
<td></td>
</tr>
</tbody>
</table>

**KEY TO SESSION/COURSE CODES**

- **ME**: Meet-the-Expert Luncheon
- **NL**: Named Lecture
- **DEC**: Didactic/Experiential Course
- **PS**: Panel Session
- **SSC**: Surgical Skills Course
- **SI**: Special Interest Session
- **SF**: Scientific Forum
- **TH**: Town Hall Meeting
- **VE**: Video-Based Session

- **$** Indicates that additional fees and registration apply
- **W** Indicates a Webcast session (Webcast package available for purchase)
- **S** Indicates an audio session

**Indicates that additional fees apply**

**Indicates an audio session**

For the most up-to-date information on session times and dates, go to [www.facs.org/cclincon2015](http://www.facs.org/cclincon2015).
<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Designated Tracks</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:00-7:45</td>
<td><strong>TH09</strong> Women in Surgery: The Road Travelled, the Road Ahead</td>
<td>CRS</td>
</tr>
<tr>
<td>7:00-7:45</td>
<td><strong>TH10</strong> Finding Awe in Your Work</td>
<td>RUS</td>
</tr>
<tr>
<td>7:00-7:45</td>
<td><strong>TH11</strong> How to Incorporate Clinical Ethics Within a Surgical Career</td>
<td>ETH</td>
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<tr>
<td>7:00-7:45</td>
<td><strong>TH12</strong> Metabolic and Bariatric Surgery: Accreditation Controversies</td>
<td>EDU-GEN</td>
</tr>
<tr>
<td>7:00-7:45</td>
<td><strong>TH13</strong> Is Current Surgical Training Adequate: Pros and Cons</td>
<td>EDU-RES/MED</td>
</tr>
<tr>
<td>7:00-7:45</td>
<td><strong>TH14</strong> Enhanced Reimbursement for “Premium” Surgery</td>
<td>HP-OPHTHO</td>
</tr>
<tr>
<td>7:00-7:45</td>
<td><strong>TH15</strong> Being an Expert Witness: When Are You Ready? How Do You Do It?</td>
<td>GEN-HP</td>
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<tr>
<td>7:00-7:45</td>
<td><strong>TH16</strong> From MOC to the bedside: How Can the American College of Surgeons Help You Prepare?</td>
<td>EDU-GEN</td>
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<tr>
<td>8:00-9:00</td>
<td><strong>NL09</strong> Distinguished Lecture of the International Society of Surgery</td>
<td>INT</td>
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<tr>
<td>8:00-9:30</td>
<td><strong>PS300</strong> Transanal Approaches to Colorectal Disease</td>
<td>CRS-GEN-RUS</td>
</tr>
<tr>
<td>8:00-9:30</td>
<td><strong>PS301</strong> Chest Trauma Can Be Trick: Information All General Surgeons Will Want to Know</td>
<td>GEN-TRA</td>
</tr>
<tr>
<td>8:00-9:30</td>
<td><strong>PS302</strong> Nonoperative Treatment for Appendicitis: Who, How, Why?</td>
<td>GEN</td>
</tr>
<tr>
<td>8:00-9:30</td>
<td><strong>PS303</strong> Advanced Techniques in Pediatric Laparoscopy</td>
<td>PED-GEN</td>
</tr>
<tr>
<td>8:00-9:30</td>
<td><strong>PS304</strong> Blood Thinners Are Getting Stronger and Harder to Reverse</td>
<td>GEN-NEU-VAS</td>
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<tr>
<td>8:00-9:30</td>
<td><strong>PS305</strong> What Works and What Doesn’t: An Update on Wound Healing</td>
<td>PLA</td>
</tr>
<tr>
<td>8:00-9:30</td>
<td><strong>PS306</strong> Treatment of Chronic Venous Disease: Superficial to Deep</td>
<td>GEN-PLA-VAS</td>
</tr>
<tr>
<td>8:00-9:30</td>
<td><strong>PS307</strong> Women’s Health Day: Gynecology for the Nongynecologic Surgeon</td>
<td>GEN-OBG-RUS</td>
</tr>
<tr>
<td>8:00-9:30</td>
<td><strong>PS308</strong> What Do We Do Now? Surgical Decision Making in Advanced Illness</td>
<td>GEN-GER</td>
</tr>
<tr>
<td>8:00-9:30</td>
<td><strong>SF43</strong> Pediatric Surgery IV</td>
<td>PED</td>
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<tr>
<td>8:00-9:30</td>
<td><strong>SF44</strong> Trauma IV</td>
<td>GEN-TRA</td>
</tr>
<tr>
<td>8:00-9:30</td>
<td><strong>SF45</strong> Vascular Surgery IV</td>
<td>VAS</td>
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<tr>
<td>8:00-9:30</td>
<td><strong>VE20</strong> Urological Surgery</td>
<td>URO</td>
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<tr>
<td>8:00-9:30</td>
<td><strong>VE21</strong> Subject-Oriented Symposium III: Revisional Foregut: Which Is Best?</td>
<td>GEN</td>
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<tr>
<td>8:00-11:15</td>
<td><strong>PS309</strong> Surgical Jeopardy</td>
<td>RES/MED</td>
</tr>
<tr>
<td>8:00-11:15</td>
<td><strong>SF46</strong> Surgical Oncology III</td>
<td>ONC</td>
</tr>
<tr>
<td>8:00-11:15</td>
<td><strong>SF47</strong> Critical Care Surgery</td>
<td>GEN-TRA</td>
</tr>
<tr>
<td>8:00-11:15</td>
<td><strong>SF48</strong> Surgical Education IV</td>
<td>EDU</td>
</tr>
<tr>
<td>8:00-3:30</td>
<td><strong>DEC13</strong> A Primer in Clinical Trials Design and Methodology</td>
<td>BTR-HP</td>
</tr>
<tr>
<td>8:00-4:30</td>
<td><strong>SSC13</strong> Thyroid and Parathyroid Ultrasound</td>
<td>GEN-OTO</td>
</tr>
<tr>
<td>8:00-5:15</td>
<td><strong>DEC14</strong> Annual Update in Surgical Critical Care</td>
<td>TRA</td>
</tr>
<tr>
<td>8:00-5:45</td>
<td><strong>SSC14</strong> Minimally Invasive Laparoscopic Colorectal Surgery</td>
<td>CRS</td>
</tr>
<tr>
<td>8:30-4:00</td>
<td><strong>DEC15</strong> Managing Common Anorectal Complaints</td>
<td>CRS-GEN-RUS</td>
</tr>
<tr>
<td>9:00-4:15</td>
<td><strong>SSC15</strong> Palliative Surgical Care</td>
<td>GEN-GEN-ONC</td>
</tr>
<tr>
<td>9:45-10:45</td>
<td><strong>NL10</strong> John J. Conley Ethics and Philosophy Lecture</td>
<td>ETH</td>
</tr>
<tr>
<td>9:45-11:15</td>
<td><strong>PS310</strong> Surgical Team Building: The Role of Interprofessional Education in Developing a Highly Functioning Care Team</td>
<td>EDU-HP</td>
</tr>
<tr>
<td>9:45-11:15</td>
<td><strong>PS311</strong> Current Controversies in Diagnosis and Management of Appendicitis in Children</td>
<td>GEN-PED-RUS</td>
</tr>
<tr>
<td>9:45-11:15</td>
<td><strong>PS312</strong> Fistulas, Shunts, and Peritoneal Dialysis Catheters: Tricks of the Trade</td>
<td>GEN-VAS</td>
</tr>
<tr>
<td>9:45-11:15</td>
<td><strong>PS313</strong> Managing Stress and Preventing Burnout: Strategies and Wellness Habits for Surgeons</td>
<td>GEN-HR-RES/ MED</td>
</tr>
<tr>
<td>9:45-11:15</td>
<td><strong>PS315</strong> Cancer Survivorship Care: What It Is and How to Do It</td>
<td>GEN-ONC</td>
</tr>
<tr>
<td>9:45-11:15</td>
<td><strong>PS316</strong> Women’s Health Day: What’s New in Body Contouring and Reconstructive Surgery</td>
<td>PLA</td>
</tr>
</tbody>
</table>
POSTGRADUATE COURSE FEES AND INFORMATION
Only registered meeting attendees may purchase Postgraduate (DEC/SSC) Course tickets. Seating capacities are limited and ticket requests will be filled on a first-come, first-processed basis. All Postgraduate Courses require a ticket for admission. Tickets for some of the Postgraduate Courses may also be purchased on-site, subject to availability and any applicable course prerequisite requirements. Tickets may be exchanged for an alternate course prior to the start of the course and based on availability. **No course refunds will be accepted after Monday, September 14, 2015.**

<table>
<thead>
<tr>
<th>DESCRIPTION OF FEE CATEGORIES</th>
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<tbody>
<tr>
<td><strong>Fellow</strong></td>
</tr>
<tr>
<td><strong>Non-Fellow</strong></td>
</tr>
<tr>
<td><strong>RAS</strong></td>
</tr>
<tr>
<td><strong>Non-RAS</strong></td>
</tr>
</tbody>
</table>

ACS PROGRAM FOR VERIFICATION OF KNOWLEDGE AND SKILLS
The Board of Regents of the American College of Surgeons has approved a five-level model for verification and documentation of knowledge and skills by the Division of Education, following participation in the educational programs of the College. This model provides a framework for designing and implementing educational courses based on principles of contemporary surgical education and permits a provision of appropriate documentation to the attendees. The courses offered at Clinical Congress have been assigned verification levels of I–III, based on the requirements for each level.

**REQUIREMENTS**

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
<th>Course Ticket</th>
<th>Pre- and Posttest*</th>
<th>Skills Report Card</th>
<th>Course Evaluation</th>
<th>Self-Assessment</th>
</tr>
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<tbody>
<tr>
<td>I</td>
<td>Verification of attendance</td>
<td></td>
<td>▲</td>
<td>▲</td>
<td></td>
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<tr>
<td>II</td>
<td>Verification of satisfactory completion of course objectives</td>
<td>▲</td>
<td>▲</td>
<td>▲</td>
<td>▲</td>
<td>▲</td>
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<tr>
<td>III</td>
<td>Verification of knowledge and skills</td>
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<tr>
<td>IV</td>
<td>Verification of preceptor experience</td>
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<tr>
<td>V</td>
<td>Verification of satisfactory patient outcomes</td>
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</tbody>
</table>

* A passing score of 75 percent or higher is required on the posttest.

All Postgraduate Courses with a designated verification level of II and III have a Self-Assessment component toward Maintenance of Certification (MOC) Part 2. All requirements of these Postgraduate Courses, as outlined above, must be completed in order to receive **AMA PRA Category 1 Credit(s)**™ and count for Self-Assessment Credit toward Part 2 of the American Board of Surgery MOC Program.

**Verification of completion of all requirements for Postgraduate Courses will be completed following the conclusion of Clinical Congress. Please allow up to four to six weeks for notification to claim certificates.**
**Postgraduate Courses**

**DIDACTIC/EXPERIENTIAL COURSES**

<table>
<thead>
<tr>
<th>Course Code</th>
<th>Course Title</th>
<th>COURSE FEES</th>
</tr>
</thead>
<tbody>
<tr>
<td>DEC01</td>
<td>Review of the Essentials of Vascular Surgery</td>
<td>$525 Fellow</td>
</tr>
<tr>
<td>DEC02</td>
<td>Emergency General Surgery Update 2015</td>
<td>$550 Fellow</td>
</tr>
<tr>
<td>DEC03</td>
<td>Fundamental Use of Surgical Energy (FUSE)</td>
<td>$425 Fellow</td>
</tr>
<tr>
<td>DEC04</td>
<td>Trauma Update 2015</td>
<td>$550 Fellow</td>
</tr>
<tr>
<td>DEC05</td>
<td>E/M Coding, Profitable Practice Operations, and Strategy: 2015 Basic Coding Workshop</td>
<td>$525 Fellow</td>
</tr>
<tr>
<td>DEC06</td>
<td>Surgical Education: Principles and Practices</td>
<td>$475 Fellow</td>
</tr>
<tr>
<td>DEC07</td>
<td>Measure Twice, Cut Once! Optimizing Surgical Systems of Care</td>
<td>$475 Fellow</td>
</tr>
<tr>
<td>DEC08</td>
<td>Mastering General Surgery CPT Coding: 2015 Advanced Coding Workshop</td>
<td>$525 Fellow</td>
</tr>
<tr>
<td>DEC09</td>
<td>General Surgery Review Course</td>
<td>$1,100 Fellow</td>
</tr>
<tr>
<td>DEC10</td>
<td>Practical Communication Skills for Difficult Patient Encounters</td>
<td>$475 Fellow</td>
</tr>
<tr>
<td>DEC11</td>
<td>Improving Patient Safety and Team Performance in Your OR: The Nontechnical Skills for Surgeons (NOTSS) System</td>
<td>$475 Fellow</td>
</tr>
<tr>
<td>DEC12</td>
<td>MOC Review: Essentials for Surgical Specialties</td>
<td>$425 Fellow</td>
</tr>
<tr>
<td>DEC13</td>
<td>A Primer in Clinical Trials Design and Methodology</td>
<td>$475 Fellow</td>
</tr>
<tr>
<td>DEC14</td>
<td>Annual Update in Surgical Critical Care</td>
<td>$575 Fellow</td>
</tr>
<tr>
<td>DEC15</td>
<td>Managing Common Anorectal Complaints</td>
<td>$550 Fellow</td>
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</tbody>
</table>

**Surgical Skills Courses**

<table>
<thead>
<tr>
<th>Course Code</th>
<th>Course Title</th>
<th>COURSE FEES</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSC01</td>
<td>Bariatric Surgery: Managing Complications—Skills and Strategies</td>
<td>$975 Fellow</td>
</tr>
<tr>
<td>SSC02</td>
<td>Advanced Skills Training for Rural Surgeons: Laparoscopic Bile Duct Exploration and Facial Lacerations</td>
<td>$975 Fellow</td>
</tr>
<tr>
<td>SSC03</td>
<td>Oncoplastic Breast Reconstructive Surgery</td>
<td>$1,500 Fellow</td>
</tr>
<tr>
<td>SSC04A</td>
<td>Surgical Endoscopy: Advancing Minimally Invasive Surgery and Retooling Our Workforce (Lecture only)</td>
<td>$375 Fellow</td>
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<tr>
<td>SSC04B</td>
<td>Surgical Endoscopy: Advancing Minimally Invasive Surgery and Retooling Our Workforce (Lecture and Lab)</td>
<td>$990 Fellow</td>
</tr>
<tr>
<td>SSC05**</td>
<td>Practical Applications of Ultrasonography in the ICU (ECHO)</td>
<td>$915 Fellow</td>
</tr>
<tr>
<td>SSC06</td>
<td>Rib Plating</td>
<td>$675 Fellow</td>
</tr>
<tr>
<td>SSC07**</td>
<td>Ultrasound for Pediatric Surgeons</td>
<td>$680 Fellow</td>
</tr>
<tr>
<td>SSC08</td>
<td>Endovascular Skills for Hemorrhage Control</td>
<td>$1,000 Fellow</td>
</tr>
<tr>
<td>SSC09</td>
<td>Advanced Colonoscopy Skills Course: New Interventions and Frontiers</td>
<td>$995 Fellow</td>
</tr>
<tr>
<td>SSC10A</td>
<td>Laparoscopic Inguinal and Ventral Hernia Repair (Lecture only)</td>
<td>$350 Fellow</td>
</tr>
<tr>
<td>SSC10B</td>
<td>Laparoscopic Inguinal and Ventral Hernia Repair (Lecture and Lab)</td>
<td>$990 Fellow</td>
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<tr>
<td>SSC11**</td>
<td>Advanced Hepatopancreaticobiliary (HPB) Ultrasound</td>
<td>$990 Fellow</td>
</tr>
<tr>
<td>SSC12</td>
<td>Performing Total Mesorectal Excision (TME)</td>
<td>$995 Fellow</td>
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<tr>
<td>SSC13**</td>
<td>Thyroid and Parathyroid Ultrasound</td>
<td>$1,350 Fellow</td>
</tr>
<tr>
<td>SSC14A</td>
<td>Minimally Invasive Laparoscopic Colorectal Surgery (Lecture only)</td>
<td>$475 Fellow</td>
</tr>
<tr>
<td>SSC14B</td>
<td>Minimally Invasive Laparoscopic Colorectal Surgery (Lecture and Lab)</td>
<td>$1,500 Fellow</td>
</tr>
<tr>
<td>SSC15</td>
<td>Palliative Surgical Care</td>
<td>$800 Fellow</td>
</tr>
</tbody>
</table>

**Prerequisite course requirements; please review course descriptions for details.**

Register online at [www.facs.org/clincon2015/register](http://www.facs.org/clincon2015/register) for these Didactic/Experiential Courses and Surgical Skills Courses.
DEC01 | Review of the Essentials of Vascular Surgery
Track: VAS
6 credits, Verification Level II
Saturday, October 3 | 8:00 am–3:30 pm
Chair: Kwame S. Amankwah, MD, FACS, Syracuse, NY
Co-Chair: Timur P. Sarac, MD, FACS, New Haven, CT
This course will review the essentials of contemporary vascular surgery practice with a focus on updated data and techniques of relevance for the general surgeon whose practice includes vascular surgery. Topics will include diagnosis and management of both medical and surgical treatment of peripheral arterial disease, including carotid disease, aneurysms, and venous disease, including deep vein thrombosis and pulmonary embolism (DVT/PE), amputations, the diabetic foot, and access for hemodialysis.
Sponsored by: Advisory Council for Vascular Surgery
Fee: FELLOW $525 | NON-FELLOW $625
RAS $265 | NON-RAS $295

DEC02 | Emergency General Surgery Update 2015
Track: GEN, RUS, TRA
6 credits, Verification Level II
Saturday, October 3 | 8:30 am–4:00 pm
Chair: Clay Cothren Burlew, MD, FACS, Denver, CO
Co-Chair: Steven M. Steinberg, MD, FACS, Columbus, OH
Common emergency general surgery problems have seen an evolution in management paradigms. This course will review the latest data on myriad surgical emergencies, including perforated esophagus, complications of peptic ulcer disease, necrotizing pancreatitis, incarcerated and strangulated hernias, clostridium difficile (c. diff) colitis, and diverticulitis. Operative and nonoperative treatment options will be discussed and current evidence-based recommendations reviewed.
Sponsored by: Committee on Trauma and the Advisory Council for General Surgery
Fee: FELLOW $550 | NON-FELLOW $625
RAS $300 | NON-RAS $340

DEC03 | Fundamental Use of Surgical Energy (FUSE)
Track: GEN
4 credits, Verification Level II
Saturday, October 3 | 9:00 am–1:15 pm
Chair: Daniel B. Jones, MD, FACS, Boston, MA
Co-Chair: Thomas N. Robinson, MD, FACS, Boston, MA
Energy-based devices may facilitate or even enable complex procedures, yet despite their frequent use, they remain poorly understood. This Postgraduate Course is open to all physicians and allied health care professionals. It is designed to inform and promote best practices for the use of electrosurgical, ultrasonic, and other energy sources in the operating room (OR). Any health care professional who has ever used an energy-based device in the OR will better understand how it works, when to apply it, and what possible hazards and errors can occur.
Sponsored by: Advisory Council for General Surgery and the Committee on Emerging Surgical Technology and Education
Fee: FELLOW $425 | NON-FELLOW $425
RAS $240 | NON-RAS $240

DEC04 | Trauma Update 2015
Track: TRA
6 credits, Verification Level II
Sunday, October 4 | 8:00 am–3:30 pm
Chair: Robert C. Mackerise, MD, FACS, San Francisco, CA
Co-Chair: Kimberly K. Nagy, MD, FACS, Chicago, IL
Trauma care continues to evolve. This course will examine advances in diagnosis, resuscitation, and management. New technology both in and out of the operating room will be discussed and challenges for the future examined.
Sponsored by: Committee on Trauma
Fee: FELLOW $550 | NON-FELLOW $625
RAS $300 | NON-RAS $340

DEC05 | Evaluation and Management (E/M) Coding, Profitable Practice Operations, and Strategy: 2015 Basic Coding Workshop
Track: HP
6 credits, Verification Level II
Sunday, October 4 | 8:30 am–4:00 pm
Chair: Albert Bothe, Jr., MD, FACS, Danville, PA
Co-Chair: Linda M. Bamey, MD, FACS, Dayton, OH
This course is focused on fine-tuning the business and reimbursement side of a surgeon’s practice. Participants will receive the information and tools needed to code E/M services with confidence, use modern payment technologies, evaluate and improve billing and collections systems, and prepare for the coming changes in medical care reimbursement. Learning objectives include selecting the correct category of code for office and hospital services, implementing new strategies for moving toward new payment models, identifying key financial indicators for monthly review, and reducing the chance of an audit by documenting correctly.
Sponsored by: General Surgery Coding and Reimbursement Committee
Fee: FELLOW $525 | NON-FELLOW $605
RAS $265 | NON-RAS $295

DEC06 | Surgical Education: Principles and Practice
Track: EDU
6 credits, Verification Level II
Sunday, October 4 | 8:30 am–4:00 pm
Chair: Roy Phitayakorn, MD, FACS, Boston, MA
Co-Chair: Adnan A. Alseidi, MD, FACS, Seattle, WA
The objective of this course is to enhance the teaching skills of surgeons active in student and resident education. The principles of adult learning, mentoring, needs assessment, questioning skills, conference management, feedback, and performance evaluation will be reviewed. In addition, participants will develop a thorough generational understanding of the practical applications of these principles, both in and out of the operating room. This course includes a workshop with interactive, small group discussion.
Sponsored by: Division of Education
Fee: FELLOW $475 | NON-FELLOW $540
RAS $265 | NON-RAS $295

DEC07 | Measure Twice, Cut Once! Optimizing Surgical Systems of Care
Track: EDU, INFO
7 credits, Verification Level II
Sunday, October 4 | 9:00 am–4:30 pm
Chair: Peter J. Fabri, MD, FACS, Tampa, FL
Surgeons are in a unique position to maximize surgical care by applying principles of health systems engineering (HSE) to their practices. Learn the critical differences between HSE and the traditional approaches to quality improvement. Simple HSE strategies can be used to identify potential problems, measure them in a feasible way, interpret results, propose solutions, and make adjustments as needed. Microsoft Excel can be used for all the necessary tools, and a few very powerful techniques will be taught to help clinicians understand, analyze, and improve their systems of care and to measure outcomes important to them. This course will teach the fundamental principles and skills of HSE to help surgeons lead the way in making important changes to practice and collaborating better with the other members of the performance improvement team. (Participants will need to bring a laptop computer with Excel 2007 or a later version. Lunch will be provided.)
Sponsored by: Division of Education
Fee: FELLOW $475 | NON-FELLOW $550
RAS $225 | NON-RAS $265

DEC08 | Mastering General Surgery CPT Coding: 2015 Advanced Coding Workshop
Track: HP
6 credits, Verification Level II
Monday, October 5 | 9:45 am–5:15 pm
Chair: Mark T. Savarise, MD, FACS, Salt Lake City, UT
Co-Chair: Christopher K. Senkowski, MD, FACS, Savannah, GA
This course is an in-depth focus on evaluation and management (E/M) services. It will cover how to identify and document the appropriate level of service and also will cover reimbursement issues, including ways to expedite reimbursement with fewer denials by understanding the billing rules. In addition, the course will address Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), modifiers, and the surgical global package. Learning objectives include effectively incorporating 2015 CPT code changes and coding guidelines into practice, differentiating CPT rules and Medicare reimbursement rules, applying coding and modifier guidelines to accurately report multiple procedure combinations, and articulating why the surgeon’s participation in the coding reimbursement process is critical to the bottom line of the practice.
Sponsored by: General Surgery Coding and Reimbursement Committee
Fee: FELLOW $525 | NON-FELLOW $605
RAS $265 | NON-RAS $295
DEC09 | General Surgery Review Course

**Track:** GEN, TRA
12 credits, Verification Level II
Monday, October 5 | 10:00 am–5:00 pm
**Chair:** Laura J. Moore, MD, FACS, Houston, TX
**Co-Chair:** Sam G. Pappas, MD, FACS, Maywood, IL
This two-day course will provide a concise review of a majority of the essential content areas in general surgery. The course will help surgeons comply with Maintenance of Certification requirements and help guide their preparation for recertification examinations. A distinguished faculty will use an interactive case-based format that will cover many of the core elements of general surgery as defined by the American Board of Surgery. The course content will be based on a modular system to include: abdomen, gastrointestinal tract, trauma, critical care, breast, endocrine, vascular, perioperative, and general surgical problems in related specialties. Questions will be available for review by participants prior to the course. During the course, an interactive audience response system will be used, and following the audience response, the correct answer will be discussed by the faculty. At the conclusion of the course, participants will receive a syllabus with all the questions, answers, supporting discussions, and bibliographies.

**Sponsored by:** Division of Education

**Fee:**
- FELLOW $1,100 | NON-FELLOW $1,245
- RAS $625 | NON-RAS $700

DEC10 | Practical Communication Skills for Difficult Patient Encounters

**Track:** EDU, GEN, ETH
6 credits, Verification Level II
Monday, October 5 | 10:00 am–5:00 pm
**Chair:** David R. Urbach, MD, FACS
**Co-Chair:** Margaret (Gretchen) L. Schwarze, MD, FACS, Madison, WI
This course will focus on common communication problems that lead to difficult patient encounters, review the "categories" of difficult patients, and will provide general advice about how to manage problem interactions. The surgeon's understanding of his or her subjective feelings is the cornerstone of any plan to handle difficult patients. The session will provide practical advice and "scripts" for dealing with common problem encounters, such as explaining to patients that symptoms are functional, ending an encounter, and dealing with the aggressive patient.

**Sponsored by:** Division of Education

**Fee:**
- FELLOW $475 | NON-FELLOW $545
- RAS $250 | NON-RAS $285

DEC11 | Improving Patient Safety and Team Performance in Your OR: The Nontechnical Skills for Surgeons (NOTSS) System

**Track:** EDU
6 credits, Verification Level II
Tuesday, October 6 | 8:30 am–4:00 pm
**Chair:** Douglas S. Smink, MD, MPH, FACS, Boston, MA
**Co-Chair:** Steven J. Yule, PhD, Boston, MA
Nontechnical skills (situation awareness, decision making, leadership, communication, and teamwork) are increasingly considered essential for the successful surgeon. The aim of this workshop is to raise awareness of the impact of nontechnical skills on surgical performance. The workshop will be structured around the four categories of nontechnical skills detailed in the NOTSS skills taxonomy. The conceptual background to each category will be described. Participants will then view and discuss simulated operations, focusing on the observable behaviors of the surgeons involved. Structured methods of analyzing behavior will be used to aid this process in an interactive manner. Participants will gain knowledge of the NOTSS handbook and learn to identify and assess nontechnical skills in the operating room.

**Sponsored by:** Division of Education

**Fee:**
- FELLOW $475 | NON-FELLOW $545
- RAS $250 | NON-RAS $285

DEC12 | MOC Review: Essentials for Surgical Specialties

**Track:** EDU, GEN
4 credits, Verification Level II
Tuesday, October 6 | 12:30–4:45 pm
**Chair:** Robert R. Lorenz, MD, FACS, Cleveland, OH
**Co-Chair:** Robert R. Bahnsen, MD, FACS, Columbus, OH
Do you have to take a Maintenance of Certification (MOC) exam? The surgical fundamentals are competencies that are common to all the surgical specialties and are tested during the MOC recertification process. They include topics such as: emergency airway management, DVT prophylaxis, post-op management including MI recognition, conscious sedation, treatment of anaphylaxis, blood conservation, and pain management and patient safety issues, to name but a few. This course seeks to bring subject matter experts to educate surgeons from all the subspecialties on these topics, with an emphasis on preparation for MOC specific to these fundamental competencies. This is a one-stop shop for you to quickly get up to speed through a refresher course for all these areas and concentrate on the studying the other materials specific to your subspecialties.

**Sponsored by:** Division of Education

**Fee:**
- FELLOW $425 | NON-FELLOW $425
- RAS $240 | NON-RAS $240

DEC13 | A Primer in Clinical Trials Design and Methodology

**Track:** BTR, HP
6 credits, Verification Level II
Wednesday, October 7 | 8:00 am–3:30 pm
**Chair:** Kamal M. F. Itani, MD, FACS, West Roxbury, MA
**Co-Chair:** Heidi Nelson, MD, FACS, Rochester, MN
This one-day course is based on the five-day intensive course offered every other year by the American College of Surgeons Division of Research and Optimal Patient Care. This course is recommended for surgeons who plan to engage in clinical research trials but do not have the time to devote five days. Expert faculty will use a combination of didactic lectures and examples to develop concepts and skills in the design, implementation, and analysis of randomized clinical trials; funding mechanisms and budget development; outcomes (medical, patient-centered); and dissemination of results through publications.

**Sponsored by:** Surgical Research Committee

**Fee:**
- FELLOW $475 | NON-FELLOW $545
- RAS $250 | NON-RAS $285

DEC14 | Annual Update in Surgical Critical Care

**Track:** TRA
7 credits, Verification Level II
Wednesday, October 7 | 8:00 am–5:15 pm
**Chair:** Ali Salim, MD, FACS, Boston, MA
**Co-Chair:** Heidi L. Frankel, MD, FACS, Pasadena, CA
The field of surgical critical care is undergoing rapid change. The purpose of this session is to provide a succinct, practical review of the major changes that should be integrated into the practices of surgeons who attend this session. This fast-paced review will cover relevant changes to critical care practices that have occurred over the last year. Dynamic experts in the field will review the literature and provide tips and tricks for implementing these changes into practice.

**Sponsored by:** Committee on Trauma

**Fee:**
- FELLOW $575 | NON-FELLOW $655
- RAS $315 | NON-RAS $345

DEC15 | Managing Common Anorectal Complaints

**Track:** CRS, GEN, RUS
6 credits, Verification Level II
Wednesday, October 7 | 8:30 am–4:00 pm
**Chair:** Elisa H. Birnbaum, MD, FACS, St. Louis, MO
**Co-Chair:** Jennifer S. Beaty, MD, FACS, Omaha, NE
Management of hemorrhoids, anal fistulas, anal fissures, and pilonidal sinus are a major component of general surgery practice. Over the past decade, many new technologies have appeared on the scene, making it challenging for the contemporary surgeon to decide where they fit in day-to-day practice.

**Sponsored by:** Advisory Council for Colon and Rectal Surgery

**Fee:**
- FELLOW $550 | NON-FELLOW $625
- RAS $390 | NON-RAS $340
SSC01 | Bariatric Surgery: Managing Complications—Skills and Strategies
Track: GEN
6 Hours, Verification Level III
Saturday, October 3, 2015 | 10:00 am–5:30 pm
Chair: Jeffrey Marks, MD, FACS, Cleveland, OH
Bariatric procedures and their associated complication management strategies have evolved over the last 10 to 20 years to include flexible endoscopy as a mainstay. This course will define the role of flexible endoscopy as primary endoscopic bariatric therapy and also the endoscopic management of surgical complications related to bariatric surgery. The hands-on session will then expose the participant to these different flexible endoscopic techniques. Participants of this course must have basic flexible endoscopic skills.
Sponsored by: Committee on Surgical Skills Training for Practicing Surgeons
Fee: FELLOW $975 | NON-FELLOW $1,125
RAS $490 | NON-RAS $565

SSC02 | Advanced Skills Training for Rural Surgeons: Laparoscopic Bile Duct Exploration and Facial Lacerations
Track: GEN, RUS, PLA
8 Hours, Verification Level III
Saturday, October 3, 2015 | 8:30 am–5:30 pm
Chair: Amy L. Halwerson, MD, FACS, FASCRS, Chicago, IL
Co-Chair: David C. Borgstrom, MD, FACS, Cooperstown, NY
This year’s course will include the topics of laparoscopic bile duct exploration and facial plastic surgery. Both of these modules have been taught in prior rural skills courses and received extremely positive feedback. The laparoscopic bile duct exploration module will practice the technique of laparoscopic bile duct stone extraction via the cystic duct and utilizing a cholecodochotomey on a task-specific simulator. The facial plastic surgery module will cover the techniques of facial lesion excision and options for defect closure as well as laceration repair of the eyelids, lip, and cheek.
Sponsored by: Advisory Council for Rural Surgery
Fee: FELLOW $975 | NON-FELLOW $1,125
RAS $490 | NON-RAS $565

SSC03 | Oncoplastic Breast Reconstructive Surgery
Track: GEN, ONC
6 hours, Verification Level III
Saturday, October 3, 2015 | 10:00 am–5:15 pm
Chair: V. Suzanne Klimberg, MD, FACS, Little Rock, AR
Co-Chair: Shawnia C. Willey, MD, FACS, Washington, DC
This session will cover an up-to-date review of advances in management strategies for patients with breast cancer and comorbidities. The goal of the course is to increase the competencies and performance of health care professionals involved in treating this patient population, which will ultimately improve the quality of life and overall survival of patients with this disease.
Sponsored by: Committee on Surgical Skills Training for Practicing Surgeons
Fee: FELLOW $1,500 | NON-FELLOW $1,725
RAS $750 | NON-RAS $890

SSC04 | Surgical Endoscopy: Advancing Minimally Invasive Surgery and Retooling Our Workforce
Track: GEN
8 Hours, Verification Level III
Saturday, October 4, 2015 | 8:00 am–5:30 pm
Chair: John D. Mellinger, MD, FACS, Springfield, IL
Co-Chair: Brian J. Dunkin, MD, FACS, Houston, TX
Therapeutic endoscopy is changing the face of surgery. Gastroesophageal reflux disease (GERD), Barrett’s esophagus, achalasia, anastomotic leaks, and intestinal fistulas are all being managed with endoscopic therapies. This course will demonstrate to participants how to use flexible endoscopy to take better care of surgical patients both in and out of the operating room. It will also describe how the American Board of Surgery is working toward retooling the surgical workforce by mandating a curriculum in flexible GI endoscopy with validated metrics of performance for all general surgical residents. A hands-on lab will introduce participants to techniques and technologies that can be readily introduced into their practices, including placing stents, mucosal ablation, endolumenal therapies for GERD, endoscopic suturing, endoscopic mucosal resection, and per oral endoscopic myotomy (POEM).
Sponsored by: Advisory Council for General Surgery
Part A Fee (Lecture only)
8:00 am–12:15 pm (4 hours CME):
FELLOW $375 | NON-FELLOW $430
RAS $190 | NON-RAS $215
Part B Fee (Lecture and Lab)
8:00 am–5:30 pm (8 hours CME):
FELLOW $990 | NON-FELLOW $1,140
RAS $495 | NON-RAS $570

SSC05 | Practical Applications of Ultrasonography in the ICU (ECHO)
Track: EDU, TRA
7 Hours, Verification Level III
Sunday, October 4, 2015 | 8:30 am–5:15 pm
Chair: Paula Ferrada, MD, FACS, Richmond, VA
Co-Chair: Amy C. Silsey, MD, FACS, Phoenix, AZ
This course focuses on the ICU patient population, emphasizing relevant ultrasound skills for the surgical intensivist. Recently, bedside echocardiography has emerged as a valuable tool in the assessment of critically ill patients. Included in this module is an introduction to the use of a limited echocardiogram assessing cardiac function and volume status. Additionally, evaluation of the thoracic cavity for the presence of fluid (hemothorax or pleural effusion) is included. The didactic sessions will review indications for bedside ECHO and thoracic imaging. Case studies will illustrate the application of ECHO in the management of critically ill patients. This course will provide hands-on experience in a small group format with experienced instructors.
Sponsored by: National Ultrasound Faculty
Fee: FELLOW $915 | NON-FELLOW $1,055
RAS $460 | NON-RAS $530

SSC06 | Rib Plating
Track: GEN, TRA
4 hours, Verification Level III
Sunday, October 4, 2015 | 9:00 am–2:15 pm
Chair: John Mayberry, MD, FACS, Portland, OR
This course consists of a didactic session followed by lab instruction with faculty experts in rib fracture open reduction and internal fixation (ORIF). At the conclusion of the course attendees can expect to be well-versed in the indications, technical challenges, and basic surgical principles of rib fracture ORIF.
Sponsored by: Committee on Surgical Skills Training for Practicing Surgeons
Fee: FELLOW $575 | NON-FELLOW $780
RAS $335 | NON-RAS $390

SSC07 | Ultrasound for Pediatric Surgeons
Track: GEN, PED
6 Hours, Verification Level III
Monday, October 5, 2015 | 9:45 am–5:15 pm
Chair: Stefan Scholz, MD, FACS, Pittsburgh, PA
Co-Chair: Marcus D. Jarboe, MD, FACS, Ann Arbor, MI
This course is intended to provide pediatric surgeons with an introduction to ultrasound and the basic skills needed for use in their practices. This course includes brief didactic sessions on the physics of ultrasound instrumentation and scanning techniques and the clinical applications in the neonatal and pediatric patient. Particular attention is given to ultrasound-guided techniques as applicable to pediatric surgeons in their daily practice.
In comparison with previous courses, this course now offers an expanded hands-on session with stations briefly focusing on diagnostic techniques (FAST, cervical and abdominal windows and findings) but, most importantly, on teaching interventional procedures such as vascular access or placement of drains.
Ultrasound techniques will be practiced on human models as well as on simulators. This course covers ultrasound basics for the pediatric/neonatal patient; trauma/FAST examination; diagnosis of soft-tissue abscess, appendicitis, hypertrophic pyloric stenosis, intussusception, and intestinal malrotation; diagnosis and treatment of intracavity fluid collections (abdominal/thoracic); insertion of arterial lines and peripheral and central venous catheters; interventional biopsy techniques for tumors and masses; and other pediatric applications.
Sponsored by: Advisory Council for Pediatric Surgery
Fee: FELLOW $680 | NON-FELLOW $780
RAS $340 | NON-RAS $390
Surgical Skills Courses

**SSC08 | Endovascular Skills for Hemorrhage Control**

**Track:** VAS

6 Hours, Verification Level III

Monday, October 5, 2015 | 10:00 am–5:15 pm

**Chair:** L. van der Sluis, MD, PhD, FACS, FCCP, FACC, Mirani, Canada

**Co-Chair:** Abbas Al-Bayati, MD, FACS, Baptist, FL

There is an ever-evolving role of endovascular techniques for traumatic vascular injuries. These techniques should be incorporated into the early treatment algorithm of trauma patients, particularly for those requiring difficult operative exposure. This course will provide both lecture and hands-on skills in the use of the Resuscitative Endovascular Balloon Occlusion of the Aorta (REBOA) and the necessary tools used in the procedure. This is for vascular and non-vascular surgeons. Note: Live fluoroscopy will be used during the surgical skills lab portion of the course.

Sponsored by: Committee on Surgical Skills Training for Surgeons

**Fee:**
- FELLOW $1,000 | NON-FELLOW $1,275
- RAS $500 | NON-RAS $575

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**SSC09 | Advanced Colonoscopy Skills Course: New Interventions and Frontiers**

**Track:** CRS, RUS

4 Hours, Verification Level III

Monday, October 5, 2015 | 1:00–5:15 pm

**Chair:** Richard L. Whelan, MD, FACS, New York, NY

**Co-Chair:** Paul C. Sheltto, MD, FACS, Boston, MA

The last few years have brought new improvements in advanced technique for polypectomy (for example, EMR), endoluminal management of anastomotic leaks, stents to relieve obstruction, and clips to treat bleeding, to name a few.

Sponsored by: Advisory Council for Colon and Rectal Surgery

**Fee:**
- FELLOW $950 | NON-FELLOW $1,125
- RAS $500 | NON-RAS $575

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**SSC10 | Laparoscopic Inguinal and Ventral Hernia Repair**

**Track:** EDU, GEN

7.25 Hours, Verification Level III

Tuesday, October 6, 2015 | 8:00 am–4:45 pm

**Chair:** Carla M. Pugh, MD, PhD, FACS, Madison, WI, Stony Brook, NY

**Co-Chairs:** Aurora D. Pryor, MD, FACS, Stony Brook, NY, and Michael J. Rosen, MD, FACS, Solon, OH

The learning curve for laparoscopic hernia repair has been quoted to be more than 50 cases despite participation in formal training courses. Prior work assessing skills learned during animal and simulation-based training courses reveals incomplete transfer to live operating room environments. As most courses largely focus on technical aspects of laparoscopic hernia repair, assessment of cognitive and decision-based approaches is warranted.

Sponsored by: Committee on Emerging Surgical Technology and Education

**Part A Fee (Lecture only)**

8:00–11:30 am (3.25 hours CME):
- FELLOW $350 | NON-FELLOW $405
- RAS $175 | NON-RAS $205

**Part B Fee (Lecture and lab)**

8:00 am–4:45 pm (2.5 hours CME):
- FELLOW $990 | NON-FELLOW $1,140
- RAS $495 | NON-RAS $570

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**SSC11 | Advanced Hepatopancreaticobiliary (HPB) Ultrasound**

**Track:** GEN, ONC

7.75 Hours, Verification Level III

Tuesday, October 6, 2015 | 8:30 am–5:45 pm

**Chair:** Ellen J. Hagopian, MD, FACS, Neptune, NJ

**Co-Chairs:** Reid B. Adams, MD, FACS, Charlottesville, VA, and Junji Machi, MD, FACS, Honolulu, HI

The goal of this postgraduate course is to provide surgeons and surgical gastrointestinal (GI) fellows (hepatobiliary, advanced GI, minimally invasive, surgical oncology, transplant) with advanced education and training in HPB ultrasound. This course will review the basic principles of ultrasound and will provide in-depth instruction on the techniques of ultrasound in HPB surgery. Centering on intraoperative and laparoscopic abdominal ultrasound, the course will provide a comprehensive understanding of the anatomy of the HPB system in addition to ultrasound techniques, methods, and guidance.

Sponsored by: National Ultrasound Faculty

**Fee:**
- FELLOW $990 | NON-FELLOW $1,140
- RAS $495 | NON-RAS $570

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**SSC12 | Performing Total Mesorectal Excision (TME)**

**Track:** CRS

4 Hours, Verification Level III

Tuesday, October 6, 2015 | 9:00 am–1:15 pm

**Chair:** Connor Delaney, MCh, PhD, FACS, FACSRS, Cleveland, OH

**Co-Jose:** Jose Guillen, MD, FACS, New York, NY

TME has been shown to dramatically reduce the local recurrence rate for rectal cancer surgery. National workshops from around the world have documented the efficacy and feasibility of using a workshop format to teach TME and improve outcomes for patients with rectal cancer.

Sponsored by: Advisory Council for Colon and Rectal Surgery

**Fee:**
- FELLOW $995 | NON-FELLOW $1,145
- RAS $500 | NON-RAS $575

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**SSC13 | Thyroid and Parathyroid Ultrasound**

**Track:** GEN, QTO

7 Hours, Verification Level III

Wednesday, October 7, 2015 | 8:00 am–4:30 pm

**Chair:** Lisa Ann Orloff, MD, FACS, Stanford, CA

**Co-Chair:** Russell B. Smith, MD, FACS, Omaha, NE

The objective of this course is to introduce the practicing surgeon to office-based ultrasound examination of the thyroid and parathyroid glands and related pathology. The distinction of normal from malignant lymphadenopathy will be emphasized with a demonstration of the comprehensive examination of lymph node basins in cervical levels I–VI. The techniques of ultrasound-guided FNA of thyroid nodules and lymph nodes will be demonstrated in didactic lecture format. In addition, skill sessions will allow the surgeon to develop skills to perform diagnostic neck ultrasound. Patient volunteers will allow supervised hands-on experience with transverse and longitudinal ultrasound methods. The techniques of FNA of lesions will be performed using phantom models. Attendees will be instructed in the practical detail and hurdles in developing office-based ultrasound.

Sponsored by: National Ultrasound Faculty

**Fee:**
- FELLOW $1,350 | NON-FELLOW $1,555
- RAS $675 | NON-RAS $775

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**SSC14 | Minimally Invasive Laparoscopic Colorectal Surgery**

**Track:** CRS

8 Hours, Verification Level III

Wednesday, October 7, 2015 | 8:00 am–5:45 pm

**Chair:** Brian D. Badgwell, MD, FACS, Little Rock, AR

**Co-Chair:** Zara Cooper, MD, FACS, Roxbury, MA

Palliative surgery represents 13 percent of operations and more than 1,000 procedures per year at major centers. In addition, approximately 40 percent of surgical consultations at cancer centers fulfill the criteria for palliative care. However, there is a paucity of palliative surgical research to guide decision making for common advanced cancer diagnoses such as malignant bowel obstruction, gastrointestinal bleeding secondary to metastatic malignancy, and malignant ascites. The lack of evidence-based guidelines for treatment of these advanced cancer clinical scenarios combined with surgeons often receiving little instruction in common palliative care concepts can lead to ambiguity in treatment selection. This surgical skills course will use a multi-institutional, multi-disciplinary panel of clinicians with experience in palliative surgical care to outline common diagnoses involving interaction between palliative medicine and surgery. The course will provide instruction in various approaches to palliative surgical consultation utilizing patient simulation stations for practicing end-of-life discussions and the consent process for palliative surgery. Additional skill stations will offer common palliative surgical interventions.

Sponsored by: Committee on Surgical Skills Training for Practicing Surgeons

**Fee:**
- FELLOW $800 | NON-FELLOW $905
- RAS $400 | NON-RAS $455

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**SSC15 | Palliative Surgical Care**

**Track:** GEN, GER, ONC

6 Hours, Verification Level III

Wednesday, October 7, 2015 | 9:00 am–4:15 pm

**Chair:** Brian D. Badgwell, MD, FACS, Little Rock, AR

**Co-Chair:** Zara Cooper, MD, FACS, Roxbury, MA

Palliative surgery represents 13 percent of operations and more than 1,000 procedures per year at major centers. In addition, approximately 40 percent of surgical consultations at cancer centers fulfill the criteria for palliative care. However, there is a paucity of palliative surgical research to guide decision making for common advanced cancer diagnoses such as malignant bowel obstruction, gastrointestinal bleeding secondary to metastatic malignancy, and malignant ascites. The lack of evidence-based guidelines for treatment of these advanced cancer clinical scenarios combined with surgeons often receiving little instruction in common palliative care concepts can lead to ambiguity in treatment selection. This surgical skills course will use a multi-institutional, multi-disciplinary panel of clinicians with experience in palliative surgical care to outline common diagnoses involving interaction between palliative medicine and surgery. The course will provide instruction in various approaches to palliative surgical consultation utilizing patient simulation stations for practicing end-of-life discussions and the consent process for palliative surgery. Additional skill stations will offer common palliative surgical interventions.

Sponsored by: Committee on Surgical Skills Training for Practicing Surgeons

**Fee:**
- FELLOW $800 | NON-FELLOW $905
- RAS $400 | NON-RAS $455

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Meet-the-Expert Luncheons use an informal and nontraditional didactic approach and allow attendees to converse with leading experts about specific clinical issues. These popular sessions encourage open, case-based discussions without any formal media. Tickets cost $45 and are available for purchase by all registered physician and medical student attendees. Individual luncheons are limited to no more than 35 participants. Each day 16 luncheons are simultaneously scheduled over the lunch break. CME credit is available for these sessions.

### MONDAY, OCTOBER 5
1:15–2:15 PM

**ME101 | Antireflux Gadgets and Gimmicks**
Track: GEN
Facilitated by: Brant K. Oelschlager, MD, FACS, Seattle, WA

**ME102 | Approaches to Nipple-Sparing Mastectomy**
Tracks: GEN, TRA
Facilitated by: Jay K. Harness, MD, FACS, Orange, CA

**ME103 | Fixation of Rib Fractures**
Tracks: GEN, TRA
Facilitated by: Thomas K. Varghese, Jr., MD, FACS, Dayton, OH

**ME104 | Diversifying Your Surgical Career**
Track: EDU
Facilitated by: Margaret M. Dunn, MD, FACS, Dayton, OH

**ME105 | Evaluation and Management of Pancreatic Cysts**
Track: GEN
Facilitated by: Peter J. Allen, MD, FACS, New York, NY

**ME106 | Genitourinary Trauma**
Tracks: TRA, URO
Facilitated by: Richard A. Santucci, MD, FACS, Detroit, MI

**ME107 | Integrating New Technology into Surgical Practice**
Tracks: EDU, INFO
Facilitated by: Marcovalerio Melis, MD, FACS, New York, NY

**ME108 | Medullary Thyroid Carcinoma: What Do You Need to Know?**
Tracks: GEN, ONC, OTO
Facilitated by: Douglas B. Evans, MD, FACS, Milwaukee, WI

**ME109 | How to Write a Successful Patient-Centered Outcomes Research Institute (PCORI) Grant**
Tracks: BTR, GEN, ONC
Facilitated by: George J. Chang, MD, FACS, Houston, TX

**ME110 | Nonoperative Management of Appendicitis**
Track: GEN
Facilitated by: Michael J. Stamos, MD, FACS, FASCRS, Orange, CA

**ME111 | Opioid Prescribing: Striking the Balance between Patient Care and the Law**
Tracks: ETH, GEN, GER
Facilitated by: Bridget N. Fahy, MD, FACS, Albuquerque, NM, and Joan L. Huffman, MD, FACS, Shepherd, MT

**ME112 | Optimizing Outcomes in Liver and Pancreatic Surgery**
Tracks: GEN, OHC
Facilitated by: Perry Shen, MD, FACS, Winston-Salem, NC, and Flavio G. Rocha, MD, FACS, Seattle, WA

**ME113 | Pediatric Urology**
Tracks: PED, URO
Facilitated by: David A. Bloom, MD, FACS, Ann Arbor, MI

**ME114 | Practical Tips for Thyroidectomy**
Track: GEN
Facilitated by: Ashok R. Shaha, MD, FACS, New York, NY

**ME115 | Quality Improvement in Your Cancer Program**
Tracks: HP, OHC
Facilitated by: Peter S. Hopewood, MD, FACS, Falmouth, MA, and Mary J. Milroy, MD, FACS, Yankton, SD

**ME116 | Treatment Options for Anal Fissure**
Track: CRS
Facilitated by: Amir L. Bastawrous, MD, FACS, Seattle, WA

### TUESDAY, OCTOBER 6
11:30 AM–12:30 PM

**ME201 | Addressing Chronic Pain following Inguinal Hernia Repair**
Track: GEN
Facilitated by: John B. Hanks, MD, FACS, Charlottesville, VA, and Peter T. Hallowell, MD, FACS, Charlottesville, VA

**ME202 | Anorectal Surgery**
Track: CRS
Facilitated by: Herand Abcarian, MD, FACS, Chicago, IL

**ME203 | Balancing an Academic Career and Personal Needs**
Tracks: BTR, EDU, RES/MED
Facilitated by: Bruce L. Gewertz, MD, FACS, Chicago, IL, and Leigh A. Neumayer, MD, FACS, Tucson, AZ

**ME204 | Breast Cancer Management in 2015**
Tracks: GEN, OHC
Facilitated by: Lee G. Wilke, MD, FACS, Madison, WI

**ME205 | Complex Abdominal Trauma**
Tracks: GEN, TRA
Facilitated by: David V. Feliciano, MD, FACS, Indianapolis, IN

**ME206 | Current Management of Thyroid Nodules**
Tracks: GEN, OHC
Facilitated by: Carmen C. Solorzano, MD, FACS, Nashville, TN

**ME207 | Enteral Access for Nutrition**
Tracks: GEN, PED, TRA
Facilitated by: Todd A. Ponsky, MD, FACS, Akron, OH

**ME208 | Necrotizing Soft-Tissue Infections**
Tracks: GEN, TRA
Facilitated by: Eileen M. Bulger, MD, FACS, Seattle, WA

**ME209 | Increasing Diversity in the Surgical Workforce**
Tracks: BTR, GEN, RES/MED
Facilitated by: Mallory Williams, MD, FACS, Toledo, OH, and Mary C. McCarthy, MD, FACS, Dayton, OH

**ME210 | Informatics for Managing Surgical Workflow**
Tracks: HP, INFO
Facilitated by: T. Forcht Dagi, MD, FACS, Newton Centre, MA

**ME211 | Laparoscopic Para-Esophageal Hernia Repair: Still Indicated after All These Years?**
Tracks: CTS, GEN
Facilitated by: James D. Luketich, MD, FACS, Pittsburgh, PA

**ME212 | Lymphedema after Breast Surgery**
Tracks: GEN, OHC
Facilitated by: Lisa A. Newman, MD, MPH, FACS, Ann Arbor, MI

**ME213 | Neuroendocrine Tumors of the Pancreas: What Do I Need to Know?**
Track: GEN
Facilitated by: Geoffrey B. Thompson, MD, FACS, Rochester, MN

**ME214 | Optimal Esophagectomy**
Tracks: CTS, EDU
Facilitated by: Shanda H. Blackmon, MD, MPH, FACS, Rochester, MN

**ME215 | The Art and Science of Sacral Nerve Stimulation**
Tracks: GEN, PED, URO
Facilitated by: Steven Teich, MD, FACS, New Albany, OH; Seth A. Alpert, MD, FACS, Columbus, OH; and Tracy L. Hull, MD, FACS, Cleveland, OH
CME credit is not available for these sessions.

SUNDAY, OCTOBER 4

Medical Student Program
Day I: 11:30 am–6:00 pm
The Division of Education invites students from all four years of medical school to attend Clinical Congress and participate in this program specially designed for students who are considering a career in surgery. Programming is varied from day to day, and students are welcome to attend all or selected portions of this three-day program. The program is free to ACS Medical Student Members who register in advance. Nonmembers will be charged a reduced registration fee.

Topics include exploring various lifestyle issues in surgery, learning about community outreach ideas for surgery interest groups, navigating the residency application process, and interviewing successfully.

Speakers will include College leaders and surgical educators at both the medical student and resident levels. Students will be able to hone their interviewing skills in interactive sessions with surgeons as well as network with specialty surgeons, surgical residents, residency program directors, and others.

Also incorporated in this program is the Medical Student Program Poster Session, during which 40 medical students present their research in one of two categories: clinical, outcomes, innovation, or educational research; or basic science research. There will be a first-, second-, and third-place award in each category.

Students who are enrolled in a U.S., Canadian, or international allopathic or osteopathic medical school are invited to attend this comprehensive program. For regularly updated information about the Medical Student Program and the Medical Student Program Poster Session, visit www.facs.org/clincon2015/special/medical-student. For additional information, please contact Nicole Laroco at nlaroco@facs.org or 312-202-5404.

Sponsored by Committee on Medical Student Education

Focus on RAS-ACS
11:30 am–3:00 pm
The Resident and Associate Society of the American College of Surgeons (RAS-ACS) is devoted to the needs and concerns of trainees and young surgeons in all disciplines. The Focus on RAS-ACS session is a dynamic program tailored to Residents and Associate Fellows in the ACS. Informational discussions will take place on RAS-ACS, descriptions of opportunities for involvement, and inspirational content on the topic of leadership will be provided by outgoing ACS President Andrew L. Warshaw, MD, FACS, and RAS-ACS Chair Joseph V. Sakran, MD, MPH, MPA. Please join us in this exciting session to learn more about your organization and how you can become a surgical leader.

Resident and Associate Society Symposium—Social Media: Threat to Professionalism and Privacy, or Essential for Current Surgical Practice?
3:00–5:30 pm
Social media has become an integral part of our private and professional lives. Hospitals, practices, and individual surgeons have websites, blogs, and Facebook accounts, and many surgeons are avid users of Twitter. While social media represents an unprecedented way of engaging colleagues and patients, it also poses challenges and even threats to professionalism and privacy. What should physicians do when they get “friend requests” from their patients? Should attending surgeons be “Facebook friends” with their residents? How much information about their private lives should/must physicians disclose publicly or on the Web? These are only a few of the questions we will discuss at the RAS-ACS Symposium. Attendees will be provided with an overview of the opportunities and pitfalls of using social media as well as a roadmap on the navigation of these challenges.

This session will be followed by audience questions and interaction. For additional information, please contact RASNews@facs.org Refer to the registration section of the ACS website at www.facs.org/clincon2015/register.

MONDAY, OCTOBER 5

Surgery Resident Program Starting Surgical Practice: Essentials for Success
10:00 am–6:00 pm
The ACS Division of Education invites surgery residents from all postgraduate year levels to participate in a special program designed to assist surgical residents with essential nonclinical issues they face during residency training and the transitional period to their posttraining career. The program is free to ACS Resident Members who register in advance. Nonmembers will be charged a reduced registration fee.

Featured topics will include personal financial planning and debt management, job-seeking strategies and negotiation skills, and reduction of liability risks. Additionally, interactive sessions will be offered in which residents may explore different types of practice settings and other topics.

Speakers will include not only leaders from surgery but also a certified financial planner and an expert in physician career development.

For additional information, please contact Ms. Cheryllynn Sherman at 312-202-5424 or csherman@facs.org or go to www.facs.org/education/surgery-resident. Register online for this special program at www.facs.org/clincon2015/register.

Medical Student Program
Day II: 12:45–6:00 pm
For a full description of this program, refer to the Sunday schedule. Note that programming is varied from day to day and students are welcome to attend all or selected portions of this three-day program.

For regularly updated information about the Medical Student Program, visit www.facs.org/clincon2015/special/medical-student. For additional information, contact Nicole Laroco at nlaroco@facs.org or 312-202-5404.

Sponsored by Committee on Medical Student Education

Young Fellows Association Program
4:00–5:45 pm
The Young Fellows Association (YFA) welcomes Initiates, Fellows who are 45-years-old or younger, and those “young at heart” to the Annual YFA Program. The YFA Program includes an overview of the association’s activities by the current Chair and Vice-Chair, Michael J. Sutherland, MD, FACS, and Jacob Moalem, MD, FACS, respectively; a round-table discussion; and updates by the YFA Workgroups. The program ends with a networking reception that provides the opportunity for Initiates and Young Fellows to interact with the new ACS President and YFA leadership.
Cardiothoracic Surgery in the Future: Technology Overview for Residents and Medical Students

**5:30–9:00 pm**
Fee: $25 (includes dinner)

**Course Directors:**
- James I. Fann, MD, FACS, Stanford, CA
- Thomas E. MacGillivray, MD, FACS, Boston, MA
- Daniel L. Miller, MD, FACS, Atlanta, GA

This course will introduce surgery residents and medical students to conventional and complex procedures performed by cardiothoracic surgeons. New technologies and cardiothoracic surgery training paradigms, such as the integrated six-year residency, will be discussed.

The primary focus of the session will be hands-on experience with specific cardiothoracic surgical procedures. Participants will experience and have the opportunity to perform these surgical procedures using synthetic and tissue-based simulation models. The program will be taught by cardiothoracic surgeons who are leaders in their respective fields of cardiac and general thoracic surgery. A buffet dinner will be available at 5:30 pm.

For additional information, please contact Nicole Schroeder, STS Education Manager, at nschroeder@sts.org.

Please refer to the registration section of the ACS website at www.facs.org/clincon2015/register.

*Sponsored by the American College of Surgeons and The Society of Thoracic Surgeons*

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**TUESDAY, OCTOBER 6**

2015 Scientific Forum Dedication/Excellence in Research Awards

**8:00–9:00 am**

The Scientific Forum Committee will dedicate the Scientific Forum abstract supplement to Michael T. Longaker, MD, MBA, FACS, Stanford, CA. Introduction will be made by Geoffrey C. Gurtner, MD, FACS, with remarks by Dr. Longaker immediately following. After the dedication, Mary T. Hawn, MD, FACS, Scientific Forum Committee Chair, will distribute approximately 16 awards for excellence in research. Surgery residents and their mentors are invited to attend the dedication and awards distribution.

Posters of Exceptional Merit*

**11:30 am–12:30 pm**

*CME is available for this session

More than 300 posters will be on display at the Clinical Congress but only a select few will be designated Posters of Exceptional Merit. Scientific Forum Committee Chair Mary T. Hawn, MD, FACS, and Vice-Chair Dennis P. Orgill, MD, FACS, will facilitate a lunchtime tour and discussion of the Posters of Exceptional Merit. Authors will present their distinguished work and answer questions prior to the award presentation for the Best Scientific Poster.

*Sponsored by Scientific Forum Committee*

Operation Giving Back
Open Mic: Advocating for Surgery Around the World

**11:30 am–12:30 pm**

This open mic session is designed to educate attendees about the efforts in global surgery with a special focus on education, service, and research. We will discuss the current framework of surgical resident education in global health, service provided by ACS Fellows around the globe, and research to better understand the global burden of surgical disease. A three to five minute reporting format will be employed to discuss existing efforts.

*Sponsored by Operation Giving Back*

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Medical Student Program

**Day III: 1:00–6:00 pm**

For a full description of this program, refer to the Sunday schedule. Note that programming varies from day to day, and students are welcome to attend all or selected portions of this three-day program.

For regularly updated information about the Medical Student Program, visit www.facs.org/clincon2015/special/medical-student.

For additional information, please contact Nicole Laroco at nlaroco@facs.org or 312-202-5404.

*Sponsored by Committee on Medical Student Education*

Chapter Speed Networking

**3:00–5:00 pm**

Join the Governors of the Chapter Activities Domestic and International Workgroups for a new, fun, chapter-related social event where you will have the opportunity to share your background and learn about the work of other ACS chapters in a relaxed and open setting. Chapter Speed Networking is an opportunity to accelerate your Clinical Congress networking experience through short, concise meetings and is a great way to build lasting connections with colleagues, members, and staff of other ACS chapters from across the globe. A short introductory session, with how-to tips to make the most of your networking experience, will start the event.

Beverages and appetizers will be available during Chapter Speed Networking. This event is being hosted by the Governors’ Chapter Activities Domestic and International Workgroups. For more information, contact Donna Tieberg, Chapter Services Manager, at dtieberg@facs.org or 312-202-5361.

Rural Surgeons Open Forum and Oweida Scholarship Presentation

**4:15–5:45 pm**

The session opens with the introduction of the 2015 Nizar N. Oweida Scholarship recipient, Alexander J. Poole, MD, FACS, FRCSC, a general surgeon practicing in Whitehorse, YT.

The Advisory Council for Rural Surgery (ACRS) sponsors this open forum to facilitate direct communication with rural surgeons and the ACRS. Following a brief description of the current projects of the ACRS, we will hold an open forum with all in attendance. This forum will focus on the delivery of 24/7 rural surgery care. What are the essential tools? What are the essential staffing needs? What has worked for you? What are the barriers to 24/7 quality surgical care? The ACRS encourages you to bring your concerns, thoughts on education needs, coverage, call, triumphs, and so on. The ACRS is committed to being your vehicle to make change, to be your voice to ACRS leadership, and to make the ACRS even more relevant to your practice. We are committed to helping you provide optimal surgical care to your patients in your community.

For additional information, contact Tyler Hughes, MD, FACS, ACRS Chair, at tylerh@mcphersonhospital.org or David Borgstrom, MD, FACS, ACRS Committee on Education, at david.borgstrom@bassett.org.
Air Transportation
The ACS has arranged special meeting discounts on United Airlines. These special discounts are available by booking with United directly (independently or through a travel agent). Be sure to reference the ACS Z Code and Authorization Number below to obtain the special fares.
United Airlines
800-426-1122
7:00 am–9:00 pm CST, Monday – Friday
8:00 am–6:00 pm CST, Saturday – Sunday
Z Code: ZTEZ
Authorization Number: 973454
Purchase your ticket online at www.united.com and receive a discount off the lowest applicable fares. When booking online, please enter ZTE2973454 to receive your discount.

Car Rental
Avis is designated as the official car rental company for Clinical Congress 2015. Special meeting rates and discounts are available on a wide selection of GM and other fine cars. To receive these special rates, be sure to mention your Avis Worldwide Discount (AWD) number when you call.
Avis Reservations
800-331-1600
www.avis.com
AWD Number: B169699

Visa Information
International Fellows, guest physicians, and meeting attendees: The process of obtaining a visa to attend meetings in the U.S. now takes much longer. You are strongly urged to apply for a visa as early as possible, preferably at least 60 days before the start of the meeting. For detailed information regarding obtaining a visa, please visit http://travel.state.gov/visa/temp/types/types_1262.html. For information regarding the Visa Waiver Program (VWP), please visit http://travel.state.gov/visa/temp/without/without_1990.html.
You may request a letter from the College welcoming you to the meeting by visiting www.facs.org/clincon2015/international-attendees/visa.

Affiliate Group Functions
Groups planning a social function or business meeting to be held in conjunction with Clinical Congress are required to obtain approval. If events are to be held at one of the participating venues/hotels, affiliate groups are required to secure event space through ACS. For more information and to request function space, visit http://web2.facs.org/meetings/events/or contact Carrie Ryan, Meetings Coordinator, ACS Convention and Meetings, at cryan@facs.org. Space assignments are made on a first-come, first-processed basis. After the space request deadline of April 10, 2015, space is more limited and is assigned on an availability basis.

Shuttle Bus Service
Complimentary shuttle bus service will be provided for all registrants at regular intervals between McCormick Place West and most designated ACS Clinical Congress hotels. For a list of hotels on the shuttle route, please refer to the Housing Information section. Schedules and routes will be available at McCormick Place West and participating hotels.

Help and Information Center
Portable Help and Information Centers will be located throughout McCormick Place West and will be available during registration hours. Assistance with general information, travel, housing, and local information will be available.

Lost and Found
Lost and found areas will be located in the ACS Convention Office at the Hilton Chicago and in the Convention and Exhibit Office at McCormick Place West. People looking for or who have found lost items should contact one of these offices.

Prayer Room
A prayer room will be available at McCormick Place West during the meeting and open during registration hours. Room location will be indicated in the Program Book distributed at the meeting.

Nursing Mothers’ Room
A nursing mothers’ room will be available during the meeting and located in the first aid room by the shuttle transportation center at McCormick Place West.

Child Policy
The ACS policy regarding children is as follows:
Under 12—Not permitted on Social Program tours
Under 16—Not permitted on exhibit floor or in scientific sessions
16 and over—Must have a badge to enter exhibit area or meeting rooms
This policy includes infants in strollers and arms.

Camp ACS
The American College of Surgeons is once again partnering with ACCENT on Children’s Arrangements, Inc. to provide an on-site children’s program in Chicago, IL. ACCENT has prepared a program with activities such as arts and crafts and active games designed to entertain your children while you are attending meetings and sessions. The camp, which is offered to all children ages six months through 17 years, will be located at the Hilton Chicago. For more information on Camp ACS, visit our website at www.facs.org/clincon2015/register/camp-acs.

Bistro ACS
The Best Way to Eat, Meet, and Network at Clinical Congress 2015

We know it can be difficult to find a well-balanced, healthy meal or a place to sit and talk during a convention. Bistro ACS provides a comfortable setting for attendees and exhibitors to eat, meet, and network with colleagues and fellow attendees. Conveniently located in the exhibit hall at McCormick Place West, Hall F2, the Bistro’s all-inclusive, upscale buffet-style lunch is the ideal dining destination during Clinical Congress 2015. Bistro ACS will be open Monday, October 5, through Wednesday, October 7.

Attendees may purchase individual bistro tickets at the time of registration. Tickets are priced at $25 per ticket. Those wishing to purchase group tickets in advance may visit www.bistroACS.com. Ticket sales will also be available on-site at the Bistro ACS booth located in the Central Concourse at McCormick Place West.

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A prayer room will be available during the meeting and located in the first aid room by the shuttle transportation center at McCormick Place West.

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Who Should Attend and What’s Included?

Registration is open to all physicians and individuals in the health care field and includes a name badge, Program Book, and entrance to the exhibits and all sessions except for postgraduate courses and Meet-the-Expert Luncheons*. Please refer to information on registration location, hours, and fees. To review the full registration policies and submit your Clinical Congress 2015 registration, visit www.facs.org/clincon2015/register.

* The following sessions are included with your Clinical Congress registration and are not ticketed. Registering for these sessions does not guarantee seating within the course. Seating is provided on a first-come, first-served basis until the meeting room is full.
- Named Lectures
- Panel Sessions
- Scientific Posters
- Video-Based Sessions
- Surgical Forum
- Town Hall Meetings

Registration and Membership Questions

Should you have any questions regarding Clinical Congress registration, contact Registration Services. Phone registrations are not accepted. E-mail: registration@facs.org
Phone: 312-202-5244
Fax: 312-202-5003

Should you have any questions regarding your ACS membership prior to registering for the Clinical Congress, contact Member Services.

Fellow Dues and Status
877-277-0036 or dues@facs.org
Associate Fellow, Resident, Medical Student, and Affiliate Members
800-293-4029 or enroll@facs.org

2015 Clinical Congress Initiates
800-621-4111 or acsinitiate@facs.org

For information on becoming a member of the College and to complete a membership application, visit www.facs.org/member-services/join.

REGISTRATION FEES AND CREDENTIALS

All registrations must be received by 11:59 pm CT on the date indicated in order to receive the corresponding registration rate.

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<th>CATEGORY</th>
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<td>Commercial Press</td>
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Attendees must be members of the American College of Surgeons at the time of registration to receive the member rate. Refunds will not be provided to those who become members after registering.

Commercial Representatives may obtain the commercial registration form by e-mailing a request to registration@facs.org.

* A Retired ACS Fellow is an individual who has notified the College, meets the ACS definition of Retired, has been granted Retired status, and is officially listed in the ACS database as Retired. The ACS definition of a Retired member is a surgeon who is not in the active practice of providing surgical or nonsurgical patient care, participating in funded research, or performing compensated teaching or administrative duties. Questions about Retired member status should be directed to dues@facs.org.

** All nonmembers who pay the applicable Clinical Congress registration fees will have their membership application fees waived if they apply for American College of Surgeons membership on-site at the Clinical Congress.

Additionally, the American College of Surgeons offers discounted registration fees for both member and nonmember residents and medical students. To take advantage of the discount, nonmember residents and medical students must submit a letter verifying their educational status at the time of registration. Residents should obtain a letter from their program director; students should contact their department chairs.
Guest Registration

Guests may register for Clinical Congress by paying the applicable registration fee. All Guest registrants must be accompanied by a Scientific Program registrant of another category. Guest Registration is meant for nonmedical attendees only. Guests are not eligible for CME credits or Certificate of Attendance, nor can they attend Postgraduate Courses or Meet-the-Expert Luncheons.

The Guest Registration fee entitles you to attend scientific sessions, view the technical and scientific exhibits, purchase tour tickets, and use the shuttle bus service.

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<td>Children 15 Years and Under</td>
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Guest Program Tours and Events

Important Note: All tours will depart from and return to the Hilton Chicago unless otherwise noted. Please meet in the lobby of the hotel unless otherwise indicated. We recommend that you arrive at least 15 minutes prior to the scheduled tour time and wear comfortable walking shoes for all tours. Unless otherwise indicated, all lunches and dinners referred to are included in the price of the tour. Tours will be held rain or shine, unless otherwise notified. Children under 12 years of age are not permitted on tours. All children 12 years and older must be accompanied by an adult.

<table>
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<td>ST02 11:30 am–2:00 pm</td>
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<td>ST03 2:10 pm</td>
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<td>ST04 5:00–10:30 pm</td>
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<td>ST06 10:30 am–2:30 pm</td>
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<td>ST07 2:00–3:30 pm</td>
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<td>ST08 5:00–10:30 pm</td>
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<tr>
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<td>ST11b 1:00–3:00 pm</td>
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<tr>
<td>ST12 1:00–4:00 pm</td>
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<tr>
<td>ST16 3:00–4:00 pm</td>
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<td>ST17 4:00–5:00 pm</td>
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<td>ST13 7:30 pm</td>
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<tbody>
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<td>ST14 10:00 am–12:00 noon</td>
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<tr>
<td>ST15 1:00–5:00 pm</td>
</tr>
</tbody>
</table>

Note: These events will not take place at the Hilton Chicago. Visit [www.facs.org/clincon2015](http://www.facs.org/clincon2015) for a complete description of all Tours and Events.
General Housing Information

Book your room through Travel Planners at one of the official Clinical Congress Hotels!
To obtain the necessary amount of meeting and exhibit space at the convention center and hotels, the ACS must commit to a minimum number of guest rooms. If that commitment is not met, the ACS will incur significant financial penalties and have difficulty obtaining sufficient meeting space in the future. This issue can have a major impact on the programs that the ACS is able to offer in the future. You can help the ACS avoid penalties by booking your reservation through the official housing company.

Suite Raffle
To thank you for booking your reservation through Travel Planners in the official housing block, you will be entered in a raffle to win an upgrade to a one-bedroom suite for your entire hotel stay, valid for reservations for dates of stay that include October 4–8, 2015. Your reservation must be made by September 9, 2015, in order to qualify for the raffle. Winner(s) will be notified via e-mail on September 11, 2015.

Applying for Hotel Accommodations
The following housing procedures apply to all general registrants of the Clinical Congress. If you are a Regent, Officer, Past-Officer, Advisory Council Chair, Governor, Recipient of the Distinguished Service Award, Special Invited Guest, or Standing Committee Chair and are applying for the Hilton Chicago, use the special housing application sent to you.

Housing Procedures
The ACS has appointed Travel Planners to coordinate housing for the 2015 Clinical Congress. Reservation requests will be processed on a first-come, first-served basis and must be received by Wednesday, September 9, 2015. Reservations received after the housing cut-off date of Wednesday, September 9, 2015, or after the room blocks are filled, are subject to space and rate availability. Housing requests can be made using ONE of the following options:

- **GO ONLINE** to www.tphousing.com/Ph2/index2.aspx?EICode=3116&Attcode=72 to submit your Clinical Congress hotel reservation. A credit card is needed to guarantee your reservation at the time of booking. The online reservation service is available 24 hours a day, seven days a week.
- **CALL** Travel Planners at 888-810-4455 or 212-532-1660 (international attendees) between 9:00 am and 7:00 pm ET, Monday through Friday. A credit card is needed to guarantee your reservation at time of booking.
- **FAX** your completed Clinical Congress Hotel Reservation Form (which can be found at www.facs.org) to 212-779-6128. A credit card is needed to guarantee your reservation.
- **MAIL** your completed Hotel Reservation Form (which can be found at www.facs.org) and mail with credit card guarantee to:
  
  Travel Planners/ACS Housing Bureau
  
  381 Park Ave. South, 3rd Floor
  
  New York, NY 10016

Please do not send your request directly to the hotel or to the ACS office; doing so will only delay the processing of your request. If you do not receive acknowledgement within 72 hours, please contact Travel Planners at acs@tphousing.com or at the phone numbers indicated. Please verify your acknowledgment for accuracy. It is the only acknowledgment you will receive.

Deposit Policies
Reservations made via the website, phone, fax, or mail will require a credit card (American Express, VISA, or MasterCard) for guarantee purposes only. Credit cards will not be charged at the time the reservation is made. Credit cards will only be charged directly by the hotel if your reservation is not cancelled at least 72 hours prior to arrival or in accordance with your hotel’s cancellation policy as noted on your confirmation.

Changes and Cancellations
Do not call or write the ACS office to change or cancel your reservation. Changes to and/or cancellation of your reservation should be made with Travel Planners (the ACS official housing bureau) until **September 29, 2015, at 7:00 pm ET**. Beginning September 30, you must contact the hotel directly to make any changes. Please ask for a confirmation number when canceling or changing your reservation directly with the hotel.

Your credit card will not be charged unless you cancel your reservation less than 72 hours in advance of arrival date or in accordance with your hotel’s cancellation policy as noted on your reservation confirmation.
The Centers for Medicare & Medicaid Services (CMS) has made the Quality and Resource Use Reports (QRURs) available to help solo practitioners and group practices better understand their performance in quality and cost metrics. Quality and cost metrics are increasingly being used for accountability purposes under federal value-based purchasing programs.

What is the purpose of QRURs?

QRURs are confidential feedback reports that provide information regarding the cost and the quality of health care that physicians and group practices render to Medicare fee-for-service (FFS) patients. The reports are intended to provide comparative performance data that physicians can use to improve the care provided to Medicare beneficiaries.

CMS also uses some of the information in the QRURs to calculate the physician value-based payment modifier (VM). The VM, implemented in the Affordable Care Act, provides either bonus payments, payment penalties, or a neutral adjustment (no bonus or penalty) to physicians’ Medicare payments based on the quality and cost of the services they provide in comparison with the performance of their peers.

All physicians and group practices will be subject to VM payment in 2017 based on the quality metrics they report in 2015 and the cost of their care. They may be subject to Medicare payment penalties of as much as –4 percent based on quality and cost performance. The quality metrics used to calculate the VM are based on performance in the Physician Quality Reporting System (PQRS). Therefore, it is critical that all surgeons participate in PQRS in 2015 and in the future. For more information on the VM program, go to www.facs.org/advocacy/regulatory/vbm. For more information on the PQRS program, go to www.facs.org/advocacy/regulatory/pqrs.

What is the methodology behind the 2013 QRURs?
The 2013 QRURs include data assessing a group practice or solo practitioner’s performance on cost as well as performance on quality measures. Performance is determined using standardized scoring, which indicates the number of standard deviations from the mean benchmark (expected value) a physician’s or group practice’s performance falls for a given measure. For more information, refer to pages 12–14 of the CMS 2013 QRUR Detailed Methodology document.*

Quality benchmarks are determined by the national mean for each measure’s performance rates in the year prior to the performance year—for example, 2012 data are used to determine the 2013 benchmark. However, cost benchmarks determined by the national mean of performance rates in the current performance year—meaning 2013 QRURs used 2013 data. All cost measures are also payment standardized to adjust for geographic differences, risk-adjusted based on patient characteristics, and adjusted to reflect the specialty mix of professionals in the group. For more information, refer to pages 25–27 of the CMS 2013 QRUR Detailed Methodology document.*

What information does the 2013 report include?

Physicians who were part of group practices of 100 or more eligible health care

professionals are subject to the VM starting in 2015 based on their performance in 2013. Therefore, the currently available QRURs provide information on how the group’s quality and cost performance in 2013 could affect their Medicare payments in 2015 under the VM. For physicians using tax identification numbers (TINs) and who participated in the Group Practice Reporting Option program in 2013, the 2013 QRURs also report the PQRS incentive payment earned in that year. For all other physicians, the QRURs provide a preview of how the group or solo practitioner may fare under the VM in the future. The VM will apply to all group practices and solo practitioners in 2017 and will be based on 2015 reporting.

Who has access to the reports? In October 2014, CMS made QRURs available to physicians and group practices that meet the following criteria:

- Had at least one physician who billed for Medicare-covered services under the TIN in 2013
- Had at least one quality or cost measure included in the QRUR related to at least one Medicare FFS case

The 2013 QRURs were not distributed to groups that did not have at least one physician or for which no quality or cost data could be computed. QRURs also currently are unavailable for groups and solo practitioners that participated in the Medicare Shared Savings Program, the Pioneer Accountable Care Organization Model, or the Comprehensive Primary Care Initiative in 2013.

Surgeons should follow the instructions on the CMS’ Quick Reference Guide for Accessing the 2013 QRUR document to obtain their report.†

Are resources available to help me understand my QRUR? Several resources are available to help surgeons understand their QRURs. On April 9, CMS hosted a webinar for American College of Surgeons (ACS) members regarding the QRURs. During this webinar, CMS walked through each element of the report and answered questions. A recording of the webinar is available at https://attendee.gotowebinar.com/recording/8136109334751154177. Additionally, several ACS and CMS resources comprise more information about the report (see sidebar, this page). ♦

References:
The North Dakota Rural Surgery Support Program: Providing surgical services to communities in need

by Robert P. Sticca, MD, FACS, and Mary O. Aaland, MD, FACS

Approximately 20 percent of the U.S. population lives in rural areas. In comparison with metropolitan locations, rural communities often are understaffed with health care providers. Most rural patients would prefer to receive their medical care in their own communities whenever the services are available. Unfortunately, for many rural communities, surgical care is very limited or nonexistent. The demand for general surgeons in rural locations is projected to be among the highest of any medical specialty in the next decade.1,2

To help ensure that surgical patients in the state have access to the care they need, the University of North Dakota School of Medicine and Health Sciences (UND SMHS) launched a Rural Surgery Support Program (RSSP) in July 2014. This column outlines the rationale for starting the RSSP, explains how it works, and describes the initial effects of the program.

Need for rural surgeons
Rural communities often have a difficult time recruiting and retaining general surgeons due to several factors, which are listed in Table 1 on page 59.3,4 Indeed, rural general surgery practices offer unique advantages and challenges. As the plight of the rural surgeon becomes increasingly apparent, health care leaders continue to search for solutions to some of the major problems associated with rural surgical practice.

Many rural hospitals rely on their surgeon(s) for financial viability. Many small rural communities have only one general surgeon who is often tasked with providing a broad
spectrum of surgical services, both in general surgery and other surgical specialties. In many critical access hospitals, the population and volume of surgical procedures can only support one surgeon who is often on call 24/7 for weeks at a time, leading to the most common problem for rural surgeons—surgeon burnout. Burnout and professional dissatisfaction can occur in response to the need for continuous coverage as well as multiple other challenges that face the typical rural surgeon.

Retention of rural surgeons is also adversely affected by the number of surgeons leaving rural practice after only a few years because of burnout. When a rural surgeon leaves a community, he or she leaves behind a huge gap in access to health care for patients in that area, which can affect the ability of the hospital to continue to offer inpatient services. The loss of regular surgical services also affects the retention of other core staff who are tied to the provision of regular surgical services, including certified registered nurse anesthetists, operating room nurses, surgical assistants, surgical technicians, and other ancillary personnel.

In North Dakota, surgeon shortages almost always happen

TABLE 1.
IMPEDEMENTS TO RURAL SURGERY RECRUITMENT/RETENTION

- Professional/social isolation
- Lack of practice coverage for vacations, attendance at continuing medical education programs, new skill training
- Lower reimbursement/increased expenses
- Limited resources and capabilities of rural hospitals
- Call coverage and lifestyle concerns
- Administrative requirements for practice maintenance
- Increasing regionalization of medical care
- Difficulty in recruitment and retention
- Decreased interest in broad-spectrum general surgery practice
- Increasing subspecialization in general surgery
- Lack of broad-based training for rural surgery practice

RSSP SUCCESS IN A RURAL COMMUNITY

Hettinger is a rural community in southwest North Dakota with a population of approximately 1,200, and the West River Regional Medical Center is the sole medical facility in the county. The only general surgeon, who practiced for more than 30 years, announced his intention to retire in 2009. Despite years of recruitment efforts and many offered incentives, the community was unable to replace its retiring surgeon, who left in 2013. Most of the recruited surgeons shied away due to lack of coverage for time away from the practice. With the advent of the RSSP in July 2014 and the ability to guarantee eight weeks of coverage per year, the medical center was able to recruit a full-time surgeon within two months, stabilizing the much-needed surgical services in this health care facility and the community.

Newspaper clipping from the September 26, 2014, Adams County Record
In its initial phase, the RSSP has provided practice coverage for rural surgeons, helped in the recruitment of a permanent surgeon for the community, and improved educational opportunities for hospital staff and physicians.

TABLE 2. UND SMHS RSSP: EXISTING AND PLANNED SERVICES

Existing
- Practice coverage—Two-week maximum
- Recruitment support and advice
- Continuing education in surgery and trauma

Planned
- Surgical credentialing
- Quality programs, including the American College of Surgeons National Surgical Quality Improvement Program
- Peer review

In recognition of the challenges facing rural surgeons in North Dakota, the department of surgery at UND SMHS developed the RSSP to aid rural hospitals and surgeons in the state. The purpose of the program is to stabilize surgical coverage in rural communities in need. The guiding principle is to meet the specific needs of the rural community, which are determined by invested community leaders, their surgeon(s), and the representatives from the RSSP. The program is flexible and can provide a range of support depending on the needs of each community (see Table 2, this page).

Several unique aspects of the medical environment in North Dakota necessitated and facilitated the development of this program. North Dakota is a rural state, and 87 percent (39 of 45) of the hospitals are classified as rural. Of the rural hospitals, 80 percent (31 of 39) are critical access hospitals, and 67 percent (26 of 39) have or would like to have the resources to provide surgical care (see map, page 61).

The UND SMHS is the only medical school in North Dakota, and it is sponsored by the state. The people of the state and their elected officials expect the medical school to develop programs to support the health care needs of rural communities. For many years, the rural communities of North Dakota have had difficulty recruiting and retaining general surgeons to rural hospitals. In its initial phase, the RSSP has provided practice coverage for rural surgeons, helped in the recruitment of a permanent surgeon for the community, and improved educational opportunities for hospital staff and physicians.
Other activities are planned as the program matures (see Table 2).

**Program initiation**
The RSSP program was established July 1, 2014, with initial startup funding from the UND SMHS and the North Dakota State Legislature. The program was designed to be financially self-sufficient within one year. A division of rural surgery was established within the department of surgery at UND, and a director, Mary Aaland, MD, FACS, a co-author of this column, was hired to develop the program. Dr. Aaland visited all rural hospitals in the state to explain the program and its benefits to rural hospitals. She received an overwhelmingly positive response from both hospital administrators and the rural surgeons. Initial coverage assignments were scheduled in October 2014 and have increased as the program has gained recognition.

**Program structure**
The program is administered by the department of surgery, with all contracts and revenues channeled through the department. Participating hospitals may sign up for a specific time period or implement an open-ended contract that will take effect when the need arises. An established fee structure is in place, which is based on length of coverage and services provided. The RSSP does not bill for any clinical activities or procedures that the covering surgeon provides. Clinical billing is the responsibility of the home institution, which retains all revenues from clinical services. The RSSP surgeon guarantees to provide and complete all necessary documentation to maximize clinical revenue for the institution. The only responsibilities of the home institution are the daily or weekly fee and the provision of appropriate housing for the RSSP surgeon. All other costs, including liability insurance, meals, and administrative expenses, are the responsibility of the RSSP program and calculated into the fee structure. The fees typically are 30 percent to 50 percent lower than at most locum tenens agencies, a savings that benefits the home hospital administration.

**Initial experience**
In the year since the RSSP began, both the initial response and the requests for use of the program have been impressive, reinforcing the authors’ belief that programs...
of this type can be very helpful and in some cases critical to stabilize rural surgery practices. Our experiences have identified some key components of the program that have resulted in benefits to rural surgery (see Table 3, this page). In areas with competing health systems, the neutrality of the sponsoring organization can be critical, as institutions are often leery of working with a program from a competing institution. Our community-based medical school serves well in this function because it does not have a hospital and works with all hospitals in the state to educate our physicians for the future.

The ability to have coverage provided by a surgeon who is known, licensed, and credentialed in the state has also been very valuable. The perception of that surgeon as someone who wants to help and preserve rural surgery practices and is available for post-assignment follow-up conversations has also been well received. In its first year of operation, the RSSP has scheduled assignments that will occupy almost the entire next year for Dr. Aaland, and we are now considering hiring another surgeon to meet the needs of the participating institutions.

In summary, the RSSP has been well received by rural hospitals that have been affected by the many challenges associated with maintaining rural surgical services. We anticipate that the program will continue to provide needed coverage and other services to help rural hospitals stabilize and maintain their surgical capabilities in North Dakota.

### TABLE 3.
**KEY COMPONENTS AND ADVANTAGES OF THE RSSP**

<table>
<thead>
<tr>
<th>KEY COMPONENTS</th>
<th>ADVANTAGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dedicated surgeon recognized and credentialed at participating institutions</td>
<td>Mutual familiarity between institution and covering surgeon, improved continuity of care</td>
</tr>
<tr>
<td>Neutrality of sponsoring organization</td>
<td>Elimination of concerns about competition between institutions or health systems</td>
</tr>
<tr>
<td>Cost</td>
<td>Significant savings for participating institutions</td>
</tr>
<tr>
<td>Availability</td>
<td>In-state availability of a surgeon familiar with patients and hospital systems</td>
</tr>
<tr>
<td>Credentialing</td>
<td>The covering surgeon’s credentials are obtained and maintained by administrative support, eliminating tedious and costly credentialing process for each assignment</td>
</tr>
<tr>
<td>Recruitment</td>
<td>Recruitment advantages for single-surgeon hospitals that are able to guarantee a specific number of weeks off for recruited surgeons</td>
</tr>
</tbody>
</table>

**REFERENCES**

Cancers of the stomach and esophagus are a substantial cause of morbidity and mortality worldwide. In the last 15 years, randomized data from the U.S. and Europe have emerged in support of multimodality treatment strategies for the management of resectable cases—specifically, preoperative chemoradiotherapy for tumors of the esophagus and perioperative chemotherapy or adjuvant chemoradiotherapy for gastric cancers. Also during this time, a growing array of novel targeted agents have been introduced and applied to the management of a variety of tumor types. More recently, studies have sought to improve the efficacy of existing approaches with more active therapeutic combinations.

**Treatment paradigms**

The two randomized trials upon which contemporary treatment paradigms for gastric cancer in the U.S. are based are Intergroup 0116 and the MAGIC (MRC Adjuvant Gastric Infusional Chemotherapy) trial. The former established the efficacy of chemoradiotherapy and 5-Fluorouracil (5-FU)/Leucovorin (LV) after surgical resection. The latter established epirubicin, cisplatin, and 5-FU (ECF) administered perioperatively as a first-line chemotherapy regimen. These two studies demonstrated similar survival advantages with disparate approaches. The apparent equipoise between these strategies has undercut efforts to establish a consensus approach.

A number of ongoing and recently completed clinical trials have been designed to reconcile different elements of these competing approaches. One such study is Cancer and Leukemia Group B (CALGB) 80401, a randomized phase III multicenter trial designed to determine whether a postoperative chemoradiotherapy regimen including ECF improves overall survival in patients with completely resected gastroesophageal (GE) junction or gastric adenocarcinoma compared to 5-FU/LV (as in the Intergroup 0116 regimen). Secondary endpoints examined were disease-free survival and adverse events. Between 2003 and 2009, 546 patients (5-FU/LV: 280; ECF: 266)—most of whom had locally advanced (T3/T4 or node-positive) disease—were randomized to adjuvant 5-FU/LV or ECF followed by 5-FU-based chemoradiotherapy. A similar proportion of patients in each arm completed therapy, although Grade 4 toxicities were higher in the 5-FU/LV arm. Three-year disease-free (46 percent versus 47 percent) and overall (50 percent versus 52 percent) survival were not significantly different between the 5-FU/LV and ECF arms. Treatment with either 5-FU/LV or ECF achieved a near-identical median survival (37 and 38 months, respectively) to that achieved with chemoradiotherapy (36 months) in the Intergroup 0116 trial.

**Combining treatment options**

Therapeutic options for the management of metastatic GE cancer remain limited. A growing understanding of the molecular pathways underlying tumorigenesis has prompted efforts to combine targeted...
therapies with conventional cytotoxic chemotherapy. Targets of interest include the human epidermal growth factor (HER) family receptors (for example, epidermal growth factor receptor [EGFR], HER2 and HER3), among others. ToGA (trastuzumab for gastric cancer), a large phase III trial in metastatic gastric cancer examining the role of HER2-targeted therapy using trastuzumab in addition to cisplatin plus capecitabine/5-FU, showed significantly improved objective response rates (35 percent to 47 percent, p=0.0017), progression-free survival (5.5 to 6.7 months, p=0.0002), and overall survival (11.1 to 13.8 months, p=0.0046) in the trastuzumab arm.3

While early studies indicated efficacy of agents targeting EGFR in proximal gastric and esophageal cancers, more recent randomized phase III trials (panitumumab in REAL-3 and cetuximab in EXPAND) have not reproduced this success.4,5 In parallel with these observations, CALGB 80403/Eastern Cooperative Oncology Group 1206 was conducted as a phase II multicenter trial designed to determine objective response rates in patients with chemotherapy-naive and metastatic adenocarcinoma or squamous cell carcinoma of the esophagus or GE junction (Siewert I/II) randomized to combinations of anti-EGFR monoclonal antibody cetuximab (C) with three disparate regimens: (a) ECF, (b) IC (irinotecan/cisplatin), or (c) FOLFOX (5-FU/LV/oxaliplatin) (see figure, this page). Between 2006 and 2009, 245 patients (ECF-C: 82, IC-C: 83, FOLFOX-C: 80 patients) were randomized: Stratify by: ECOG 0-1 vs. 2 Adenocarcinoma vs. SCC

**ECF + cetuximab (n=82)**
- Weekly cetuximab
- Epirubicin
- Cisplatin
- 5-FU

- Objective response rate (CR+PR) = 57.8%
- Grade 3–4 toxicity = 75%
- Median OS = 11.5 mo

**IC + cetuximab (n=83)**
- Weekly cetuximab
- Cisplatin
- Irinotecan

- Objective response rate (CR+PR) = 45.6%
- Grade 3–4 toxicity = 86%
- Median OS = 8.9 mo

**FOLFOX + cetuximab (n=80)**
- Weekly cetuximab
- Oxaliplatin
- 5-FU
- Leucovorin

- Objective response rate (CR+PR) = 53.6%
- Grade 3–4 toxicity = 79%
- Median OS = 12.4 mo
These studies, and others that have yet to mature, add to our growing understanding of these diseases, but they also underscore the significant gaps in our knowledge.

**REFERENCES**


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**Unanswered questions**

These studies, and others that have yet to mature, add to our growing understanding of these diseases, but they also underscore the significant gaps in our knowledge. It remains difficult to reconcile elements of existing randomized studies on resectable gastric cancer (for example, the efficacy of perioperative but not adjuvant chemotherapy alone in the U.S., and the apparent need for adjuvant radiotherapy in the U.S. but not in Asia).

It also remains clear that the promise of targeted therapies has not been fulfilled for many of the more aggressive malignancies. Further studies are needed to address these challenges and provide a basis for more effective treatments. ♦
Before World War II, postoperative infections were the most common causes of surgical complications and deaths and would create havoc for hospitals, surgeons, and patients. One of the primary methods of preventing infections was the proper application of a dressing on the wound at the completion of an operation, with daily dressing changes occurring until the wound healed.

**ACS study**
In 1928, the ACS Hospital Research and Information Department conducted a study of the types and numbers of dressings used in hospitals. The investigators estimated that the average hospital, performing 10 operations per day, would use 545,000 dressings per year on surgical patients.* Most dressings were made by hand to the specifications of the hospital and often to the individual surgeons. Dressings were usually stitched by the hospital’s nurses, forcing them away from their more important patient care duties. The materials used to make dressings, such as gauze and cotton, were not standardized, although detailed specifications for gauze were recommended by the U.S. Department of Commerce in 1928.

The ACS study showed that more than 5,000 types of dressings, such as laparotomy pads or sponges of various sizes, were used in the nation’s 7,000 hospitals, and as many as 1,500 varieties of a single type of dressing were used for the same purpose, such as a sponge for absorbing blood during a laparotomy.

ACS leaders believed that reducing the types of dressings and their variations would save hospitals money, eliminate material waste, and reduce the workload burden on nurses. Committed to achieving these goals, the College undertook the standardization of dressings in 1930.

**College standardization**
The standards, which were published in the June 1930 issue of the Bulletin, categorized dressings into the following eight classes*:

- Sponges for wiping blood and fluids
- Abdominal packs for walling off organs during operation
- Sterile gauze dressings to cover incisions during an operation
- Pads to absorb drainage after operations
- Gauze drains and tampons
- Bandages
- Binders
- Dressings for specialized purposes

Specifications were established for dressings of different sizes in each class, such as large, medium, small, and pointed tonsil sponges. The fabrication for each sponge was explained in minute detail. For example, the creation of a small 2” x 2” sponge was explained through the following steps:

ACS leaders believed that reducing the types of dressings and their variations would save hospitals money, eliminate material waste, and reduce the workload burden on nurses.

Cut 20” x 12” gauze to 6” x 6”, folded to approximately 1¾” x 1½”, 12 ply. Fold over two opposite edges ½”. Bring other two edges to center line of cut gauze. Fold again at same center line, giving piece four ply, approximately 1½” x 5¼”. Fold each end in so that length is divided into three equal parts, giving finished sponge approximately 1¾” x 1½”.

Cotton or cellulose wadding was incorporated between layers of gauze for absorbent dressing pads and maternity pads. Abdominal packs were quilted by sewing along the edges and at designated points of length and width. Additional instructions were given regarding the use of abdominal packs:

- It is advisable that intra-abdominal sponges, packs, or rolls be rendered visible to the X ray by means of dyes or by inclusion in the fabric of a metal object, such as a disk or flat ring, which should be well covered with fabric, securely fastened, and non-corrosive. No sponge, dressing, or similar article should be allowed to enter or to remain in a cavity during an operation unless firmly anchored to a tape or a heavy cord extending to the outside and having a metal ring, disk, or forceps attached to the outer end.

The impact of standardization

These requirements for abdominal packs, or laparotomy pads, became the standard for every hospital in the nation, and they remain the standard to this day. They have saved an untold number of patients from the complications of retained sponges and the additional operations needed to remove them.

The ACS classification and specifications for dressings markedly reduced the varieties of dressings used throughout the country. The need for larger quantities of more specific types of dressings meant an expanded market for ready-made dressings, a void which commercial firms rapidly filled by using mass production techniques.

Within a few years of implementing dressing standards, the College had achieved its goals of reducing hospital costs, eliminating waste, and returning nurses to the bedside. ♦
The Joint Commission continues to receive reports of wrong procedure, wrong patient, wrong site, and wrong side operations. Although reporting these events is not mandatory in most states, some estimates put the national incidence rate as high as 40 per week.* Wrong site surgery can have devastating consequences for patients and health care providers, and it can be extremely costly to health care organizations.

To help organizations reduce the occurrence of this type of event, The Joint Commission Center for Transforming Healthcare launched its Targeted Solutions Tool (TST) for Wrong Site Surgery in 2012. This online tool, highlighted in the October 2012 issue of the Bulletin (page 60), guides accredited organizations through a free, step-by-step process to identify, measure, and reduce risks in key processes that may contribute to wrong site surgery.† Over the last three years, the TST has undergone several improvements that have led to better results.


The TST has proven to be an effective patient safety and quality tool since its launch. The original participating institutions were able to use the TST for Safe Surgery to assess their internal risks for wrong site, wrong side, and wrong patient surgery and then to apply the suggested solutions.

Changes to the TST
To more accurately depict the purpose of the TST, the center renamed it the TST for Safe Surgery in late 2014. The TST for Safe Surgery remains an online application that helps health care institutions evaluate risks across their surgical departments and divisions, including scheduling, preoperative, and operating room (OR) areas. The TST does the following:

• Allows a health care institution to critically assess its entire system of care for operative and interventional procedures, from the time a patient gives consent through the completion of the operation

• Identifies specific risk points in the scheduling of procedures, in preoperative care or services rendered in the preoperative holding area, and in the OR that could potentially lead to a wrong site surgery event

• Standardizes practices and promotes consistency in perioperative processes across multiple physicians and health care professionals within the same organization

• Encourages safe surgery practices that are critical to patient safety

In addition, the TST for Safe Surgery can help organizations determine how well health care professionals are adhering to an existing safe surgery checklist and provide data that can be used to make the checklist more effective.

A useful tool
The TST has proven to be an effective patient safety and quality tool since its launch. The original participating institutions were able to use the TST for Safe Surgery to assess their internal risks for wrong site, wrong side, and wrong patient surgery and then to apply the suggested solutions. On subsequent analysis, these changes led to a reduction of this risk by 46 percent in the scheduling area, 63 percent in the preoperative area, and 51 percent in the OR area.‡

“‘There are few things that can be more personally devastating to a surgeon than performing an operation on the wrong patient or the wrong site,” said ACS Immediate Past-President Carlos A. Pellegrini, MD, FACS, FRCSI(Hon), The Henry N. Harkins Professor and Chair, department of surgery, University of Washington, Seattle. “Unfortunately, many surgeons do not realize the ease with which a chain of events can be started that can lead to wrong site surgery. Whether it was communication with the scheduler in the clinic, or a wrong click in the computer when selecting a box indicating ‘right’ or ‘left,’ or an X ray that was looked at or interpreted backwards, the event can happen and the only way to avoid the error is to create enough safety barriers to minimize its occurrence. I encourage my colleagues to review the TST for Safe Surgery along with those in their organization that focus their work on patient safety and quality.”

The TST for Safe Surgery is available free of charge to all Joint Commission-accredited institutions, along with the center’s other TSTs for hand hygiene and hand-off communications. In late 2015, the center plans to launch the new TST for Preventing Falls. To learn more about the center, visit centerfortransforminghealthcare.org.
Inhalation injury is a topic well studied and strongly associated with high rates of morbidity and mortality. The temperature and composition of the toxins that result from combustion rapidly attack tissues and disseminate quickly to the cellular level. This lethality has been exploited throughout the history of warfare. In 423 BC, Spartan general Thucydides recorded the earliest use of a toxic inhalant. Later, Pliny the Younger used inhalation as a form of execution, subjecting caged victims to smoke from burning greenwood. His uncle, Pliny the Elder, died in 79 AD in the eruption of Mount Vesuvius. His body was found two days later beneath the ash, with no apparent external injuries.

Assault on the respiratory system
The assault of inhalation injury first begins in the oral cavity and oropharynx with microvascular changes that lead to edema. The cascading inflammatory process involves complement histamine and reactive oxygen and nitrogen species. The ensuing edema with absent capillary integrity is compounded by increased microvascular pressure and decreased plasma oncotic pressure from large volume resuscitations. Airway patency is soon compromised and can quickly lead to death if the health care provider does not anticipate these changes.

Although less common, thermal injuries to the tracheobronchial tree can occur with explosions or with forceful entry of steam pushing past the glottis. Gases are typically cooled before entering the larynx and more distal areas. More commonly, injuries to these areas are secondary to chemical irritants and toxins. The caustic materials trigger additional inflammatory responses, resulting in hyperemia and shedding of columnar epithelium. Similarly, changes in bronchial microvasculature, along with hyper-secretion of goblet cells, form exudative casts that can block already edematous, constricted, and inflamed airways. Changes to the lung parenchyma are delayed, typically seen 18–24 hours after injury with worsening edema, compliance, and PaO$_2$/FiO$_2$ ratios.

Systemic toxicity results from the smoke’s components; the destructive array can vary depending on the industrial compounds involved. For example, combustion of
ubiquitous materials such as cellulose and polyvinyl chloride produce carbon monoxide (CO). The affinity of CO for hemoglobin is 200 times greater than that of oxygen, creating carboxyhemoglobin (COHb). Not only does the oxygen-hemoglobin dissociation curve shift to the left, but CO also inhibits cytochrome-a and P-450 enzyme systems. Ultimately, less oxygen is available to the tissues, and cellular systems are also prevented from using oxygen.

There are special considerations with this pathology. To achieve resuscitation, thermal injuries accompanied by inhalation injury will require increased volumes of fluid by as much as 50 percent above those predicted through standard formulas. The concern for worsening pulmonary edema should not prompt clinicians to restrict intravenous fluids; on the contrary, the lung microvascular permeability changes seen with inhalation injury are worsened by inadequate fluid resuscitation. Furthermore, conventional pulse oximeters cannot distinguish between oxyhemoglobin and COHb; therefore, COHb must be measured via arterial or venous CO oximetry. A quantitative level can assess the severity of injury and dictate the urgency and aggressiveness of treatment and intervention.

Inhalation injury is an independent risk factor for mortality. Mortality indices, such as the revised Baux score, include burn size, age, and inhalation injury. The presence of inhalation injury adds the equivalent of 17 years to a patient’s age or an additional burn surface area of 17 percent. Ultimately, smoke inhalation is the leading cause of death due to fires. For those patients who do survive, long-term sequelae can result from laryngeal damage causing persistent hoarseness and dysphonia, and some patients may show obstructive and restrictive patterns on pulmonary function tests as many as eight years after injury.

**NTDB findings**

To examine the occurrence of inhalation injuries in the National Trauma Data Bank® (NTDB) research dataset for 2013, admissions medical records were searched using the International Classification of Diseases, Ninth Revision, Clinical Modification diagnosis codes. Specifically searched were records that contained one of the following external cause of injury codes (E-code): E890.1 (fumes from combustion of polyvinylchloride [pvc] and similar material in conflagration in private dwelling), E890.2 (other smoke and fumes from conflagration in private dwelling), E891.1 (fumes from combustion of polyvinylchloride [pvc] and similar material in conflagration in other and unspecified building or structure), or E891.2 (other
Activities that generate smoke, such as a campfire, barbecues, or an old-fashioned fish boil, may be tantalizing to watch. However, being confined in an enclosed space with all smoke and no fire can lead to a devastating and potentially fatal injury.

References

Dear sir or madam,

To whom it may concern,

Dr. Thal remembered for his love of medicine

I was saddened to read of the death of Erwin Thal, MD, FACS. I knew Dr. Thal well, as I was a resident in neurosurgery at Parkland Hospital, Dallas, TX, while he was in his general surgery residency. As noted in the obituary (Bull Am Coll Surg. 2015;100[2]:40), he was an accomplished surgeon and a leader in the field of trauma. However, the characteristic of his persona that I grew to respect the most, not mentioned in the text but captured in the accompanying photographs, was his love of medicine and the unquantifiable joy he took in his practice. Just look at the smile captured in the published portrait! That was Dr. Thal.

At times, that joy bubbled over to infect all around him. One day in 1988, I was flying from San Antonio, TX, to Washington, DC, with a scheduled stop in Dallas. On the flight from San Antonio to Dallas I rapidly developed intense and severe abdominal pain. As soon as the plane landed, I called a friend in Dallas and told him to find Dr. Thal, and tell him that I was in a cab on my way to Parkland Hospital with an acute abdomen. The cab driver through the dispatcher repeated the message. I was assured Dr. Thal had gotten the message and was waiting for me in the emergency department (ED).

Upon arrival, I stumbled from the cab, through the swinging doors, into the triage lobby of the ED. There was Dr. Thal—all five feet and five inches of him—wearing his long white coat and his brilliant, comforting smile. Surrounding him were about 25 students, interns, and residents all in long white coats, “ready to care for you,” as he put it. By the time they had me on a gurney, I was feeling better, knowing he was there, as I passed, otherwise uneventfully, my first kidney stone. Medicine and surgery, and especially the College, have lost a true ambassador of the profession.

A moment of silence, please.
Clark Watts, MD, FACS
Georgetown, TX

Addressing the source of surgeon burnout

I truly enjoyed the article on managing burnout in the March issue of the Bulletin (Bull Am Coll Surg. 2015;100[3]:26-29) and agree that this problem is growing in surgery as more surgeons become employees of large organizations. Unfortunately, the article does not provide systemic methods to prevent burnout, but
rather treats it like an individual problem. Christina Maslach carefully elucidates in her 1997 book *The Truth about Burnout—How Organizations Cause Personal Stress and What to Do about It* (Jossey-Bass) that burnout is a consequence of systemic organizational problems, and she offers solutions to it, including the following:

- Set reasonable work expectations
- Give workers control
- Reward and recognize in a way that is meaningful for the individual
- Build community in the workplace
- Build fairness in the workplace. A workplace is perceived to be fair when three key elements are present: trust, openness, and respect
- Develop, communicate, and live organizational values

Exercise, hobbies, and spending time with friends and family may improve a surgeon’s quality of life, but to truly prevent burnout, the individual must work in a functional workplace. As more surgeons become employees of large health care systems, it is the responsibility of these systems to provide a supportive, meaningful, and fair workplace.

Charles M. Ferguson, MD, FACS
LaGrange, GA

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**PreOp program applauded**

The exceptional May 2015 issue of the *Bulletin* contained many gems, including the articles on “going green” in the operating room, corneal transplants in developing countries, principles for surgeons, and the one that resonated so deeply with me—“PreOp program: Can we achieve a ‘trickle-up’ effect?”

At Cornell University Medical College, New York, NY, in April 1959, I finally had my surgical rotation under the New York Hospital greats like Frank Glenn, MD, FACS, with two months to go in my senior year. Internships had long been solidified, and I was headed for straight medicine at NY Hospital. The thrill, joy, wonder, and the “fixing it today” aspect of the surgical theatre was a complete revelation for me, and I knew that I, who could repair and build anything from electric systems to leaking faucets, belonged in surgery. I kept my promise to fulfill the internship and after that was completed, began my surgical residency, albeit not very proficient at tying sutures for a while, at the University of California, San Francisco.

Had I been privileged to scrub in and participate in surgical procedures earlier than my last two months of medical school, the path would have been a bit shorter, and, as described in the article, I would have “loved the operating room” much sooner. The program outlined by the authors is worthy and is “an opportune time to pique medical students’ interest in surgery and guide them toward surgical careers.”

John N. Baldwin, MD, FACS
Twain Harte/Monterey, CA
2015 Leadership program:
Leading with influence and overcoming resistance to change

by Tony Peregrin

“Each of you is here because of your role as a leader,” said Patricia L. Turner, MD, FACS, Director, American College of Surgeons (ACS) Division of Member Services, in her opening comments at the fourth annual Leadership & Advocacy Summit, April 18–21, at the JW Marriott, Washington, DC. “This year’s program features actionable topics that each of you may employ at your home institution,” she added, referring to presentations covering an array of leadership issues, including the following: overcoming resistance to change, moving from a transactional to a transformational leadership style, managing physician burnout, and negotiating employment contracts.

Part of a dual meeting held in conjunction with the Advocacy program, the 2015 Leadership sessions also featured success stories from ACS chapters in Tennessee, Louisiana, and Pennsylvania. Attendees met in breakout groups organized by state and region after these presentations to identify opportunities for chapter development and enhanced member engagement. (Member Services staff are compiling the information presented in the breakout session reports and will provide a summary of these presentations later this year.)

The 2015 Leadership & Advocacy Summit drew 417 attendees representing all levels of ACS leadership, including Regents, Governors, Advisory Council Members, Chapter Officers, Resident Member leaders, and others.

“Broker and build relationships with surgeons in your own communities,” suggested Dr. Turner, who noted the steadily increasing number of summit participants each year as an example of how surgeons are continuing to seek innovative ways to connect with each other and learn how their peers are leading with influence while overcoming resistance to change.

Leading with influence

“People don’t follow you because of what you do, they follow you because of who you are,” according to Doug McKinley, PsyD, MCC, managing partner of Xcellero Group, Naperville, IL. Dr. McKinley, an expert in the leadership development of medical professionals and hospital and health care administrators, said leading with influence is more effective than leading from a position of authority in fostering long-term change. “Leading with influence means changing minds,
Dr. McKinley...said leading with influence is more effective than leading from a position of authority in fostering long-term change.

hearts, and actions,” Dr. McKinley said, while leading with persuasion simply “involves getting someone to say yes or no, without getting to underlying behaviors.”

Leading with influence, according to Dr. McKinley, starts with an understanding of what he calls the three elements of credible communication: tone (38 percent), nonverbal communication (55 percent), and words (7 percent). Each percentage describes the relative effect of tone, nonverbal communication, and body language when speaking with others. He emphasized the importance of recognizing communication cues that an individual may not realize he or she is exhibiting, especially nonverbal cues (for example, posture or eye contact) that might diminish a person’s ability to lead by influence.

“Assuming that others do contrary things because it’s in their makeup or they actually enjoy doing them—and ignoring any other potential motivational forces—is a mistake,” Dr. McKinley said.

Additionally, he encouraged summit participants to “make sure your story aligns with your values and beliefs” to amplify an individual’s ability to lead by influence. “What are your beliefs? How do you see yourself?” he asked, adding, “If I am in a conversation with you and you don’t believe me, the conversation is not productive. If you don’t believe who I am, you won’t believe me as leader.”

Chapter success stories
The achievements of the Tennessee, Louisiana, and the four Pennsylvania Chapters were shared by ACS chapter officers with the aim of inspiring other chapters to boost member engagement and satisfaction and to improve chapter effectiveness.

Tennessee Chapter
Daniel Beauchamp, MD, FACS, deputy director, Vanderbilt-Ingram Cancer Center, Nashville, TN, and President, ACS Tennessee Chapter, noted several accomplishments over the last year, particularly an increase in dues-paying members. He also highlighted improved patient outcomes as a result of the Tennessee Surgery Quality Collaborative (TSQC).

“We traditionally have a low rate of members paying dues, and we have made a concerted effort to engage regional leadership to make personal calls and send e-mails to those individuals who are on the member roster but are not paying dues,” Dr. Beauchamp said. In 2014, dues-paying members were up nearly 11 percent from 2013 and 18 percent from 2012.

The TSQC is a unique partnership between the Tennessee Chapter of the ACS, the Tennessee Hospital Association, and the BlueCross BlueShield (BCBS) of Tennessee Health Foundation. The program began with 10 hospitals in 2008 and grew to 22 hospitals by the first quarter of 2012, and, according to Dr. Beauchamp, these hospitals perform more than half of the general and vascular surgeries in the state. TSQC cumulative improvements from 2009 through the third quarter of 2014 include the following:

• 42.9 percent decline in mortality
• 2,332 fewer cases with surgical site infections
• 3,602 fewer patients with a postoperative occurrence
• $56.3 million savings in complications-related costs

According to Dr. Beauchamp, for 2015 and 2016, the BCBS of Tennessee Health Foundation
Dr. McKinley

Dr. Beauchamp

Mr. Campbell

has offered funding for half of the total cost of participation, including program fees and the required clinical abstractor. The six current rural TSQC hospitals will also receive a small grant to cover 25 percent of their costs.

**Louisiana Chapter**

Members of the ACS Louisiana Chapter accomplished two primary goals over the past year, according to William S. Richardson, MD, FACS, a bariatric surgeon at the Ochsner Medical Center, New Orleans, LA, and ACS Governor. The chapter hosted mock oral examinations, administered by Fellows, for postgraduate year-4 residents, and expanded its social media presence.

This year’s mock oral exams included 20 examiners and 14 resident participants, with 10 chapter members donating the use of their hotel rooms at the chapter’s annual meeting for the exams.

To expand its social media capabilities over the last year the leaders of the Louisiana Chapter redesigned its website to create a more responsive design that is more user-friendly on smartphones and tablet devices. The chapter continues to be active on Facebook and Twitter to promote announcements, annual meeting information, and chapter dues-related postings.

**Pennsylvania Chapters**

Following up on the chapter success story he presented at the 2014 Leadership & Advocacy Summit, Francis D. Ferdinand, MD, FACS, FRCS, FACC, a thoracic and cardiac surgeon at Lankenau Medical Center, Wynnewood, PA, and ACS Governor for Pennsylvania, emphasized the importance of leaders in states with multiple chapters working together to find areas of synergy. “We were like silos in the farms in Lancaster County,” said Dr. Ferdinand, referring to the state’s four chapters—Metropolitan Philadelphia, Keystone, Northwestern, and Southwestern. He credited previous Leadership Summit meetings for revitalizing inter-chapter communication in Pennsylvania, which he said is particularly key when it comes to advocacy-related issues.

Dr. Ferdinand encouraged chapter leaders to leverage the ACS Communities to foster communication, particularly in states with multiple chapters. The ACS Communities, which can be accessed through the facs.org home page, is the College’s members-only communications tool, where members may share information and experiences and build professional relationships. “It’s important to have strong relationships with the College because it makes our job easier and [allows us to] achieve great things,” Dr. Ferdinand said, referring to the opportunities provided by ACS Communities to connect with both colleagues and College leaders.

**Transformational leadership**

Moving from transactional leadership—a managerial mindset that focuses primarily on getting the job done—to a transformational leadership style that inspires team members to develop creative and enduring solutions was the focus of What Got You Here Won’t Get You There, presented by Ron Campbell, PhD, director, Leadership Research Institute, San Diego, CA. Developing a transformational leadership approach, according to Mr. Campbell, involves redefining what it means to be successful versus effective. A successful leader prompts team members to complete a task by virtue of his or her title or position of authority, whereas an effective leader is
Dr. Gracias Mr. Burke Mr. Kindler

someone who fosters productivity by being a mentor and developing team members’ skill sets.

“What got you here is being a successful leader,” said Mr. Campbell, “but what gets you to the next level is recognizing the bad habits that prevent you from being an effective leader.” Mr. Campbell outlined examples of negative leadership habits, including the following:

• Winning too much (overly competitive behavior)

• Adding too much value (the urge to add one’s “two cents” to every conversation)

• Starting statements with “no,” “but,” or “however” (overuse of negative qualifiers)

• Punishing the messenger (misdirected and nonproductive criticism)

• Withholding information (refusing to share information to leverage an advantage over others)

Surgical leadership of the future
Surgeons who want to effectively lead hospital and academic systems in the future must identify the differences between leaders and managers, according to Vincente Gracias, MD, FACS, interim dean, professor of surgery, and chief of acute care surgery, Rutgers Robert Wood Johnson Medical School, New Brunswick, NJ. “Managers deal with the status quo, while leaders deal with change. Managers work in the system, enforce the rules, and coordinate effort and alignment, while leaders work on the system, change organizational rules, and coach and empower self-leaders,” Dr. Gracias noted in his presentation, Cultivating Surgical Leadership: The Next 100 Years. Dr. Gracias was introduced to session attendees by Joseph V. Sakran, MD, MPH, FACS, Chair, ACS Resident and Associate Society.

In an Ohio State University leadership study conducted in the 1940s—one that is still widely cited today, according to Dr. Gracias—survey respondents listed two essential components of leadership: “initiating structure” (task-oriented leaders) and “consideration” (people-oriented approach.) “We love working around the operating room table, but we have to also enjoy working around the conference room table,” said Dr. Gracias, emphasizing the importance of both leadership styles.

The future of successful surgical leadership will require physicians to learn to motivate without fear, which is especially important in reaching quality metrics. Dr. Gracias suggested motivating staff with additional training, appropriate recognition, and shared goals.

“Surgeons are leaders—born or forged,” Dr. Gracias said in closing. “If we can learn to manage, we are the perfect storm to help design the future of health care.”

Resiliency: Overcoming burnout
In Resiliency: Overcoming Physician Burnout, Andy Kindler, PsyD, MCC, managing partner, Xcellero Group, emphasized the importance of identifying the symptoms of burnout and providing strategies for developing a more buoyant career and home life. “The problem with burnout is that it’s invisible…and we don’t want to admit we are experiencing it,” said Mr. Kindler. “It’s a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who do people-oriented work of
Citing research published in the October 2012 issue of the *Archives of Internal Medicine*, Mr. Kindler noted that of 7,288 physicians, 45 percent reported at least one symptom of burnout. About half of the session participants raised their hands when he asked if they or someone they knew has suffered from burnout.

Mr. Kindler highlighted his personal struggle with burnout as a business executive. He said the key to overcoming burnout is recognizing the symptoms, which may include the following:

- Emotional exhaustion: Feelings of being emotionally overextended and exhausted by one’s work
- Depersonalization: Unfeeling and impersonal response toward recipients of one’s service, care treatment, or instruction
- Decreased feelings of personal accomplishment: Diminished sense of competence and successful achievement in one’s work

“Denial is not a solution,” Mr. Kindler said. “Rebuild your resilience by raising your positivity ratio—halt the negative self-talk—and by reframing your current reality objectively versus emotionally.”

**Employee contracts**

Michael Burke, JD, Kalogredis, Sansweet, Dearden and Burke, Ltd., Wayne, PA, presented Understanding and Negotiating an Employment Agreement, which included practical information on negotiating compensation; restrictions on practice; and “practice specifics,” such as duties, scheduling, and outside services or “moonlighting.”

“When negotiating an employee contract, remember you will not obtain every change that you desire, so focus on key provisions, especially within a health system environment, and make sure you understand what it is you are agreeing upon,” Mr. Burke advised. He noted that contract practice specifics are typically general in terms of duties, and scheduling provisions are often vague, but he suggested that potential part-time employees push for more specifics, particularly regarding schedule.

Mr. Burke said many employee agreements require “exclusive service” for moonlighting or performing outside services, meaning that it is necessary to obtain employer consent before engaging in outside services. Provisions for nonclinical work, such as speaking, writing, or expert witness work, may be set forth in an agreement.

“One of the first things all physician clients turn to in an agreement is the section on compensation,” Mr. Burke said. “While many agreements still include base salary, incentive compensation may be at the employer’s sole discretion. Look for comparables from friends and colleagues when negotiating compensation,” he advised.

Most employers pay liability insurance, according to Mr. Burke, although physicians negotiating an employment contract need to be cognizant of the type of insurance provided. If the employer is providing “occurrence-based” liability insurance, then no “tail coverage” is required upon termination, and the employee does not need to be concerned about the continuation of coverage after leaving the employer. If the coverage is “claims-made,” then tail coverage may be needed for claims filed after termination for services performed before termination.
Managers work in the system, enforce the rules, and coordinate effort and alignment, while leaders work on the system, change organizational rules, and coach and empower self-leaders,” Dr. Gracias noted in his presentation, Cultivating Surgical Leadership: The Next 100 Years.

A FELLOW’S PERSPECTIVE ON THE SUMMIT

Why are you here?
To lead, to advocate, and to connect

by Kathryn A. Hughes, MD, FACS

Why are you here?
I was asked this question more than once at the American College of Surgeons (ACS) Leadership & Advocacy Summit. As a practicing community surgeon, I seem to have struck some of the other surgeons as an unusual participant in the 2015 summit.

But my presence didn’t seem all that unusual to me. I want to share why I felt that way and why next year you should also consider accepting your invitation to participate. As Patricia L. Turner, MD, FACS, Director, ACS Division of Member Services, noted early on in the program, many of our colleagues now participate in the summit, and attendance and interest have grown steadily each year since the summit began in 2012. This year’s numbers were the highest to-date.

As for me, I attended for two reasons: leadership and advocacy. OK, three: connection.

All surgeons are leaders
As surgeons, we are trained to head our clinical teams, starting with our team in the operating room. This expands to the clinical teams we lead, as with trauma and burn care, breast and cancer care, and the myriad other clinical, educational, administrative, and management teams that define our practices. The team concept is ingrained in our training and approach to care, positioning surgeons well as the team concept expands to other clinical specialties, practices, and care-delivery models. Even starting in these small ponds, we lead.

These experiences, and the character and charisma we have developed in our operative and clinical training and practice, draw many surgeons into positions of leadership in their hospitals, organizations, and communities. We have a tendency to take charge and to act (even if we sometimes must work on our tact) because that is what surgeons do. It’s who we are. And as we become comfortable leading in one pond, we jump to another, this one a little larger, then on to the next bigger pond. Whether in a large academic practice, a state or national organization, or a small community setting—wherever we answer the call to lead, it is continued on next page

There are specific “boilerplate provisions” in every employment agreement that physicians should carefully review, according to Mr. Burke. “The ‘entire agreement’ clause constitutes the entire understanding between employer and employee related to its subject matter. All oral or written correspondence or discussions are superseded by this agreement. I always tell my clients, if it’s not in the agreement—even if it was in the agreement letter— the employer did not specifically agree to it,” Mr. Burke explained.

The “notice provision” is another boilerplate provision that physicians should review because it defines how formal written notices are to be given, which is important for employees when receiving a notice of termination without cause, for example, or when the physician is providing notice that they intend to leave the employer.

“Try to be as educated about the process as possible and remember not to take the [negotiation] process personally. If necessary, have a health care attorney review the agreement,” Mr. Burke advised.

Innovative leadership
“Physicians, I would argue, are natural leaders, and creativity is the most desirable leadership attribute,” said David B. Hoyt, MD, FACS, ACS Executive Director, during his Leadership Summit closing remarks. A key “principle of innovation,”
A FELLOW’S PERSPECTIVE, CONTINUED

important to embrace any opportunity to enhance and enrich the skills we need to be successful leaders, such as those presented at the summit.

All surgeons are advocates
We advocate every day on behalf of our patients. Every time we must confront an insurance company to cover a procedure or a test, every time we meet with administrators to add to the capital budget so we can update our equipment, every time we sit with our patients and their families to educate them about and discuss treatment options and plans, we are advocating. All of these things that we do in the day-to-day care of our patients and in the communities we serve are about advocating.

Advocacy for our patients is a core principle of medicine and surgery; just as surgeons are drawn to leadership roles, we are similarly compelled to weave advocacy efforts into the fabric of our work. It is natural, then, to be drawn from the lower-case advocacy of our daily work to upper-case Advocacy, organizing and working with our peers to expand that service to the larger community, the state, and the nation; and to serve not just the constituency of our patients, but our peers, colleagues, organizations, and institutions.

Leadership and advocacy walk together and work together, as the scope of our service expands and grows. Connection and communication are both the tools and the foundation in the work of leadership and advocacy.

Connection
Connection is the third big reason I attended the Leadership & Advocacy Summit. More than just mingling and networking—although the summit was an excellent opportunity for that, too—I reunited with old friends and colleagues and met new ones. The summit even gave me the chance to meet surgeons I have been connected with virtually through the Internet and social media. I hope to maintain, or even build on, these connections beyond the space of the meeting itself. Just as connection and communication form the foundation on which leadership and advocacy are built, they are also the foundation for collaboration.

At this time when we are experiencing so many things that divide our profession as physicians, and our discipline as surgeons, connection and communication help build the bridges we need to work together to

continued on next page
participate in MIPS in a way that best fits their practice environment.

An emphasis on providing quality care will continue to be a top priority for the ACS, and Dr. Hoyt outlined several ongoing initiatives, such as a surgical quality manual currently in development; ACS support of the American Society of Anesthesiologists perioperative surgical home model of health care delivery; the development of guidelines for the perioperative care of geriatric patients; and ACS collaborative efforts with the Strong for Surgery project, which identifies evidence-based practices to optimize the health of patients before surgery.

Challenges presented by these and other new quality initiatives are best met by surgeons who embody the characteristics of strong leadership, Dr. Hoyt said. It is up to surgeons to take the lead on important issues in order to propel the profession into the future.

The fifth annual Leadership & Advocacy Summit will take place April 9–12, 2016, at the JW Marriott in Washington, DC.

Where will you be?
If you keep quiet because you think your voice does not matter or that you will not be heard, then you will be proven right. If you do not get involved because you think that you will not make a difference, you won’t. Only by speaking up can you have the chance to be heard. Only by becoming involved will you have a chance to make a difference. You may be met with indifference or skepticism, even outright opposition. Your audience may be small. The impact of your efforts may seem insignificant. But if you speak, if you act, you can have an effect. Even a small impact matters. It only takes one or two others to hear you speak or to observe your actions to follow your lead and magnify your efforts. The ideas spread; the effect grows. When that happens, you have become a person of influence and a leader.

This is why I was there. This is why all of us were there. This is why next time, you should be there, too.

Will you be in Washington, DC, next April?
2015 Advocacy program: Attendees learn the power of a unified voice

by Kevin R. Walter

The Advocacy portion of the fourth Leadership & Advocacy Summit of the American College of Surgeons (ACS), April 18–21 in Washington, DC, provided a forum to highlight the power surgeons have in influencing laws and policies that affect patients and the profession. More than 300 people registered for the Advocacy Summit, which focused on teaching surgeons the skills they need to be effective advocates and then providing them with opportunities to put their advocacy skills into action. The recurring message heard throughout the event was that building relationships with your elected officials and participating in advocacy efforts make a difference.

The SGR is dead: What now? This year’s summit occurred on the heels of Congress’ unprecedented bipartisan vote to repeal the broken sustainable growth rate formula (SGR) used to calculate Medicare physician payments—the College’s number one federal advocacy priority for many years.

The summit kicked off with a panel of senior staff in the ACS Division of Advocacy and Health Policy (DAHP). They spoke about the history of the College’s campaign to repeal the SGR and what lies ahead as a result of the Medicare Access and Children’s Health Insurance Program (CHIP) Reauthorization Act being signed into law. Patrick V. Bailey, MD, FACS, ACS Medical Director for Advocacy; Christian Shalgian, Director, DAHP; and Matthew Coffron, Manager of Policy Development, DAHP, described how the College harnessed relationships with the influential House Doctors Caucus to influence legislators’ efforts to shape the bill. Surgeons’ advocacy efforts resulted in positive payment updates rather than a freeze in the final law.

The panelists acknowledged that the hard-fought victory was made possible in part by ACS members’ participation in past Advocacy Summits, meetings with lawmakers in district offices, and through the thousands of letters and phone calls surgeons made to Capitol Hill. (See related story, page 10.)

Following up on the panel discussion, ACS President Andrew L. Warshaw, MD, FACS, FRCSEd(Hon), set the stage for participants’ meetings on Capitol Hill. While leading the victory celebration for the SGR’s repeal, Dr. Warshaw noted, “We have goals, challenges, things we need to accomplish on behalf of our patients and the profession, and you are the agents of that [progress]. The SGR is dead; we have to worry about what comes after.”
Capitol Hill meetings

In addition to thanking members of Congress for their overwhelming support and votes for the Medicare Access and CHIP Reauthorization Act, summit participants advocated at their meetings with legislators on Capitol Hill for trauma and emergency care reform, changes in the critical access hospital 96-hour rule, expedited access to new treatment options, and cancer initiatives. Specific actions that summit participants asked members of Congress to take with respect to these issues are as follows:

- Trauma and emergency care reform
  - Cosponsor H.R. 836, the Health Care Safety Net Enhancement Act.
  - Cosponsor H.R. 865, the Good Samaritan Health Professionals Act.
  - Reauthorize trauma systems and emergency care pilot projects to ensure access to trauma care.
  - Reauthorize trauma centers and trauma service availability grants to protect access to essential life-saving services.
  - Include funding for trauma programs in the fiscal year 2016 Labor/Health and Human Services/Education Appropriations Act.

- Critical Access Hospital 96-Hour Rule: Cosponsor H.R. 169/S. 258, the Critical Access Hospital Relief Act, to ensure that patients can continue to receive appropriate surgical care at critical access hospitals.

- Research development
  - Continue bipartisan work to expedite future cures and to allow the Food and Drug Administration and National Institutes of Health (NIH) to get new treatments, devices, and cures to patients more quickly, safely, and efficiently.
  - Pass legislation that appropriately supports federally funded basic research.

- Cancer initiatives
  - Cosponsor a House Resolution that supports accreditation of cancer programs. The resolution highlights the importance of accreditation in ensuring patient access to high-quality, comprehensive cancer care.

  - Support increased funding for NIH and Centers for Disease Control and Prevention cancer programs, ensuring that funding for cancer research and prevention programs is a top priority in fiscal year 2016 and beyond.

Congress does listen

Bradford Fitch, president and chief executive officer of the Congressional Management Foundation, a Washington, DC-based not-for-profit organization dedicated to building trust and effectiveness in Congress, pointed to polling data that demonstrate that lawmakers do pay attention to their constituents. Mr. Fitch highlighted a Rasmussen Reports poll that showed only 16 percent of the American population think their members of Congress care what the people in the district think. He contended that the 84 percent who think their voice doesn’t matter are incorrect, pointing to a foundation survey of members of the House of Representatives. When asked to rank the most important aspects of their job, 95 percent of the representatives put staying...
in touch with constituents at the top of their list. The foundation surveyed senior congressional staff in 2005 and 2010 asking the same question and obtained almost identical results. Congressional staff were also asked how much influence various advocacy strategies might have on their legislator’s stance on issues for which they had not yet formulated a position. An in-person visit from a constituent topped the responses (97 percent), followed by contact from a constituent's representative organization, such as the ACS (96 percent).

**Tips on being heard**

With these data in mind and with the understanding that lawmakers genuinely do care about the wants and needs of their constituents, surgeon advocates must provide a strong voice in their communities. To aid in making that voice heard, Mr. Fitch shared the following tips:

- **Have a long-term strategy.** “If you don’t build relationships year-round, you are less likely to succeed,” he said.

- **Participate in group events such as the Advocacy Summit and schedule a meeting with lawmakers when they are back in their districts.** “Being a surgeon, you’re important in the community, and you will get a meeting,” Mr. Fitch said.

- **Participate in town hall meetings.**

  Given their intimate size and structure, town hall meetings can be another effective vehicle for promoting a given position. Mr. Fitch presented several tips to take full advantage of the town hall setting, including the following:

  - Go early and meet the district staff; build a long-term relationship with them because there is little turnover in district offices.

  - Go to multiple town hall meetings; ask the same question or make the same comment each time to keep the issue top of mind.

  - Some town hall meetings take place via telephone; ask a question during the call.

Personalized e-mails are a preferred way to correspond with members of Congress, according to senior congressional staff. Mr. Fitch said it is essential that these messages include the following:

- **Information about the impact a bill would have on the district**

- **The reason for supporting or opposing a bill**

- **A personal story**

Peter Masiakos, MD, FACS, (left), and former State Senator Steven Baddour, (D-MA), now partner at McDermott, Will and Emery LLP, gave a joint presentation on strategies for successful state advocacy. Dr. Masiakos built a relationship with Mr. Baddour as a legislator. All-terrain vehicle safety legislation passed in the state legislature, largely as a result of Dr. Masiakos’ persistence.

Kate Goodrich, MD, director of the Quality Measurement and Health Assessment Group, participated in the panel presentation, The Changing World of Health Care: Road to the Future.
While leading the victory celebration for the SGR’s repeal, Dr. Warshaw noted, “We have goals, challenges, things we need to accomplish on behalf of our patients and the profession, and you are the agents of that [progress]. The SGR is dead; we have to worry about what comes after.”

How to become active now

At the Strategies for Successful State Advocacy session, J. Patrick Walker, MD, FACS, a general surgeon from Crockett, TX, suggested that Fellows begin to build relationships at the state level. Dr. Walker said that if you hold a meet-and-greet for a legislator after the legislative session, the lawmaker will remember you. He cautioned, however, that you must know all of the facts of a bill—be the subject matter expert when approaching a lawmaker on a given issue.

Another way to become active now is to join the American College of Surgeons Professional Association Political Action Committee (ACSPA-SurgeonsPAC), which provides the tools necessary to help achieve surgery’s advocacy goals and increase the profile of surgeons and surgical patients on Capitol Hill. The ACSPA-SurgeonsPAC enhances the College’s ability to develop relationships with representatives and senators so that they can become educated about the issues affecting surgical practices.

The 2016 Leadership & Advocacy Summit will take place April 9–12 at the JW Marriott, Washington, DC.

TWEETS FROM THE ADVOCACY SUMMIT

Many participants in the Advocacy Summit shared their experience at the Advocacy Summit via social media. Following are some tweets that Fellows, residents, and chapters sent from the meeting:

Maya Babu, MD, @MayaBabuMD Apr 20:
Neurosurgery engaged in advocacy w/American College of Surgeons! @AmCollSurgeons @neurosurgery @AANSNeuro #ACSLAS15

Craig Forleiter, MD, MBA, @cmf53 Apr 20:
@RASACS [Resident and Associate Society of the ACS] empowering resident members of #ACSLAS15 to advocate for their patients and themselves @MountSinaiNYC

South Texas ACS Chapter, @STXACS Apr 20:
Congrats to our very own @STXACS member Dr. Walker for presenting on Strategies for Successful State Advocacy at #ACSLAS15! @AmCollSurgeons

Prathima Nandivada, MD, @DrPrathima Apr 20:
Don’t be timid! “As surgeons, you have instant credibility with political officials.” —Former MA Senator [Steven] Baddour @AmCollSurgeons #ACSLAS15

Mark Healy, MD, @markheals Apr 21:
Appreciated meeting @SenStabenow this AM. Thanks for supporting MSQC [Michigan Surgical Quality Collaborative] and Michigan surgeons! #acslas15 #surgery

Michael Garren, MD, FACS, @MichaelGarrenMD Apr 21:
Off to Capitol Hill to advocate for Trauma care, Critical Access hospitals, research & GME #ACSLAS15
Juan A. Asensio, MD, FACS, FCCM, FRCS, was honored at a formal investiture last November at Saint Patrick’s Cathedral in New York, NY, as a Knight of Malta. Dr. Asensio directs the comprehensive Level I trauma center at CHI Health Creighton University Medical Center, Omaha, NE, where he is a professor of surgery and chief of the division of trauma surgery and surgical critical care. In addition, he is director of the university’s trauma center and trauma program.

The more than 900-year-old Order of Malta is the only remaining active military order from the Crusades. Members assist patients in need, including the young, elderly, handicapped, homeless, and those with terminal illnesses. Through its worldwide relief corps, Malteser International, the order assists refugees and victims of natural disasters, epidemics, and armed conflicts.

Morehouse School of Medicine, Atlanta, GA, in May unveiled a new medical library, named in honor of the late M. Delmar Edwards, MD, FACS, a former trustee of the college; the first African American to practice surgery in Columbus, GA; and a trailblazer for many young surgeons. Dr. Edwards died in Atlanta in 2009 at age 83, but he left a legacy as a surgeon, activist, educator, and philanthropist. Through the former Columbus-Fort Benning Medical Scholarships, one of the largest endowed scholarship funds at the school, now renamed the M. Delmar Edwards, MD, Endowed Scholarship, he helped many medical students complete their education. A native of Arkansas, Dr. Edwards was the third African American admitted to the University of Arkansas College of Medicine, Fayetteville.

Stanley J. Kurek, Jr., DO, FACS, professor of surgery, University of South Florida Morsani College of Medicine, and medical director, trauma, acute care surgery and surgical critical care, Lawnwood Regional Medical Center, Ft. Pierce, FL, was recently elected to a one-year term as the 28th president of the Eastern Association for the Surgery of Trauma (EAST). His EAST presidential message is available at www.east.org/news-and-events/news-details/5/message-from-the-east-president.

Barry M. Manuel, MD, FACS, a recipient of the American College of Surgeons (ACS) Distinguished Service
Award (DSA) and Past-President of the Massachusetts Chapter of the College, received the Massachusetts Medical Society’s (MMS) 2015 Award for Distinguished Service. The prestigious honor is given annually to an MMS member who has made a lasting contribution to the practice of medicine over a lifetime and made significant contributions to the goals of the MMS.

The award was presented to Dr. Manuel at the MMS annual meeting May 1 in Boston. In 2010, the MMS honored Dr. Manuel with the Lifetime Achievement Award.

Dr. Manuel served as associate dean for continuing medical education, 1980–2014, and professor of surgery, 1982–2014, at the Boston University School of Medicine (BUSM). With his June 30 retirement, he now holds the titles of associate dean emeritus and professor of surgery emeritus. In addition, the Office of Continuing Medical Education at Boston University will be renamed the Barry M. Manuel Office of Continuing Medical Education. Dr. Manuel received the DSA from the ACS in 1993 and in 1997 was the recipient of BUSM’s Distinguished Alumni Award.

Robert W. Panton, MD, FACS, River Forest, IL, was elected vice-speaker of the Illinois State Medical Society (ISMS) during its recent annual meeting. A board-certified specialist in ophthalmology, Dr. Panton practices at Rush Oak Park Hospital; West Suburban Hospital in Oak Park, IL; and Westlake Hospital and Loyola Gottlieb Memorial Hospital, Melrose Park, IL.

He served as Chicago Medical Society president in 2013–2014. Dr. Panton is also a fellow of the American Academy of Ophthalmology. ♦

**Bulletin online exclusive**

The Young Fellows Association Advocacy & Issues Workgroup winning essay—"Achieving our personal best through advocacy”—written by Kevin Koo, MD, MPH, MPhil, is available this month as a Bulletin online exclusive.

To read the essay, visit bulletin.facs.org/2015/07/achieving-our-personal-best-through-advocacy/. ♦
Study cites ACS NSQIP as exemplary clinical data registry

According to results from a study published recently in the *Journal for Healthcare Quality*, the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP®) is one of few exemplary clinical data registries currently in use. The researchers evaluated 153 registries that contained health service and disease outcomes data and found most of the others failed to measure and track outcomes in a meaningful way.

Data from the ACS NSQIP registry have generated valuable insights about surgical infections, transformed practice, and improved patient outcomes, according to Martin A. Makary, MD, MPH, FACS, senior study investigator and professor of surgery at the Johns Hopkins University School of Medicine, Baltimore, MD. Study authors said the hallmarks of a good registry include data that account for differences in patient case complexity across hospitals, broad hospital participation, meaningful measurement of complications, independent data collection, and open access to hospital performance for taxpayer-funded registries.

Investigators found that most other registries studied offered poor data monitoring and reporting, which detracts from national efforts to study disease, guide patient choice of optimal treatments, formulate health policies, and track physician and hospital performance. Dr. Makary noted most registries were underdeveloped, underfunded, and often not based on sound scientific methodology.

According to Heather Lyu, MD, lead author of the study and a research fellow at Johns Hopkins, exemplary registries illustrate the power to improve outcomes and inform best practices. A press release regarding the study is available at [http://goo.gl/hIKBMy](http://goo.gl/hIKBMy).

Register now for ACS NSQIP Conference, July 25–28, in Chicago

Online registration for the 2015 American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP®) Conference, July 25–28, at the Chicago Hilton, IL, is open at [www.acsnsqipconference.org](http://www.acsnsqipconference.org). Conference space is limited. The registration fee will be waived for the first two registrants from enrolled ACS NSQIP and Pediatric sites. This waiver does not apply to Medical Students, Residents, and participants in the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program. View the agenda on the conference brochure at [www.acsnsqipconference.org/wp-content/uploads/2015/05/Agenda_05_07_15.pdf](http://www.acsnsqipconference.org/wp-content/uploads/2015/05/Agenda_05_07_15.pdf).

Best-selling author Marcus Engel, MS, will deliver a keynote speech, *The Other End of the Stethoscope*. As a college freshman, Mr. Engel was blinded and nearly killed after being struck by a drunk driver. Following two years of rehabilitation, more than 300 hours of reconstructive facial surgery, and a multitude of life changes, Mr. Engel brings a unique perspective to patient care. Many nursing schools nationwide have used his presentation to teach the fundamentals of caregiving. He is working on his fifth book, *Narrative Nursing*, to help nurses overcome compassion fatigue and burnout.

Attendees at the 10th ACS NSQIP National Conference will enjoy a wide range of informative workshops, interactive general and breakout sessions on quality improvement, and abundant networking opportunities. For details regarding registration, contact Registration Services at 312-202-5244, or registration@facs.org. For questions about the conference, contact ACS NSQIP staff at 312-202-5261 or nsqipconference@facs.org.
Are you taking advantage of all the American College of Surgeons has to offer?

“As the largest and most robust surgical organization in the world, we have so much to offer surgeons of all specialties, at any point in their careers. From transition to practice support for those just starting out, to ongoing training and education, to advocacy and leadership, we help surgeons advance their careers and elevate the profession in a way no other organization can.”

— Patricia L. Turner, MD, FACS, Director, ACS Division of Member Services

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- Robust research data and programs that focus on outcomes and other quality issues
- Scholarships and Fellowships
- A major visibility program to enhance your public image, underscoring why surgeons are an essential and integral part of this country’s health care delivery system
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ACS seeks to fill six vacancies on Commission on Cancer

The American College of Surgeons (ACS) is seeking six Fellows to fill vacancies on the Commission on Cancer (CoC). The initial term of appointment is three years with eligibility for re-election to a second term. Members may hold office or serve as Vice-Chair of a committee or subcommittee during their second term. New members will be recommended by the Nominating Committee, selected in October by the Executive Committee, and then brought before the full CoC membership for approval at the CoC’s Annual Meeting. The ACS Board of Regents will confirm the final list of new members, and the CoC will announce the new members in late October.

Surgeons who meet the following criteria and are interested in becoming a member of the CoC should contact cocapplication@facs.org to receive an application and for more information. The completed application, curriculum vitae, and any letters of recommendation must be received at the same address no later than Saturday, August 15.

CoC member criteria include:

- May not be a former CoC member who represented the ACS
- Full ACS Fellowship status
- Staff appointment at a CoC-accredited cancer program and a participant in cancer program activities
- Service as an effective State Chair or Cancer Liaison Physician
- Knowledge of the CoC’s goals and initiatives
- Representation of a surgical specialty, geographic area, or diverse group not currently represented on the CoC
- Interest in contributing to and enhancing CoC programs and committee work
- Ability to serve on at least one CoC committee
- Attendance and participation in at least two in-person meetings annually
- Attendance and participation in committee conference calls

A new look for ACS Surgery News!

Coming in the July issue.

Easier to read. More clinical images, in-depth features, and lively commentary. Check out digital enhancements to better serve our readers.
Editor’s note: Media around the world, including social media, frequently report on American College of Surgeons (ACS) activities. Following are brief excerpts from news stories published from March through May 2015 that mention key ACS programs and initiatives, including research findings that appear in the *Journal of the American College of Surgeons*. To access the news items in their entirety, visit the online ACS Newsroom at www.facs.org/media/acs-in-the-news.

**Having surgery? Quit smoking**
*dailyRx News, May 15, 2015*

“A new study found that current and past smoking may increase the risk of complications after urological cancer surgery. This increase was specifically seen after prostate and bladder surgeries.... [Akshay Sood, MD] and colleagues used the American College of Surgeons National Surgical Quality Improvement Program database for their study. They chose 9,014 patients who had surgery for cancer of the prostate, bladder, or kidney between 2005 and 2011. Their focus was on negative events in the 30 days after each surgery.”

**General surgery safe for pregnant women, study shows**
*Medscape, May 14, 2015*

“Using the American College of Surgeons’ National Surgical Quality Improvement Program participant user file from January 1, 2006, to December 31, 2011, the investigators identified pregnant surgical patients and matched them, on the basis of 63 preoperative characteristics, with nonpregnant women undergoing the same operations by general surgeons. At 30 days, pregnant women and nonpregnant women had similar rates of mortality (0.4 percent vs 0.3 percent, respectively; \(P=.82\)), overall morbidity (6.6 percent vs 7.4 percent; \(P=.30\)), and 21 individual postoperative complications.”

**Worse survival after lung cancer surgery for residents of poor neighborhoods**
*Reuters, May 1, 2015*

“Residents of low-income neighborhoods with few high school graduates may be more likely to die after lung cancer surgery than more affluent patients, a U.S. study finds.... Fernandez and colleagues write in the *Journal of the American College of Surgeons* that the gold standard for longer survival is catching the cancer before it spreads and operating to remove the diseased tissue. Even then,

**Most surgery outcomes aren’t tracked**
*Smithsonian Magazine, May 4, 2015*

“The study concluded that there’s a ‘substantial opportunity’ for clinicians to increase the frequencies of national registries. In the meantime, analysts must rely on scant publicly available data—such as the American College of Surgeons National Surgical Quality Improvement Program database, which provided data for this recent study of how to identify and predict which patients are at high risk for hospital readmission after a surgery—as they look for ways to improve healthcare.”
major complications happen after as many as one in three surgeries.”

**Study questions quality of U.S. health data**
*Medical Xpress, April 30, 2015*

“[Martin] Makary [MD, FACS] and team point out that several organizations maintained exemplary registries with rich, carefully analyzed data, audited and reported in a meaningful way…Makary says, data from the National Surgical Quality Improvement Program, maintained by the American College of Surgeons, have generated valuable insights about surgical infections, transformed practice, and improved patient outcomes.”

**The impact of stress while living with cancer**
*Huffington Post, April 30, 2015*

“Although many hospitals and cancer centers have screened patients for emotional distress with accompanying counseling, it has become apparent that addressing the emotional concerns of cancer patients is paramount. Now, cancer centers will need to screen patients for distress to maintain their accreditation with the American College of Surgeons. This new and valuable mandatory offering will standardize emotional counseling that is necessary for many cancer patients.”

**Income may affect survival after lung cancer surgery**
*US News & World Report, April 20, 2015*

“Lung cancer patients with less income and education are more likely to die within 30 days of cancer surgery than those with more education and money, a new study finds.

“The type of hospital where the surgery occurs also matters, said researchers who examined results of more than 215,000 lung cancer surgeries performed in the United States between 2003 and 2011.

“The findings are published in the April 20 issue of the Journal of the American College of Surgeons.”

**Mastectomies on the rise in Venezuela amid economic crisis**
*ABC News, March 24, 2015*

“Mastectomies were once the go-to procedure for women with breast tumors, but doctors now favor radiation treatment paired with less invasive surgeries that leave some of the breast intact. Only about a third of breast cancer patients in the U.S. who are treated with surgery undergo some kind of mastectomy, according to the American College of Surgeons.

“But in Venezuela, doctors are increasingly resorting to an extreme form of mastectomy that removes not just the breast, but also lymph nodes and the underlying chest wall muscle.”

**Patients bounce back faster from surgery with hospitals’ new protocol**
*Wall Street Journal, March 30, 2015*

“Dr. [Traci] Hedrick [MD, FACS] is co-author of a study published online in February in the *Journal of the American College of Surgeons* that found that the new protocol, used in colorectal surgery patients at the UVA [University of Virginia] health system, helped reduce the length of hospital stay by 2.2 days compared with a control group who had conventional treatment. It also reduced complications by 17% and increased patient satisfaction with pain control by 55%. There was a cost savings of $7,129 per patient.”
ACS and NIH initiate effort to address disparities in surgical care

As part of a collaborative effort to address disparities in U.S. health care, the American College of Surgeons (ACS) and the National Institutes of Health (NIH) National Institute on Minority Health and Health Disparities (NIMHD) presented the first Symposium on Surgical Disparities Research, May 7–8, in Bethesda, MD. Thought leaders from throughout the nation attended this meeting to discuss disparities in surgical care, outcomes, and treatment.

Co-chairing the program were ACS Past-President L. D. Britt, MD, MPH, DSc(Hon), FACS, FCCM, FRCSI(Hon), Chair, ACS Committee on Optimal Access; and Irene Dankwa-Mullan, MD, MPH, Acting Deputy Director, Extramural Programs, NIMHD.

The symposium centered on five cross-cutting themes relating to disparities: (1) patient and host factors, (2) systemic factors and access issues, (3) clinical care and quality, (4) provider factors, and (5) postoperative care and rehabilitation. Subject matter experts gave presentations on each topic, and attendees generated a list of research questions and concerns related to each topic. This list was used to develop a set of research priorities.

Keynote speakers at the symposium included:

- Atul Gawande, MD, MPH, FACS, general surgeon, Brigham and Women’s Hospital; professor, Harvard School of Public Health and Harvard Medical School; and executive director, Ariadne Labs, Boston, MA
- ACS Immediate Past-President Carlos A. Pellegrini, MD, FACS, FRCSI(Hon), The Henry N. Harkins Professor and Chair, department of surgery, and chair of the board, Institute for Simulation and Interprofessional Studies, University of Washington, Seattle
- Jonathan Woodson, MD, FACS, Assistant Secretary of Defense for Health Affairs, Washington, DC

Other speakers included representatives from the ACS, the NIH, other government agencies, and leading academic institutions. Details about the symposium will be published in the August issue of the Bulletin, available at bulletin.facs.org, and a video is available at www.facs.org/optimal-access.

WHO recognizes surgery and anesthesia in universal health coverage

At the 68th World Health Assembly on May 22, member states of the World Health Organization (WHO) unanimously passed a historic resolution recognizing emergency and essential surgery and anesthesia as vital components of universal health care proposals. This resolution is critical in developing safe and cost-effective health care systems in which surgery and anesthesia assume an integral role. Obtain more information about the resolution at http://apps.who.int/ebwha/pdf_files/WHA68/A68_31-en.pdf

Surgeons treat a range of vital conditions, but recent data published by the World Bank in Disease Control Priorities Essential Surgery (volume one) and The Lancet Commission on Global Surgery point to the acute unmet needs of more than 5 billion people worldwide who lack access to basic surgical care. Access this information at www.globalsurgery.info/.

The American College of Surgeons (ACS) recognizes that implementation of the WHO resolution will require the collaboration of many stakeholders. The ACS is committed to working with WHO, health ministries around the world, governmental and non-governmental organizations, and other surgical and anesthesia societies for the betterment of surgical care worldwide. The College also supports the vision established by The Lancet Commission on Global Surgery: Universal Access to Safe, Affordable Surgical and Anaesthesia Care When Needed. The College will continue to promote research on access to safe, affordable, and timely surgery, reporting on the WHO’s and The Lancet Commission’s recommended surgical indicators.
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MEETINGS CALENDAR

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

JULY

North Carolina & South Carolina Chapters
July 17–19
Pinehurst, NC
Contact: Jennifer Starkey, nc@ncfacs.org, www.ncfacs.org and www.scfacs.org

2015 ACS NSQIP National Conference
July 25–28
Chicago, IL
Contact: ACS NSQIP staff, nsqipconference@facs.org, www.acsnsqipconference.org

Tennessee Chapter
July 31–August 2
Knoxville, TN
Contact: Wanda McKnight, wanda@tnacs.org, www.tnacs.org

SEPTEMBER

Georgia Society of the ACS
August 29–30
Atlanta, GA
Contact: Kathryn Browning, kdb@georgiaacs.org, www.georgiaacs.org

Jacksonville Chapter
September 1
Jacksonville, FL
Contact: Patti Chapman, rotaryexecsec@aol.com

Kansas Chapter
September 11–12
Overland Park, KS
Contact: Denise Lantz, dlantz@kmsonline.org, www.kansaschapteracs.org

New Mexico Chapter
September 18–19
Albuquerque, NM
Contact: Gloria Chavez, gchavez@nmms.org

AUGUST

Colombia Chapter
August 11–14
Bogota, Colombia
Contact: Sonia Babativa, soniapatricia@ascolcirugia.org

Hawaii Chapter
August 14–15
Honolulu, HI
Contact: Gary Blecher, gbelcher@hawaiiresidency.org, hawaiifacs.org

OCTOBER

Arkansas Chapter
October 17
Little Rock, AR
Contact: Linda Townsend, lindac92@comcast.net

Israel Chapter
October 20–21
Tel Aviv, Israel
Contact: Mordechai Gutman, motti.gutman@sheba.health.gov.il

Italy Chapter
October 21–24
Milan, Italy
Contact: Giuseppe Nigri, giuseppe.nigri@uniroma1.it, www.facsitaly.org

Minnesota Surgical Society
October 23–24
Duluth, MN
Contact: Janna Pecquet, janna@mnsurgicalsociety.org, www.mnsurgicalsociety.org

FUTURE CLINICAL CONGRESSES

2015
October 4–8
Chicago, IL

2016
October 16–20
Washington, DC

2017
October 22–26
San Diego, CA