The Distinguished Philanthropist Award:

Celebrating a legacy of exceptional giving
Contents

FEATURES

Global Surgery 2030: An introduction
John G. Meara, MD, DMD, MBA, FACS, and Sarah L. M. Greenberg, MD, MPH

Global Surgery 2030: Evidence and solutions for achieving health, welfare, and economic development: Executive Summary of The Lancet Commission on Global Surgery Report

COVER STORY: The Distinguished Philanthropist Award: Celebrating a legacy of exceptional giving
Barbara L. Dean, Sarah B. Klein, and Kenneth W. Sharp, MD, FACS

Brandeis University Heller Leadership Program in Health Policy and Management provides an education on the business side of surgery
Tony Peregrin

Surgeons uncover the keys to life by performing classical music
Jeannie Glickson

Connect with the College.

Twitter.com/AmCollSurgeons
Twitter.com/ACSTrauma

Facebook.com/AmCollSurgeons
Facebook.com/ACSTrauma
Facebook.com/RASACS

YouTube.com/AmCollegeofSurgeons

Social Media Questions?
For more information or if you have comments about the American College of Surgeons' social media sites, send an e-mail to socialmedia@facs.org.

American College of Surgeons
Inspiring Quality: Highest Standards, Better Outcomes

100+years
Contents continued

COLUMNS
Looking forward 8
David B. Hoyt, MD, FACS

What surgeons should know about...The transition to ICD-10 before October 1 compliance deadline 34
Sarah Kurusz; Chad Rubin, MD, FACS; and Lee Morisy, MD, FACS

From residency to retirement: Big data and GME: Expanding the scope of patient safety and QI training 40
David C. Chang, PhD, MPH, MBA; Jordan D. Bohnen, MD, MBA; John T. Mullen, MD, FACS; and Bob S. Carter, MD, PhD

Linda W. Martin, MD, MPH, FACS; Nirmal K. Veeramachaneni, MD, FACS; Matthew H. G. Katz, MD, FACS; Y. Nancy You, MD, MHSc, FACS; Judy C. Boughey, MD, FACS; Heidi Nelson, MD, FACS; and Kelly K. Hunt, MD, FACS

Your ACS benefits: The Surgeon Specific Registry and the ACS Member Profile enhance your practice 45
Bianca Agregado and Connie Bura

A look at The Joint Commission: A new direction for “A look at The Joint Commission” 48
Carlos A. Pellegrini, MD, FACS, FRCSI(Hon)

NTDB data points: Hit the road, jacked—road rash injuries 49
Richard J. Fantus, MD, FACS, and Edmundo A. Rivera, MD

NEWS
ACS declares victory with passage of law repealing the SGR 51
Hartford Consensus III focuses on empowering the public to serve as first responders 52
In memoriam: Dr. Lloyd MacLean, ACS Past-President and “The Chief” at McGill 53
Jonathan L. Meakins, MD, FACS

News from the ACS Communities 57
Mallory Williams, MD, MPH, FACS

Dr. John E. Hutton, Jr., physician to President Reagan, buried April 1 58
Colonel James M. Salander, MD, FACS; Colonel Norman M. Rich, MD, FACS; and Captain Eric A. Elster, MD, FACS

Print or digital Bulletin? The choice is yours 60
Dr. Turner is first woman SBAS president-elect 61
Commission on Cancer to hold two educational programs in June 61
Becker’s Hospital Review names Dr. Ko one of 50 patient safety experts 62
Dr. Ellner receives inaugural Roger Schenke Award from AAPL 62
2015 Resident Trauma Papers Competition winners announced 63
Wall Street Journal article features enhanced recovery protocols 65
Chapter news 66
Donna Tieberg

SCHOLARSHIPS
2015 Health Policy Scholars announced 71
ACS awards five Faculty Research Fellowships 73
ACS awards six Resident Research Scholarships 75

MEETINGS CALENDAR
Calendar of events 76

BULLETIN OF THE AMERICAN COLLEGE OF SURGEONS ONLINE EDITION
bulletin.facs.org

• All of the content in the print version
• Easily read on mobile devices as well as on desktop computers
• Links to “related posts”
• Share content across multiple social media platforms including Facebook, Twitter, and LinkedIn
The American College of Surgeons is dedicated to improving the care of the surgical patient and to safeguarding standards of care in an optimal and ethical practice environment.
Officers and Staff of the American College of Surgeons

Officers
Andrew L. Warshaw, MD, FACS
Boston, MA
PRESIDENT
Carlos A. Pellegrini, MD, FACS
Seattle, WA
IMMEDIATE PAST-PRESIDENT
Jay L. Grosfeld, MD, FACS
Indianapolis, IN
FIRST VICE-PRESIDENT
Kenneth L. Mattox, MD, FACS
Houston, TX
SECOND VICE-PRESIDENT
Edward E. Cornwell III, MD, FACS, FCCM
Washington, DC
OFFICERS-ELECT
William G. Cioffi, Jr., MD, FACS
Sacramento, CA
VICE-CHAIR
J. David Richardson, MD, FACS
Louisville, KY
PRESIDENT-ELECT
Ronald V. Maier, MD, FACS
Indianapolis, IN
CHAIR
Gay L. Vincent, CPA
Houston, TX
TREASURER
Carlos A. Pellegrini, MD, FACS
Sacramento, CA
SECRETARY
Officers-Elect
J. David Richardson, MD, FACS
Louisville, KY
PRESIDENT-ELECT
Ronald V. Maier, MD, FACS
Seattle, WA
FIRST VICE-PRESIDENT-ELECT
Gay L. Vincent, CPA
Chicage, IL
CHIEF FINANCIAL OFFICER

Board of Regents
*Mark C. Weissler, MD, FACS
Chapel Hill, NC
CHAIR
*Valerie W. Rusch, MD, FACS
New York, NY
VICE-CHAIR
John L. D. Atkinson, MD, FACS
Rochester, MN
Margaret M. Dunn, MD, FACS
Dayton, OH
James K. Elsey, MD, FACS
Atlanta, GA
Henri R. Ford, MD, FACS
Los Angeles, CA
Julie A. Freischlag, MD, FACS
Sacramento, CA
Gerald M. Fried, MD, FACS, FRCS
Montreal, QC
James W. Gigantelli, MD, FACS
Omaha, NE
B. J. Hancock, MD, FACS, FRCS
Winnipeg, MB
Enrique Hernandez, MD, FACS
Philadelphia, PA
Lenworth M. Jacobs, Jr., MD, FACS
Hartford, CT
L. Scott Levin, MD, FACS
Philadelphia, PA
*Mark A. Malangoni, MD, FACS
Philadelphia, PA
*Raymond F. Morgan, MD, FACS
Charlotteville, VA
Leigh A. Neumayer, MD, FACS
Tucson, AZ
Marshall Z. Schwartz, MD, FACS
Philadelphia, PA
Howard M. Snyder III, MD, FACS
Philadelphia, PA
Beth H. Sutton, MD, FACS
Wichita Falls, TX
*Andrew L. Warshaw, MD, FACS
Boston, MA
Steven D. Wexner, MD, FACS
Winston, FL
*Michael J. Zinner, MD, FACS
Boston, MA

Advisory Council to the Board of Regents
(Past- Presidents)
Kathryn D. Anderson, MD, FACS
Eastvale, CA
W. Gerald Austen, MD, FACS
Boston, MA
L. D. Britt, MD, MPH, FACS, FCCM
Norfolk, VA
John L. Cameron, MD, FACS
Baltimore, MD
Edward M. Copeland III, MD, FACS
Gainesville, FL
A. Brent Eastman, MD, FACS
Rancho Santa Fe, CA
Gerald B. Healy, MD, FACS
Wellesley, MA
R. Scott Jones, MD, FACS
Charlotteville, VA
Edward R. Laws, MD, FACS
Boston, MA
LaSalle D. Leffall, Jr., MD, FACS
Washington, DC
LaMar S. McGinnis, Jr., MD, FACS
Atlanta, GA
David G. Murray, MD, FACS
Syracuse, NY
Patricia J. Numann, MD, FACS
Syracuse, NY
Carlos A. Pellegrini, MD, FACS
Seattle, WA
Richard R. Sabo, MD, FACS
Bozeman, MT
Seymour I. Schwartz, MD, FACS
Rochester, NY
Frank C. Spencer, MD, FACS
New York, NY

Executive Staff
EXECUTIVE DIRECTOR
David B. Hoyt, MD, FACS
DIVISION OF ADVOCACY AND HEALTH POLICY
Frank G. Opelka, MD, FACS
Medical Director, Quality and Health Policy
Patrick V. Bailey, MD, FACS
Medical Director, Advocacy
Christian Shalgian
Director

AMERICAN COLLEGE OF SURGEONS FOUNDATION
Martin H. Wojcik
Executive Director
ALLIANCE/AMERICAN COLLEGE OF SURGEONS
CLINICAL RESEARCH PROGRAM
Kelly Hunt, MD, FACS
Chair
CONVENTION AND MEETINGS
Felix Niespodziewanski
Director
DIVISION OF EDUCATION
Ajit K. Sachdeva, MD, FACS, FRCS
Director
EXECUTIVE SERVICES
Jane J. Lee-Kwon, MPS
Director, Executive Services
Maxine Rogers
Director, Leadership Operations
FINANCE AND FACILITIES
Gay L. Vincent, CPA
Director
HUMAN RESOURCES AND OPERATIONS
Michelle McGovern
Director
INFORMATION TECHNOLOGY
Howard Tansman
Director
DIVISION OF INTEGRATED COMMUNICATIONS
Lynn Kahn
Director
JOURNAL OF THE AMERICAN COLLEGE OF SURGEONS
Timothy J. Eberlein, MD, FACS
Editor-in-Chief
DIVISION OF MEMBER SERVICES
Patricia L. Turner, MD, FACS
Director
M. Margaret Knudson, MD, FACS
Medical Director, Military Health Systems Strategic Partnership
Girma Tefera, MD, FACS
Director, Operating Giving Back
PERFORMANCE IMPROVEMENT
Will Chapleau, RN, EMTP
Director
DIVISION OF RESEARCH AND OPTIMAL PATIENT CARE
Clifford Y. Ko, MD, MS, FACS
Director
Cancer
David P. Winchester, MD, FACS
Medical Director
Trauma
Michael F. Rotondo, MD, FACS
Medical Director
Author bios*

*Titles and locations current at the time articles were submitted for publication.

[Images of authors]  

MS. AGREGADO (a) is Manager, Surgeon Specific Registry, American College of Surgeons (ACS) Division of Research and Optimal Patient Care, Chicago, IL.

DR. BOHNEN (b) is a general surgery resident, department of surgery, Massachusetts General Hospital, Harvard Medical School, Boston.

DR. BOUGHEY (c) is professor of surgery and vice-chair of research, department of surgery, Mayo Clinic, Rochester, MN. She is Chair, ACS Clinical Research Program (ACS CRP) Education Committee.

MS. BURA (d) is Associate Director, ACS Division of Member Services, Chicago, IL.

DR. CARTER (e) is professor of surgery and chief of neurosurgery, department of surgery, University of California, San Diego.

DR. CHANG (f) is associate professor of surgery, department of surgery, and director of health care research and policy development, Codman Center, Massachusetts General Hospital, Harvard Medical School.

MS. DEAN (g) is Past-Director, ACS Executive Services, and Volunteer, Committee on Annual Giving and Communications, ACS Foundation, Chicago, IL.

DR. ELSTER (h) is professor and chairman, Norman M. Rich department of surgery, Uniformed Services University of the Health Sciences (USUHS) and Walter Reed National Military Medical Center, Bethesda, MD.

DR. FANTUS (i) is vice-chairman, department of surgery; medical director, trauma services; and chief, section of surgical critical care, Advocate Illinois Masonic Medical Center. He is clinical professor of surgery, University of Illinois College of Medicine, Chicago, and Past-Chair, ad hoc Trauma Registry Advisory Committee, ACS Committee on Trauma.

MS. GLICKSON (j) is Communications Associate, Division of Integrated Communications, Chicago, IL.

continued on next page
DR. GREENBERG (k) is chief research fellow, Paul Farmer Global Surgery Fellowship, Program in Global Surgery and Social Change, department of global health and social medicine, Harvard Medical School. She is a senior general surgery resident, department of surgery, Medical College of Wisconsin, Milwaukee.

DR. HUNT (l) is Hamill Foundation Distinguished Professor and chief, surgical breast section, department of surgical oncology, University of Texas MD Anderson Cancer Center, Houston, and Director, ACS CRP.

DR. KATZ (m) is assistant professor, department of surgical oncology, division of surgery, University of Texas MD Anderson Cancer Center.

MS. KLEIN (n) is Director, Donor Relations and Communications, ACS Foundation.

MS. KURUSZ (o) is Practice Affairs Associate, Division of Advocacy and Health Policy, Washington, DC.

DR. MARTIN (p) is a general thoracic surgeon and assistant professor, department of surgery, University of Maryland Medical School, Baltimore.

DR. MEAKINS (q) is professor emeritus, University of Oxford, UK, and was the Nuffield Professor of Surgery, University of Oxford. He is the past-Edward W. Archibald Chair of Surgery, past-professor, and past-chair of surgery, McGill University; and past-surgeon-in-chief, McGill University Health Centre, Montreal, QC. He is a past-ACS Regent.

DR. MEARA (r) is director, Program in Global Surgery and Social Change, department of global health and social medicine, Harvard Medical School. He is plastic surgeon-in-chief, department of plastic and oral surgery, Boston Children’s Hospital, MA.

DR. MORISY (s) is a general surgeon, Memphis, TN. He is a member of the ACS General Surgery Coding and Reimbursement Committee and is the ACS representative to the American Hospital Association Editorial Advisory Board of Coding Clinic for the International Classification of Diseases, Tenth Revision, Clinical Modification.

DR. MULLEN (t) is assistant professor of surgery and program director, department of surgery, Massachusetts General Hospital, Harvard Medical School.
Author bios continued

DR. NELSON (u) is Fred C. Andersen Professor of Surgery and Chair, department of surgery, Mayo Clinic, and Past-Program Director, ACS CRP.

DR. PELLEGRINI (v) is The Henry N. Harkins Professor and Chair, department of surgery, University of Washington, Seattle, and Immediate Past-President of the ACS.

MR. PEREGRIN (w) is Senior Editor, Bulletin of the American College of Surgeons, ACS Division of Integrated Communications.

DR. RICH (x) is a vascular surgeon and professor of military medicine, USUHS, and director of the Vietnam Veterans Registry.

DR. RIVERA (y) is a surgical critical care fellow, Advocate Illinois Masonic Medical Center, Chicago, and a member of the American Burn Association.

DR. RUBIN (z) is a general surgeon in private practice in Columbia, SC. He is Chair, ACS General Surgery Coding and Reimbursement Committee and is the ACS representative to the American Medical Association Specialty Society Relative Value Scale Update Committee.

DR. SALANDER (aa) is a vascular surgeon at Suburban Hospital, Bethesda, MD, and associate professor, USUHS.

DR. SHARP (bb) is professor of surgery and vice-chair for faculty affairs, department of surgery, Vanderbilt-Ingram Cancer Center, Nashville, TN, and ACS Foundation Officer.

MS. TIEBERG (cc) is Manager, Chapter Services, ACS Division of Member Services.

DR. VEERAMACHANENI (dd) is a general thoracic surgeon, University of Kansas Medical Center, Kansas City.

DR. WILLIAMS (ee) is Lieutenant Colonel, U.S. Army, Joint Task Force Bravo, and MEDEL Trauma/General Surgeon, Soto Cano Air Base. He is Editor, ACS Diversity Community, and Chair, ACS Committee on Diversity Issues.

DR. YOU (ff) is assistant professor, section of colorectal surgery, department of surgical oncology, and medical director, Familial High Risk Gastrointestinal Cancer Clinic, University of Texas MD Anderson Cancer Center.
The American College of Surgeons (ACS) has a long legacy of producing educational resources for surgeons and surgical residents seeking to deliver high-quality patient care. The latest example of these efforts came with the release of the first edition of *Operative Standards for Cancer Surgery*. This new manual, discussed in greater detail on page 43, represents a unique benefit of the decade-long relationship between the ACS and National Cancer Institute cooperative groups.

**Conceptualization and development**

*Operative Standards for Cancer Surgery* is representative of the College’s ongoing tradition of developing protocols and educational materials to assist surgeons and other health care professionals in the delivery of safe, effective surgical care. Other examples include the Advanced Trauma Life Support® student manual; the American Joint Committee on Cancer’s *Cancer Staging Manual*, now in its eighth edition; our clinical guidelines program, Evidence-Based Decisions in Surgery; *Resources for Optimal Care of the Injured Patient*, now in its sixth edition; and an ACS quality manual that is in development for surgical quality officers, which outlines the processes that should be in place in surgical institutions to ensure the provision of quality care.

The concept for *Operative Standards for Cancer Surgery* was first proposed approximately three years ago by Heidi Nelson, MD, FACS, when she was Program Director of the ACS Clinical Research Program (ACS CRP), which is part of the Alliance for Clinical Trials in Oncology. The ACS CRP Cancer Care Standards Development Committee, chaired by the present Director of the ACS CRP, Kelly K. Hunt, MD, FACS, led the effort to develop the final product.
The manual was envisioned as a response to the need for minimum evidence-based standards for various cancer procedures and as reference tool for clinical trials that include surgical interventions for four common disease sites: breast, colon, lung, and pancreas.

The manual was envisioned as a response to the need for minimum evidence-based standards for various cancer procedures and as a reference tool for clinical trials that include surgical interventions for four common disease sites: breast, colon, lung, and pancreas. Procedures covered in *Operative Standards for Cancer Surgery* include breast-conserving surgery, pancreaticoduodenectomy, and lobectomy. The focus is on describing technical elements critical to proper conduct of cancer operations where best practices can be demonstrated.

The authors have attempted to use the best evidence available, and this evidence represents the opinions of diverse and representative groups who care for cancer patients. Expert clinicians and researchers provided invaluable input that was used to develop the guidelines, and a Town Hall Meeting at the 2013 Clinical Congress provided an opportunity for attendees to learn about how the standards were created.

**Benefits for researchers, clinicians, and patients**

As is the case for all health care disciplines, the body of evidence of scientifically verifiable ways of performing cancer procedures is growing. This reference tool will spare clinical trial investigators the difficulties of establishing or re-establishing the basic principles of these operations with each new trial. Furthermore, having a set of protocols will minimize variability across study sites and improve adherence to best practices for patients receiving care both on and off a clinical trial.

It should also be useful in addressing variability in clinical practice. Much of clinical surgery is based on principles of ablation, correction of anatomic deficits, and reconstruction. The effectiveness of cancer operations has generally followed the principle of surgical removal of the malignancy. The technical elements that are critical to the proper conduct of a cancer operation ensure the use of best practices and optimal long-term outcomes.

When evidence and experience demonstrate that a procedure is essential for safe, effective, long-term outcomes, it is important to teach that technique with precision and put it forth as an evidence-based standard. As the project evolved, it became clear that this manual could also serve as an instructive text for surgical education and training.

Hence, this manual, using both text and illustrations, is not merely a surgical atlas, but rather is in many ways a textbook that emphasizes the critical steps in performing an operation and intraoperative decision making. It further can be used to provide a template for operative reports and it would be useful to the individual surgeon in analyzing his or her performance measures.

Defining those critical elements of each operation that are essential for surgical success is the purpose of *Operatives Standards for Cancer Surgery*, and the areas covered have achieved this noble goal. Drs. Nelson and Hunt and the other surgeons who led the disease site groups are to be commended for the work they have done in producing this landmark approach to surgical cancer care and for this latest addition to the College’s resources for surgeons seeking to provide optimal care. This effort will become the yardstick by which cancer care is measured going forward and should be a standard for how all of surgical care is taught.

---

If you have comments or suggestions about this or other issues, please send them to Dr. Hoyt at lookingforward@facs.org.
Global Surgery 2030: An introduction

by John G. Meara, MD, DMD, MBA, FACS, and Sarah L. M. Greenberg, MD, MPH

Editor’s note: This introduction is based on the foreword to the report published in *Surgery* and *The Lancet Global Health*. This report is the second in a series of articles that *The Lancet* Commission on Global Surgery has submitted regarding its efforts. A progress report on the commission’s activities was published in the April issue of the *Bulletin*.

Following is an Executive Summary of *The Lancet* Commission on Global Surgery (LCoGS) report on global health care disparities. LCoGS’ vision is “universal access to safe, affordable surgical and anesthesia care when needed.” At present, 5 billion people are unable to receive surgical interventions that could save lives or prevent disability. In an era in which we discuss the dawn of personalized medicine and genetic engineering with frequency and familiarity, how can more than half the world’s population live in a health care time warp, trapping them centuries in the past without access to quality care?

As the Executive Summary reveals, disparities in global surgical care are due to inaccurate assumptions, competing priorities, and a lack of resolve. For years the public health community assumed that surgery was too costly and too complex, leading public health intelligentsia to concentrate on ostensibly more cost-effective interventions, including vaccines and infectious disease treatments—all of which are necessary but no more cost-effective than surgery. In addition, the surgical and anesthesia community lacked a cohesive resolve to reverse the marginalization of surgery.

Integration of surgery and anesthesia care is critical to achieving the emerging global health care goals of sustainable development and universal health coverage. Without immediate attention and scale-up, lack of surgical care will not only continue to result in preventable death and disability but will also lead to an estimated reduction of the gross domestic product of low- and middle-income countries by as much as 2 percent by 2030. This decrease will be crippling for fragile economies struggling to emerge from poverty and instability.

In January 2014, World Bank president Jim Yong Kim, MD, PhD, addressed these realities at the first Assembly of the LCoGS, stating that “surgery is an indivisible, indispensable part of health care.” Fortunately, Dr. Kim’s words landed on fertile ground, prepared by the hard
work and dedication of numerous groups and individuals, including the thousands of frontline providers in LMICs. The year 2014 and early 2015 saw several worldwide events unfold that complemented and catalyzed the work of LCoGS. A World Health Assembly Resolution on essential surgery gained momentum with multi-country support; in January it was passed by the World Health Organization Executive Board and at press time was scheduled to go for a final vote in May. At the same time, 2015 has thus far marked a transition to a collection of health and development targets aimed broadly at poverty reduction, universal health care, and equity.

The initial LCoGS launch took place in London on April 27 and 28, in collaboration with the Royal Society of Medicine. The second launch followed shortly afterwards in Boston, MA, in May. These launches represent the culmination of more than two years of work by hundreds of people in more than 110 countries, four international meetings, and multiple regional events—all of which represents a broad, purposeful, and critical outreach effort.

The launch events in London and Boston signified the beginning of LCoGS’ education and advocacy efforts to highlight the pivotal role of surgical care in strengthening global health care systems. The formal commission report is only one part of the initial commission product. A dozen open-access, business-style teaching cases have been published to provide an educational framework focused on global surgery topics. In addition, 61 abstracts were presented at the launch in London and published in The Lancet. Numerous full-length articles are being published in The Lancet and in multiple other journals, highlighting the importance of international collaboration in combating surgery’s marginalization.

The following Executive Summary of LCoGS’ report on Global Surgery 2030 encapsulates the commission’s findings regarding the state of global surgical care and strategies for reversing decades of neglect. The authors maintain that the delivery of surgery and anesthesia care must be included by health care providers, policymakers, and funders as a central component of global health system improvement at the local level by local leaders with support from global partners. Only in this way will we be able to achieve health, welfare, and economic development for all.

REFERENCES

Global Surgery 2030: Evidence and solutions for achieving health, welfare, and economic development

Executive Summary of The Lancet Commission on Global Surgery Report

HIGHLIGHTS
- Describes the growing concerns about health care disparities that led to the formation of LCoGS
- Outlines the five key messages of LCoGS
- Urges the development of broad-based health systems solutions and the allocation of appropriate resources
Editor’s note: This executive summary of The Lancet Commission on Global Surgery was published online on April 27, 2015, by The Lancet.* It has been edited here to conform with Bulletin style and is reprinted with permission from Elsevier. The full report can be accessed at TheLancet.com/commissions/global-surgery.

Remarkable gains have been made in global health in the last 25 years, but progress has not been uniform. Mortality and morbidity from common conditions needing surgery have grown in the world’s poorest regions, both in real terms and relative to other health gains. At the same time, development of safe, essential, lifesaving surgical and anesthesia care in low- and middle-income countries (LMICs)† has stagnated or regressed. In the absence of surgical care, case-fatality rates are high for common, easily treated conditions, including appendicitis, hernia, fractures, obstructed labor, congenital anomalies, and breast and cervical cancer.

Global health burdens
In 2015, many LMICs are facing a multifaceted burden of infectious disease, maternal disease, neonatal disease, non-communicable diseases, and injuries. Surgical and anesthesia care are essential for the treatment of many of these conditions and represent an integral component of a functional, responsive, and resilient health system. In view of the large projected increase in the incidence of cancer, road traffic injuries, and cardiovascular and metabolic diseases in LMICs, the need for surgical services in these regions will continue to rise substantially from now until 2030. Reduction of death and disability hinges on access to surgical and anesthesia care, which should be available, affordable, timely, and safe to ensure good coverage, uptake, and outcomes.

Despite growing need, the development and delivery of surgical and anesthesia care in LMICs has been nearly absent from the global health discourse. Little has been written about the human and economic effect of surgical conditions, the state of surgical care, or the potential strategies for scale-up of surgical services in LMICs. To begin to address these crucial gaps in knowledge, policy, and action, The Lancet Commission on Global Surgery (LCoGS) was launched in January 2014. The commission brought together an international, multidisciplinary team of 25 commissioners, supported by advisors and collaborators in more than 110 countries and six continents.

Five key messages
The LCoGS formed four working groups that focused on the domains of health care delivery and management; workforce, training, and education; economics and finance; and information management. The commission has five key messages—a set of indicators and recommendations to improve access to safe, affordable surgical and anesthesia care in LMICs, and a template for a national surgical plan. Our five key messages are as follows:

• Approximately 5 billion people do not have access to safe, affordable surgical and anesthesia care when needed. Access is worst in LMICs, where nine of 10 people cannot access basic surgical care.

• An additional 143 million surgical procedures are needed in LMICs each year to save lives and prevent disability. Of the 313 million procedures undertaken worldwide each year, only 6 percent occur in the poorest countries.


†LMICs: Although this term has been used throughout the report for brevity, the commission acknowledges that tremendous income diversity exists between and within this group of countries.
where more than a third of the world’s population lives. Low operative volumes are associated with high case-fatality rates from common, treatable surgical conditions. Unmet need is greatest in eastern, western, and central sub-Saharan Africa and south Asia.

• An estimated 33 million individuals face catastrophic health expenses to pay for surgical and anesthesia care each year. An additional 48 million cases of catastrophic expenditure are attributable to the nonmedical costs of accessing surgical care such as transportation, lodging, and food. A quarter of the people who have a surgical procedure will incur financial catastrophe as a result of seeking care. The burden of catastrophic expenditure for surgery is highest for LMICs and, within any country, lands most heavily on poor people.

• Investing in surgical services in LMICs is affordable, saves lives, and promotes economic growth. To meet present and projected population demands, urgent investment in human and physical resources for surgical and anesthesia care is needed. If LMICs were to scale up surgical services at rates achieved by the present best-performing LMICs, two-thirds of countries would be able to reach a minimum operative volume of 5,000 surgical procedures per 100,000 population by 2030. Without urgent and accelerated investment in surgical scale-up, LMICs will continue to have losses in economic productivity, estimated cumulatively at $12.3 trillion (2010 U.S. dollars, purchasing power parity) between 2015 and 2030.

• Surgery is an “indivisible, indispensable part of health care.” Surgical and anesthesia care should be an integral component of a national health system in countries at all levels of development. Surgical services are a prerequisite for the full attainment of local and global health goals in areas as diverse as cancer, injury, cardiovascular disease, infection, and reproductive, maternal, neonatal, and child health. Universal health coverage and the health aspirations set out in the post-2015 sustainable development goals (SDGs) will be impossible to achieve
CORE INDICATORS FOR MONITORING UNIVERSAL ACCESS TO SAFE, AFFORDABLE SURGICAL AND ANESTHESIA CARE WHEN NEEDED

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>DEFINITION</th>
<th>TARGET</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to timely essential surgery</td>
<td>Percent of the population that can access, within 2 hours, a facility that</td>
<td>A minimum of 80% coverage of essential surgical and anesthesia services per country by 2030</td>
</tr>
<tr>
<td></td>
<td>can perform emergency cesarean section, laparotomy, and treatment of open</td>
<td></td>
</tr>
<tr>
<td></td>
<td>fracture (the Bellwether Procedures)</td>
<td></td>
</tr>
<tr>
<td>Specialist surgical workforce density</td>
<td>Number of specialist surgical, anesthetic, and obstetric physicians who</td>
<td>100% of countries with at least 20 surgical, anesthetic, and obstetric physicians per 100,000 population by 2030</td>
</tr>
<tr>
<td></td>
<td>are working, per 100,000 population</td>
<td></td>
</tr>
<tr>
<td>Surgical volume</td>
<td>Procedures performed in an operating theater, per 100,000 population, per</td>
<td>80% of countries by 2020 and 100% of countries by 2030 tracking surgical volume; a minimum of 5,000 procedures per 100,000 population by 2030</td>
</tr>
<tr>
<td>Perioperative mortality rate (POMR)</td>
<td>All-cause death rate prior to discharge among patients who have undergone</td>
<td>80% of countries by 2020 and 100% of countries by 2030 tracking POMR; in 2020, evaluate global data and set national targets for 2030</td>
</tr>
<tr>
<td></td>
<td>a procedure in an operating theater, divided by the total number of</td>
<td></td>
</tr>
<tr>
<td></td>
<td>procedures, presented as a percentage</td>
<td></td>
</tr>
<tr>
<td>Protection against impoverishing expenditure</td>
<td>Proportion of households protected against impoverishment from direct out-</td>
<td>100% protection against impoverishment from OOP payments for surgical and anesthesia care by 2030</td>
</tr>
<tr>
<td></td>
<td>of-pocket (OOP) payments for surgical and anesthesia care</td>
<td></td>
</tr>
<tr>
<td>Protection against catastrophic expenditure</td>
<td>Proportion of households protected against catastrophic expenditure from</td>
<td>100% protection against catastrophic expenditure from OOP payments for surgical and anesthesia care by 2030</td>
</tr>
<tr>
<td></td>
<td>direct OOP payments for surgical and anesthesia care</td>
<td></td>
</tr>
</tbody>
</table>

Note: These indicators provide the most information when used and interpreted together; no single indicator provides an adequate representation of surgical and anesthesia care when analyzed independently.

without ensuring that surgical and anesthesia care is available, accessible, safe, timely, and affordable.

Meeting the challenges

In summary, the Commission’s key findings show that the human and economic consequences of untreated surgical conditions in LMICs are large and for many years have gone unrecognized. During the past two decades, global health has focused on individual diseases. The development of integrated health services and health systems has been somewhat neglected. As such, surgical care has been afforded low priority in the world’s poorest regions.

This report presents a clear challenge to this approach. As a new era of global health begins in 2015, the focus should be on the development of broad-based health systems solutions, and resources should be allocated accordingly. Surgical care has an incontrovertible, cross-cutting role in overcoming local and global health challenges. It is an important part of the solution to many diseases—for both old threats and new challenges—and is a crucial component of a functional, responsive, and resilient health system. The health gains from scaling up surgical care in LMICs are great and the economic benefits substantial. They accrue across all disease-cause categories and at all stages of life, but especially benefit the world’s youth and young adult populations. The provision of safe and affordable surgical and anesthesia care when needed not only reduces premature death and disability, but also boosts welfare, economic productivity, capacity, and freedoms, contributing to long-term development.

Our six core surgical indicators (see table, this page) should be tracked and reported by all countries and global health organizations, such as the World Bank through the World Development Indicators, the World Health Organization through the Global Reference List of 100 Core Health Indicators, and entities tracking the SDGs.

At the opening meeting of The Lancet Commission on Global Surgery in January 2014, Jim Yong Kim, MD, PhD, President of the World Bank, stated “surgery is an indivisible, indispensable part of health care” and “can help millions of people lead healthier, more productive lives.” In 2015, good reasons exist to ensure that access to surgical and anesthesia care is realized for all.

---


2 Without ensuring that surgical and anesthesia care is available, accessible, safe, timely, and affordable.
The Distinguished Philanthropist Award:

Celebrating a legacy of exceptional giving

by

Barbara L. Dean,
Sarah B. Klein,
and
Kenneth W. Sharp, MD, FACS
This year, the American College of Surgeons (ACS) Foundation will announce the 25th recipient of the Distinguished Philanthropist Award. Since 1989, the ACS has acknowledged individuals who have distinguished themselves through their exemplary investment in the mission of the College and in philanthropy. Each recipient has contributed for different reasons, but each serves as a model donor—supporting not only the contributor’s personal passion, but also acting in alignment with the ACS values of promoting optimal patient care.

In 2010, the ACS Foundation Board of Directors assumed the responsibility of identifying and selecting nominees with the oversight of its Management Committee. (Prior to that time, the College’s Development Committee had collaborated with the ACS Honors Committee to recommend and select recipients.)

The criteria for nomination are as follows:

- A record of service to the College and the Foundation
- A leadership commitment to the practice of philanthropy
- A personal history of philanthropy to the College
- Service to the larger not-for-profit community

Notable award recipients
All past Distinguished Philanthropist Award recipients from 1989 through 2014 are listed on page 18. The following individuals are highlighted for their unique contributions to the ACS Foundation’s ongoing growth and development.

Armand Hammer, MD
The first Distinguished Philanthropist Award was presented to Armand Hammer, MD, the internationally known entrepreneur who chaired the Occidental Petroleum Corporation, Houston, TX, for more than 30 years. Dr. Hammer’s success in business allowed him to pursue his lifelong interest in art and to build a collection that became a major museum in Los Angeles, CA, after his death in 1990.

Dr. Hammer graduated from the College of Physicians and Surgeons of Columbia University, New York, NY, in 1921, but while waiting the six months before beginning his internship, he took a life-changing trip to the former Soviet Union. His original plan was to help combat the typhus epidemic, but instead he found the major health issue to be starvation. Dr. Hammer acted on this discovery by introducing the idea of trading American grain for furs and other goods from the Soviet Union. A career in business ensued, along with a commitment to help strengthen Soviet-American relations.

Although some of his business, political, and international interests and dealings provoked controversy, Dr. Hammer’s extraordinary philanthropy financed research for a cancer cure. For many years, he donated more than 90 percent of his income to charitable causes. The ACS was one of those beneficiaries, and contributions from the Armand Hammer Foundation supported a traveling surgical scholarship in his honor.

Dr. and Mrs. Jacobson
In 1993, the Honors Committee of the College selected Julius H. Jacobson II, MD, FACS, to receive the prestigious Distinguished Philanthropist Award. In addition to their many philanthropic contributions to educational and arts institutions, Dr. Jacobson and his wife, Joan, are among the top donors to the ACS Foundation and, therefore, members of the Fellows Leadership Society’s Pinnacle Circle, with cumulative donations of greater than $1 million.

Dr. and Mrs. Jacobson’s best-known contributions have led to the establishment of two annual ACS awards—the Jacobson Innovation Award and the Joan L. and Julius H. Jacobson II Promising Investigator Award. In their 20th and 10th years, respectively, each award honors surgical researchers. The Innovat-
tion Award honors living surgeons who have originated new surgical technology or techniques, and the Promising Investigator Award recognizes outstanding surgeons who are engaging in research, advancing the art and science of surgery, and demonstrating early promise of significant contribution to the practice of surgery and the safety of surgical patients.

The awards rightfully bear the Jacobson name not only because the couple provided their funding, but because they aptly describe Dr. Jacobson’s legacy, as well. Widely renowned as the “father of microsurgery,” Dr. Jacobson said in a May 2005 interview with the Bulletin that his greatest contribution to surgery was introducing the microscope to the general surgery operating room.*

The Clowes and Islami families
In the Distinguished Philanthropist Award’s history, two families have been selected for their backing of the ACS’ educational mission to support the scholarly aspirations of young surgeons, while memorializing a familial legacy: the Clowes (1991) and the Islami (1994) families.

The George H. A. Clowes, Jr., MD, FACS, Memorial Research Career Development Award (Clowes Award), established with a gift of more than $1 million, was first awarded in 1992 and supports five-year research fellowships for promising surgical investigators. This generous gift came from The Clowes Fund via the endorsement of Alexander W. Clowes, MD, FACS, to honor the distinguished contributions of his father and his lifelong interest in the needs of young surgeons. Many of the awardees have gone on to careers in academic surgical research, and several recipients are now surgical chairs and are widely respected within the research community. Included among the Clowes Award recipients is Timothy Billiar, MD, FACS, chair, department of surgery, George Vance Foster Endowed Professor, distinguished professor of surgery, University of Pitts-

burgh, PA, who remarked, “Winning [the Clowes Award] was a great honor, which is all the more meaningful because it is a link to such an excellent surgical investigator.”

In 1990, the Islami family made a contribution to the College in support of international guest scholarships through the initial generosity of Abdol Islami, MD, FACS, and Mrs. Joan Islami. Passionate advocates for providing educational opportunities to medical students from outside the U.S., Dr. and Mrs. Islami’s contribution was supplemented by their children and colleagues. Proceeds from the Islami Family Foundation originally financed an annual international guest scholarship; in recent years, funding was increased to include a second award. The Abdol H. Islami and Joan Islami International Guest Scholar Award was the first named award within the College’s international guest scholarship program, and its recipients have enjoyed many education and networking opportunities through attendance at the annual Clinical Congress and visits to U.S. medical centers with an academic emphasis.

**Dr. and Mrs. Lincke**

Several of the Distinguished Philanthropist Award recipients have been honorably named for their service and generosity to the College through a legacy gift; these recipients include Dr. and Mrs. Eric T. Lincke in 1997. By establishing a philanthropic contribution to the ACS through their estate gift planning, they became members of the ACS Foundation’s Mayne Heritage Society. Upon receiving the award, Dr. Lincke said, “The gift comes from the heart, and two-thirds of our estate is earmarked for philanthropy, which will benefit several institutions. The College is an organization I believe in. I’ve been a member for 25 years and continue to support it. I wish to see its valuable goals perpetuated in the 21st century.”

**Drs. Thomas and Nona Russell**

The 2011 Distinguished Philanthropist recipients, Thomas R. Russell, MD, FACS, and Nona C. Russell, MD, were named for their distinctive service and generosity. Drs. Russell made their first donation in 1990, and subsequently provided more than 100 separate gifts to support the College’s programs. Their years of service to the College, health care, and their community are exemplary and inspired hundreds of Fellows and friends to give to the Thomas R. Russell, MD, FACS, Faculty Research Fellowship and other non-revenue programs of the College.

**The tradition continues**

All of the ACS Distinguished Philanthropist awardees demonstrate generosity of spirit and a commitment to service. The task of selecting one finalist from the ranks of ACS donors each year can be challenging. A decision was made in 2015 to also recognize an organization with a record of giving and service that aligns with the criteria of the Distinguished Philanthropist Award recognizing individual donors. The announcement of both awards will occur later this year, and the Fellows Leadership Society of the ACS Foundation will honor the awardees at the 2015 Clinical Congress, October 4–8 in Chicago, IL.

In the last 10 years alone, these donors and thousands of other philanthropic Fellows and friends have made possible more than $26 million in contributions for ACS initiatives such as scholarships and fellowships, awards to promote surgical and outcomes research, the Archives, and lifelong learning. Without philanthropic support, access to these valued assets by Fellows and residents would be uncertain.

The ACS Foundation salutes donors and volunteers who contribute to the advancement of the College’s goals to expand and enhance benefits for Fellows and optimal care for surgical patients throughout the world. We honor and recognize all who have supported these efforts through their philanthropy and service.
Brandeis University Heller Leadership Program in Health Policy and Management provides an education on the business side of surgery

by Tony Peregrin
“Today, delivering safe, efficient, high-quality care requires a broad range of conceptual, technical, analytical, and leadership skills that physicians can no longer master on their own....”

—Dr. Chilingerian

Until the 1990s, physician leaders were primarily self-taught managers, honing leadership skills as part of their daily responsibilities, according to Jon Chilingerian, PhD, health care management professor and founding program director at Brandeis University, Waltham, MA. “When I studied physicians who became managers and hospital chief executives as part of my doctoral dissertation at MIT [Massachusetts Institute of Technology, Cambridge], most clinicians learned how to manage while on the job,” Dr. Chilingerian said. “Clinicians were tapped for high-level leadership roles because they got along with people and because they built a successful clinical department that generated revenues. Gradually, as opportunities and challenges arose [during the course of their careers], these physician leaders would learn about corporate strategy, conflict resolution, and interpreting financial statements,” he explained.

Today, delivering safe, efficient, high-quality care requires a broad range of conceptual, technical, analytical, and leadership skills that physicians can no longer master on their own, according to Dr. Chilingerian. To respond to the need for health care professionals to develop a more sophisticated business and health policy acumen, Dr. Chilingerian helped establish the Heller Leadership Program in Health Policy and Management at Brandeis. This program offers surgeons intensive training in change management, conflict negotiation, financial literacy skills, and health care policy development.

Originally presented at Brandeis’ Heller School for Social Policy and Management, this annual six-day program provides surgeon leaders with the opportunity to participate in simulation exercises emphasizing effective leadership skills and to review case studies highlighting current national health policy issues.1,2

The American College of Surgeons (ACS) has partnered with 16 surgical specialty groups to help design the course and award scholarships to surgeons who are ACS Fellows and members in good standing of these organizations.3 At press time, more than 200 clinicians have graduated from the Heller Leadership Program. In this article, four graduates of the program describe how the course influenced their role as surgeon leaders.

Robert R. Lorenz, MD, MBA, FACS
ACS/American Academy of Otolaryngology–Head and Neck Surgery (AAO-HNS) Health Policy Scholar

“Brandeis is known for [its] approach to alternative payment models, and I wanted to figure out how I could be of assistance to the College in developing these models,” Dr. Lorenz said, medical director, payment reform, risk, and contracting, Cleveland Clinic, OH. “This course was my first exposure, in a comprehensive way, to the history of health care insurance payment and [Centers for Medicare & Medicaid Services] payment methodology, and I found this quite helpful for understanding where we can go in the future.”

As both a member of the ACS Health Policy and Advocacy Group and the current co-chair of the AAO-HNS physician payment policy workgroup, Dr. Lorenz was engaged in health care policy development before attending the course in 2013.4 By participating in the program, however, Dr. Lorenz acquired essential leadership skills to advocate for his colleagues to embrace alternative payment models.

“A lot of these models are voluntary, and you have to be able to move physicians from their comfort zone, which is fee for service, toward some kind of risk-based payment format,” Dr. Lorenz said. “In order to do that, you have to do a lot of convincing—not just one or two people—but you have to convince a body of professionals. That’s not just the president or director of an organization, but it is also key opinion leaders throughout the organization.” According to Dr. Lorenz, Change Pro—the learning tool employed by the Heller Leadership Program—was particularly helpful toward this end.
The Change Pro simulation involves physicians working in small groups with 120 “days” to convince 24 members of an organization’s top management team to adopt a Six Sigma quality improvement system. The goal is to get as many adopters as possible, even if participants have no formal authority in the organization. “There is official influence and unofficial influence, and the ability to understand and really leverage all those different roles was highlighted in the simulation. I had never been exposed to this concept before taking this course,” Dr. Lorenz said.

The Heller Leadership Program attracts a mélange of health care professionals, including private practitioners, academics, front-line surgeons not yet in leadership positions, as well as seasoned surgical leaders, according to Dr. Lorenz. The mix also includes good subspecialty representation. “There was a tremendous amount of learning over meals and after hours where people talked about their own challenges within their subspecialty and within their organization. I don’t know of any other venues where that happens as efficiently as it did through this course.”

Dr. Lorenz said when the AAO-HNS introduces a policy on a national or regional level, he taps fellow Heller scholars for feedback. “I will make contact with this network and say, ‘What are you doing in Texas?’ or ‘How is this going in Florida?’”

He suggested surgeons new to health policy development keep in mind that “advocacy is a marathon and not a sprint,” and that there are likely to be more losses than wins. “Just because one initiative does not meet with success, don’t let it dissuade you. You are in it for the long term, and right now it is awkward. We are getting paid for volume, but in an era in which we are going to take on risk for disease prevention and hospitalization readmission prevention, we’re going to be in alternative payment models that will be specifically in contradiction to fee for service. It is our professional responsibility to preserve the quality of care while managing this transition as best we are able. Our advocacy efforts need to keep the patient and patient care as its North Star, and if we can accomplish that, we’ll ultimately be successful in the evolution of health care delivery.”

**John Maa, MD, FACS**

**ACS Health Policy Scholarship for General Surgeons**

After attending the Heller Leadership Program in 2009, Dr. Maa participated in more than 100 Capitol Hill visits during a yearlong health policy sabbatical, which included a six-month tenure in the College’s Washington, DC, office.

“In May of 2010, I arrived in the DC office to bring the surgical perspective to the front lines of policymaking. The value to the DC ACS staff was to have a surgeon who could share the practicing surgeon’s insights into proposed legislation,” Dr. Maa said, Immediate Past-President of the ACS Northern California Chapter and chair, University of California (UC) Office of the President Tobacco-Related Disease Research Program Scientific Advisory Committee. “We worked on a number of projects, including the pediatric loan repayment program, the general surgery rural care bonus, and—the issue I became most involved with—scope of practice regarding optometrists and ophthalmologists.”

Before the Heller course, Dr. Maa was not involved in public policy, focusing more on surgical program development, specifically the surgical hospitalist program at UC San Francisco Medical Center—an innovative approach to the delivery of emergency surgical care. After being encouraged to pursue the fellowship by his mentor, former ACS Executive Director Thomas R. Russell, MD, FACS, Dr. Maa applied for the fellowship five consecutive times.

“I believed that the Brandeis course would foster a deeper understanding of health policy outside of the surgical arena and operating room [OR],” Dr. Maa said.
“The course leaders are nationally recognized, with significant experience in Washington, DC, and I believed they would be excellent teachers and mentors.”

The Heller Leadership Program provided Dr. Maa with successful strategies for managing health care teams outside of the OR and the skills to make complex management decisions with limited information.

“In the OR, you’re making vital decisions for a single patient, but as a surgeon leader, your decisions can affect many more individuals simultaneously,” Dr. Maa said. “An exercise that Dr. Chilingerian led was a theoretical business case modeled after the Challenger Space Shuttle disaster that highlighted the steps and decisions that contributed to the tragic outcome on that day. Taught in the business school style, the activity illustrated how to manage a negative outcome and how to determine what went wrong. We explored the decision-making process involved in terminating a project and issuing the press release.

“The exercise underscored that when a surgeon moves beyond the OR and seeks to make larger policy decisions, the input and perspectives of many different people are required. Ultimately, however, there will be an executive who is responsible and accountable for the endeavor,” said Dr. Maa. “Being involved in leadership, catalyzing change, and working in advocacy, public policy, and politics are essential to the future success of the fields of medicine and surgery,” he added. “The skill sets required are different from those that produce success in the OR.”

Another important component of the course, according to Dr. Maa, was an overview of the history of health care economics in the U.S. and the competencies necessary to understand financial reports.

“The program taught me to be thoughtful and analytical in interpreting the economic reports that are being presented to you. First, surgeons should understand how these reports are prepared and their format—and have a basic understanding of accounting principles. It’s similar to interpreting an operative record—surgeons understand the blood pressure and heart rate information that is communicated in the anesthesiologist’s notes. Similarly, for health economic reports, surgeons should have a basic understanding of concepts such as net assets, liabilities, and profit margins, though it’s foreign to us. They don’t really teach this in medical school or residency,” Dr. Maa explained.

In his role at the UC Office of the President Tobacco-Related Disease Research Program, Dr. Maa helps oversee the statewide tobacco tax grant funds collected via Proposition 99. “We fund the tobacco control research, epidemiology, and educational programs across the state of California. It is a very different world from the OR. Our meeting proceedings are recorded, and the work is overseen by attorneys. We carefully evaluate laws and provide scientific feedback, which involves leading multidisciplinary teams, having a long-range time frame, and carefully analyzing budgets.

“Most importantly, what I’ve learned both through the Heller course and through my time in DC is the [value] of time and patience. Progress in the public policy arena involves a lengthy time frame. In the OR, events happen quickly. When a surgeon needs something and requests it, the expectation is that it will be available immediately to save the patient’s life. In the public policy world, success requires substantially more time, as it can take years for cases to be reviewed and for laws to be passed,” Dr. Maa said.

For surgeons new to the public policy arena, Dr. Maa said, learning to communicate with the public is key. “When you speak to Congress and to the general public, or when you write letters or editorials, learn to be concise and to write in a language that the general public can comprehend,” Dr. Maa advised. “You have to also learn to communicate with policymakers—many of whom are lawyers—in their language that is different from the vocabulary of surgery, if your intent is for them to respond to you.”
“...[S]uccessful leadership in 2015 increasingly involves the ability to negotiate, build consensus, and work in teams.”

—Dr. Roberts

Patricia L. Roberts, MD, FACS
ACS/American Society of Colon and Rectal Surgeons Health Policy Scholarship

“As surgeons we often have a ‘command and control’ approach to leadership,” said Dr. Roberts, chair, division of surgery, Lahey Hospital and Medical Center (LHMC), Burlington, MA. “However, successful leadership in 2015 increasingly involves the ability to negotiate, build consensus, and work in teams.” Dr. Roberts’ experience as a 2008 health policy scholar enhanced her ability to lead a number of initiatives, including the restructuring of perioperative services at LHMC in 2012.

As a result of the restructuring initiative, the OR is managed by an executive team that Dr. Roberts chairs. The team uses a shared governance model that includes the chair of the department of anesthesia, the associate chief nursing officer for perioperative services, and the vice-president of surgical services. This group has implemented a number of processes that have enhanced OR throughput, including improved start time and turnover time, according to Dr. Roberts.

“I think every team has its own character,” Dr. Roberts said. “You don’t have to be best friends with everyone on the team, but you do have to respect each other and communicate clearly and effectively. All team members should [have the freedom] to bring issues to the group, engage in frank and open discussions, and be able to reach an agreement and support each other.”

As chair of surgery, Dr. Roberts currently leads more than 100 surgeons who perform an estimated 22,000 operations a year, and mentoring future surgical leaders is a large component of this role. “On a personal level, the [Heller] program gave me greater insight into my leadership style and the need to identify and develop the next generation of leaders in the department,” Dr. Roberts said. In 2010 she received the Mentor Award from the Young Researchers Committee of the American Society of Colon and Rectal Surgeons Research Foundation. And in 2013, Dr. Roberts presented the keynote address at the 2013 Olga Jonasson Symposium at the University of Illinois, Chicago, on the topic of leadership challenges for the next generation of surgeon leaders.

Leadership, strategic thinking, and negotiation skills are essential for surgeon leaders, according to Dr. Roberts. “I also think emotional intelligence is key to effectively working with people, particularly one’s ability to work in teams. In today’s health care environment, it is increasingly less about the single surgeon and more about the dozens of member of the health care team and the ability to work together,” she said.

Steven D. Schwartzberg, MD, FACS
ACS Health Policy Scholarship for General Surgeons

“What I learned from Jon Chilingerian is that there is a science to change management,” said Dr. Schwartzberg, professor of surgery, Harvard Medical School; chief of surgery, Cambridge Health Alliance, MA; and past-president, Society of American Gastrointestinal and Endoscopic Surgeons. “Doctors are very smart people. We think we know everything, but what I took from this [program] is that if you want to lead change, you have to study change.”

A 2010 health policy scholar, Dr. Schwartzberg was working on an initiative that year to bring the surgical checklist into the OR. “We were having trouble. I wouldn’t say it was going badly, but it clearly wasn’t going well. After taking the course, I realized I had gone about this change management effort at my own hospital without the best processes in place. Jon taught us to define barriers, find the connectors to the barriers, and identify potential champions, and this allowed us to completely reboot how we were trying to implement the checklist. Using these techniques, we completely renovated our approach to getting...
“If young surgeons want to be effective change agents in their environment, big or small, the study of leadership and change is a good investment of their time.”
—Dr. Schwaitzberg

buy-in to the checklist. It’s 2015, and everybody uses the checklist now, but in 2010 it was a big change,” Dr. Schwaitzberg noted.

Overcoming resistance to change through an understanding of social dynamics is a fundamental component of the Change Pro simulation mentioned earlier in this article and was a particularly meaningful experience for Dr. Schwaitzberg.

“Change Pro was amazing. What you learn is that you can’t just walk into the [chief executive officer’s] office and mandate [the implementation of a new initiative] across the company,” he said. “You have to find who the influencers are and identify the connections and the barriers. In this simulation, you learn a lot about each division’s leader, their characteristics, and who they are connected with. You learn about the formal network structure and the informal network structure—both of which are important to leading change.”

Resolving differences is typically an integral part of successful change management. Individual attitudes regarding a new process can facilitate, slow down, or erode the diffusion of, for example, a clinical idea or new medical technology.

“When we adopted the in-patient electronic medical record, there was a lot of distrust, discouragement, and unrest. The process of leading the department through this change involved conflict resolution and identifying who was going to have a problem with this—and who will love this? Who will influence change? The tools as outlined by the Heller program have become a part of the way we do business on a daily basis,” Dr. Schwaitzberg said.

Another example of staff unrest that can occur in any health care system is the arrival of a new chief of surgery. “One of the hardest things for a new chief is to learn how to deal with conflict,” Dr. Schwaitzberg said. “A new chief comes into an organization—particularly if they come in from the outside—and he or she has to deal with many people who are well entrenched in their institution and who may have seen their fair share of chiefs come and go. Most people are a pleasure and a breeze, but there will be a small percentage who have not jumped onto your vision or have set up their own little fiefdom. Learning to deal with those challenges requires training and reinforcement. The goal is to lead people, which is very different than simply being in charge.”

Conflict resolution, according to Dr. Schwaitzberg, is about persuasion and reason, and these skills are not necessarily taught in residency and medical school. “If young surgeons want to be effective change agents in their environment, big or small, the study of leadership and change is a good investment of their time,” he explained.

In addition to change management and conflict resolution instruction, the Heller Leadership Program’s focus on advocacy and health care policy were especially germane to Dr. Schwaitzberg as the leader of one of the last publicly funded hospitals in Massachusetts.

“How the legislature makes public policy has a dramatic impact on publicly funded hospitals, so I was interested in the Heller program,” Dr. Schwaitzberg said. “I knew these policies impacted the hospital’s ability to even stay open. I actually applied for the scholarship twice. The first time I wrote about what I thought the scholarship would do for me, and I didn’t get it. The second time I wrote about issues I thought were important in public policy, and that obviously resonated much better with the review group.”

Dr. Schwaitzberg suggested the development of a follow-up to the Heller Leadership Program—a course available specifically to Heller course graduates featuring advanced study in the areas of change management, conflict resolution, and advocacy.

“Leading change effectively requires an investment to study the process, and one of the great things about the Heller course is that it gives you the opportunity to engage in the kind of deep thinking that we rarely have time for in our daily lives,” Dr. Schwaitzberg noted.
**Next level of specialized education**

Successful surgeon leaders understand the complexities involved in managing change, negotiating and resolving conflict, and assisting the College and other organizations with health policy and advocacy activities. Specialized education through the Heller Leadership Program is a proven way to develop surgeon leaders and enhance this leadership skill set.

For graduates of this program seeking an advanced level of training in health care management, as well as other physicians interested in this topic, Brandeis University is developing The Heller School’s Executive Master of Business Administration (EMBA) for Physicians. The program, which admits its first cohort in January 2016, is designed for practicing physicians who are currently in management positions and for those who are interested in pursuing these roles, according to Dr. Chilingerian. The EMBA for Physicians is an accelerated 16-month program that integrates the student’s medical expertise with training in areas ranging from health policy and economics to operational systems management, high-performance leadership, and health care innovation.


---

**REFERENCES**


Surgeons uncover the keys to life by performing classical music

by Jeannie Glickson
SURGEONS PERFORM CLASSICAL MUSIC

Many surgeons are as captivated by the chord progression and harmonic balance of a symphony orchestra as they are by the challenges in the operating room (OR). The surgeons featured in this article demonstrate their surgical acumen in the OR, and away from the OR they reveal their unique talents as classical musicians. These classical musicians and surgeons recognize the value of both passions.

Blending two passions

Peter F. Crookes, MD, FACS, proudly notes that he can hold his own as a classical violinist in a string quartet—and in an OR. Originally from Belfast, Ireland, Dr. Crookes has continued to improve his violin playing as he has pursued a practice in upper gastrointestinal and bariatric surgery. He is a professor and director of the medical student surgical clerkship at the University of Southern California (USC) department of surgery, Keck School of Medicine, Los Angeles.

“I grew up in an impoverished working class family in Belfast, in Northern Ireland, and my parents had no money for formal education. Still, my four siblings and I all learned to play the violin,” he said.

Dr. Crookes started playing at age 11, and music was the love of his early life. “As a kid, that’s what I did—I listened to classical music endlessly on our record player. I was totally immersed in music. Now, if I’d had more money, if I had come from a middle-class professional family, I would have wanted to go to a conservatory. That’s probably what I would have done with my life, but my parents could not afford to finance that kind of education.”

In the 1970s, as Dr. Crookes yearned for a musical career, the British government was funding free medical education to qualified students. On a full scholarship, Dr. Crookes was able to
attend the Queen's University Belfast School of Medicine, Dentistry and Biomedical Sciences and completed his surgical residency there. He came to the U.S. in 1990 for a one-year fellowship at USC and has been here ever since.

Dr. Crookes’ life has been a blending of his two passions: surgery and music. “I think what my music playing has given me is a more human face as a surgeon,” he said. “Music teaches you to listen, and listening to classical music is rather like reading a long novel. You have to understand the narrative. It’s not like listening to a three-and-a-half minute song on the radio. Classical music focuses your attention, and you have to listen to find out why things are developed. So being a musician has greatly enhanced my ability to listen as a surgeon.”

His musical background also gives him a strong sense of history. “To appreciate the compositions of Bach, Brahms, Beethoven, and Mozart, you need an understanding of what was happening in Europe in the 1700s and 1800s and then what was happening in medicine,” Dr. Crookes explained. “Life in 19th century Europe was terrible for people in many ways. This was before anesthesia. Diseases that are curable today killed the great composers. Mozart died at age 35 of strep throat. Mendelssohn died from a series of strokes at age 38. Music and surgery are two important strands of society, and to understand history is to understand where surgery was then and where we are today.”

Wunderkind turned accomplished surgeon

Dr. Crookes treasures his associations with surgeons and musicians alike. He goes back a few years with a younger colleague, pianist Hiroko Kunitake, MD, MPH. “Dr. Kunitake was a kind of a wunderkind as a kid in San Diego,” he said. Dr. Crookes happily recalls that when Dr. Kunitake was a student at the University of California, Los Angeles (UCLA) the two of them gave a combined academic lecture and recital as part of a surgical biology club meeting associated with the American College of Surgeons (ACS) 2007 Clinical Congress in New Orleans, LA, a performance he hopes that someday they can repeat in front of another audience.

Dr. Kunitake, who is today an assistant professor of surgery at the Boston University School of Medicine and an Associate Fellow of the ACS, began pounding the keys of a piano at four-and-a-half years old. “My parents lived in a small town in Texas, and I took lessons from the local teacher,” she said. “My dad was in the Navy, and we eventually moved to San Diego,” where she met piano teacher Jane Bastien, who guided Dr. Kunitake’s musical talents though high school.

Classical music was serious business in the Kunitake household. “My two brothers and I all played the piano, and we spent a lot of time practicing. In high school, I probably spent four to six hours a day at the piano.” Practice proved challenging but deeply rewarding for Dr. Kunitake, and playing the piano became an...
SURGEONS PERFORM CLASSICAL MUSIC

essential part of her life. As she learned the important role of discipline in any undertaking, she mastered the piano and seriously considered dedicating her life to performing classical music.

“After high school, I applied to both music conservatories and colleges. My parents really wanted me to have a liberal arts education.” In 1992, Dr. Kunitake became a freshman at Harvard University, Boston, MA, where she majored in biochemical science but continued to take piano lessons at the New England Conservatory of Music. After graduating from Harvard, Dr. Kunitake received a three-year fellowship from the American Pianists Association, which supported her study and performances around the country.

Dr. Kunitake then completed a doctorate in piano performance at the USC Thornton School of Music in Los Angeles. Soon after, an international piano contest would change the direction of her life: She and three other young U.S. pianists were selected to compete in the 2000 Chopin International Piano Competition in Warsaw, Poland.

The event reaffirmed her love and appreciation for classical music. “This was a fantastic, eye-opening experience for me,” Dr. Kunitake said. “It was just awesome to meet and listen to these outstanding musicians from around the world.” After the competition, she turned her attention to medicine, because science and medicine had always fascinated her.

“I had wanted to be a surgeon for a long time,” she said. “I attended medical school at UCLA, and completed my general surgical residency at Massachusetts General Hospital in Boston.” This was followed by a fellowship in colorectal surgery at the University of Minnesota, Minneapolis.

Being a surgeon and a world-class musician are not mutually exclusive. In Dr. Kunitake’s view, the two skill sets complement one another, a point supported by hematologist, oncologist, and Pulitzer Prize-winning author Siddhartha Mukherjee, MD, who noted the similarities of the two professions. Observing the contributions of Prussian-born Austrian surgeon and musician Theodore Billroth, born in 1829, who pursued the two disciplines with “almost equal verve,” Dr. Mukherjee wrote, “The professions still often go hand in hand. Both push manual skill to its limit; both mature with practice and age; both depend on immediacy, precision, and opposable thumbs.”*

“Creating something with your hands is very gratifying,” Dr. Kunitake said, noting that both disciplines require dexterity, and, at their most basic levels, are challenges of the hands as well as the mind. “I absolutely enjoyed pursuing both interests, and it has turned out to be a wonderful, interesting road for me.”

Currently, playing the piano relieves many of the stresses of Dr. Kunitake’s surgical life. “Today, I play the piano for myself. I find it very soothing and very satisfying,” she said. She also enjoys listening to other accomplished musicians play. As a Boston resident, Dr. Kunitake holds a subscription to the Boston Symphony Orchestra, where she can absorb classical music as an avid listener.

Overcoming social barriers

Becoming a surgeon requires overcoming any number of barriers. Alvin H. Crawford, MD, FACS, a pediatric spine surgeon in Cincinnati, OH, knows firsthand about overcoming social obstacles. His musical interests began at age 11 as an African-American youngster in Memphis, TN. He originally played the trumpet but switched to the clarinet, which he said was better suited to his embouchure, referring to how a player applies the lips to the mouthpiece of a brass or wind instrument. By the time he was in high school, he was spending many evenings backing up professional musicians when they came through town. He could read music and would rehearse with band members in the afternoon and perform with them in the evening. Music

---

was his life, and he fully expected to make it his career. After high school, he received a full musical scholarship to Tennessee A & I University (now Tennessee State), a historically black institution in Nashville. There he did what he loved: He studied classical music during the day and played with local bands at night.

Then one fateful day, his brother, thinking that he was reassuring him, told him that he would have no problem finding work as a high school band director after graduation. “I immediately thought, ‘But I don’t want to be a public school band director.’ I loved my high school band director but could not see that as my future. I loved challenges, and that idea just didn’t challenge me. Wasn’t there something else I could do?”

The conversation led to an epiphany for the young man. He decided to find a new life course and set his eyes on medicine. He began taking prerequisite courses for medical school and eventually graduated in 1960 with a double major in music and chemistry. He turned the practice and discipline that he had applied to his clarinet playing to his undergraduate premedical courses.

At that time in the segregated South, African-American people were generally barred from attending state-supported medical schools. Dr. Crawford refused to concede to discrimination. Touting his high scores on the Medical College Admission Test, he protested the University of Tennessee Medical School’s refusal to admit him.

Dr. Crawford rarely loses an argument, and he won this one. He was granted admission, and in 1964, he became the first African American to graduate from the school. Dr. Crawford admits that he wasn’t the most popular student on campus, but he never allowed himself to become a victim of discrimination. Despite the obstacles, he studied and worked hard and, all the while, he continued to play the clarinet. He began his residency at Chelsea Naval Hospital, MA, and completed it at the combined Harvard University Orthopaedic Program. In 1977, Dr. Crawford began his career in Ohio as director of orthopaedic surgery at Cincinnati.
Children’s Hospital Medical Center, OH, and remained chief there for 29 years.

Today Dr. Crawford is a widely respected academic orthopaedist who has given as much to the world as he has received. He has offered his orthopaedic teaching skills in such varied places as Germany, Sweden, Brazil, Colombia, Saudi Arabia, and West Africa. Specializing in treating scoliosis, Dr. Crawford is one of the nation’s foremost authorities on video-assisted thoracoscopic surgery, which allows surgeons to insert rods through small incisions to straighten the spine. He is also an authority on neurofibromatosis in children.

He has achieved many firsts in his distinguished career. He was the first African-American president of the Scoliosis Research Society, an international society that studies spinal deformities, and is a past-president of the John Robert Gladden Orthopaedic Society. He is the founding director of the Crawford Spine Center at Cincinnati Children’s, and in 2004 he was honored with the dedication of the Crawford Chair in Pediatric Orthopaedics and a subsequent chair in spine surgery.

Dr. Crawford’s clarinet playing took on a secondary role as he pursued a medical career, but now that he is a professor emeritus at the University of Cincinnati College of Medicine, he has the time to take clarinet lessons at the College-Conservatory of Music and play with a number of ensembles. He is a lead clarinetist in Cincinnati’s Queen City Concert Band, and he also plays with the University of Cincinnati Summer Community Band. In addition, he plays the saxophone in the Undercover Big Band of Cincinnati. He was a guest student in jazz improvisation at the University College Conservatory of Music this year and was recently appointed to the Dean’s Advisory Council of the University of Cincinnati College Conservatory of Music.

Playing with a band is a team sport, Dr. Crawford said. “In surgery and as a member of an ensemble, you go through a lot of the same things. You work as a member of a team in the operating room, and you play as a group. You maintain a key with other members of the band, and in surgery you need the rhythm and cooperation of the team, including the patient.”
He doesn’t consider his successful pursuit of two disciplines all that unusual. “A lot of physicians are serious musicians,” he said. “In many ways, the required skills are similar.”

Rediscovery and rejuvenation

John E. Rosenman, MD, FACS, a vascular surgeon in Burlingame, CA, who attended the University of California, San Francisco, School of Medicine, grew up in a family of musicians and a home filled with classical music. “Playing music was a tradition in my family,” he said. “My mother was a musician. My father was a surgeon and also a musician, and my siblings were all musicians. We had an ensemble in our house. We all grew up constantly playing and listening to music.” In that respect, nothing has changed for Dr. Rosenman. His wife plays the flute and cello, and their children are all musically inclined, although only his son is a professional musician.

When Dr. Rosenman took up the cello at age eight, he quickly discovered his own connection to music. Playing the cello became a challenge and a passion, and he pursued it enthusiastically. “I didn’t play with an orchestra in high school,” he said. “Primarily, I played chamber music with family and friends.” Private lessons helped him develop his craft, and he considered becoming a professional musician for a time. He began undergraduate school at Oberlin College, OH, which offers both a music conservatory curriculum and a liberal arts program. “Halfway through my first semester there, I realized that I wouldn’t be in the top tier of musicians,” he said. “I was more interested in academic topics, and I decided that music would be a better avocation.” Academics soon consumed his life. “I misconstrued how little time I would have to devote to my cello,” he said.

Then came medical school and surgical training, marriage, and three children. “I was so overwhelmed with the process of becoming a surgeon and having three little children at home that I didn’t touch the cello for a very long time.” About 25 years ago, after a 10-year hiatus, as he settled more comfortably into his professional and personal life, Dr. Rosenman returned to the cello, seeking to enhance his playing technique. For the first time since high school, he took private lessons.

“It was surprisingly easy for me to get back into it,” he said. “Actually, when I started playing again, I was better at it than I had been.” He now participates in two quartets and earnestly fits three days of practice a week into his schedule.

“When I practice the cello, I’m completely outside my work life,” he said. “It’s a place where I am completely engaged outside all of my responsibilities.” Now that he is in his mid-60s, and his surgical practice has slowed a bit, he finds time each summer to spend a week at a musical workshop for amateur musicians. In the summer of 2014, he lived in a dorm and attended a workshop at Scripps College in Claremont, CA.

“For me, it’s like Christmas in summer,” Dr. Rosenman said. “You are absorbed in music for one week. It takes you completely away from your professional life.”

Amateur musicians get to know each other through the workshops, which are offered in many major U.S. cities and internationally. “You see a lot of physicians there, but not as many surgeons. Surgery is generally so time-consuming, and it’s hard to commit to any kind of regular schedule.”

Most of Dr. Rosenman’s patients are aware of his musical skills. “In vascular surgery, many patients are long-term, and you take care of them year after year. I’ve known many of my patients for years, and they are really interested in my cello playing,” he said.

Creating beauty

Performing classical music is ultimately about creating something of beauty, which surgeons do in their own time and in their individual style. Surgeons employ the kind of discipline that has propelled their careers and turn that concentration into their music. The task requires focus, practice, and passion. Their passions, both surgical and musical, make the world a better place.
Are you prepared for the transition to the International Classification of Diseases, 10th Revision (ICD-10)? Health care providers throughout the U.S. currently use ICD-9, whereas health care providers in the rest of the world use ICD-10. In 2009, the U.S. Department of Health and Human Services published a regulation requiring U.S. providers to transition to ICD-10; the latest compliance date for the transition has been set for October 1, 2015. Although Congress has intervened and delayed previous deadlines, it is unlikely to give providers another extension.

The American College of Surgeons (ACS) encourages members to become familiar with the new code sets, to understand the differences between ICD-9 and ICD-10, and to prepare for how the change may affect day-to-day practice management. Indeed, the effect on billing processes could be profound because the transition expands the selection of diagnosis codes from a small pool to nearly 68,000. The Health Insurance Portability and Accountability Act (HIPAA) identified ICD-9 clinical modification (ICD-9-CM) as the standard code set for reporting diagnoses and inpatient procedures in 2003. ICD is a diagnostic tool for epidemiology, health management, and clinical purposes, which offers a systematic recoding, analysis, interpretation, and comparison of mortality and morbidity data collected in different countries. It also is used to monitor the incidence and prevalence of diseases and other health care problems around the world.

Currently, ICD-9-CM includes both diagnosis and procedural codes. Similar to ICD-9, ICD-10 comprises two categories of code sets. The first is ICD-10-CM, which providers will use in both the inpatient and outpatient setting to report diagnoses. The second is the ICD-10 procedure coding system (ICD-10-PCS), which will be used only to code for hospital inpatient procedures.

What is the ICD?
The Health Insurance Portability and Accountability Act (HIPAA) identified ICD-9 clinical modification (ICD-9-CM) as the standard code set for reporting diagnoses and inpatient procedures in 2003. ICD is a diagnostic tool for epidemiology, health management, and clinical purposes, which offers a systematic recoding, analysis, interpretation, and comparison of mortality and morbidity data collected in different countries. It also is used to monitor the incidence and prevalence of diseases and other health care problems around the world.

Currently, ICD-9-CM includes both diagnosis and procedural codes. Similar to ICD-9, ICD-10 comprises two categories of code sets. The first is ICD-10-CM, which providers will use in both the inpatient and outpatient setting to report diagnoses. The second is the ICD-10 procedure coding system (ICD-10-PCS), which will be used only to code for hospital inpatient procedures.

What will ICD-10 identify?
The ICD-10 code set reflects advances in medicine and uses current medical terminology. The code format is expanded, which means that providers will be able to include greater detail within the code to provide more specific information about the diagnosis. The flexibility of the ICD-10 code set allows for expanding and including new technologies and diagnoses. It also encompasses additional information about injuries and ambulatory and managed care. ICD-10 will combine diagnosis and symptom codes to better define certain conditions, increase specificity through greater code length for identification of disease processes to aid in research, and provide the ability to specify laterality. The College urges Fellows to begin preparing now, as the change is expected to be disruptive.

Is it necessary to upgrade to ICD-10?
Yes—the conversion to ICD-10 is a HIPAA code-set requirement. Providers, including physicians, are HIPAA “covered entities,” which means that they must comply with HIPAA requirements. In addition, conversion to ICD-10 is mandatory in order for providers to receive payment for the services they render. A failure to convert to ICD-10 will negatively affect payment. Although HIPAA code-set requirements only apply to HIPAA electronic transactions, it would be too
burdensome on the health care industry to use ICD-10 in electronic transactions and ICD-9 in manual transactions. Payors are expected to require ICD-10 codes to be used in other transactions, such as on paper, through a dedicated fax machine, or via the phone. The bottom line is that hospitals and third-party payors should be ready for ICD-10, so surgeons and other health care professionals should be as well.

How does the transition to ICD-10 affect hospital-employed surgeons?
The transition will affect hospital-employed surgeons very similarly to private practice surgeons. Although employed surgeons will be able to rely on their institutions or health systems to train their staff, they will still need to provide their billing and coding staff with the documentation and paperwork necessary to accurately code claims using ICD-10.

What are some specific differences between ICD-9-CM and ICD-10-CM?
The differences between the ICD-9-CM and ICD-10-CM code sets may not be immediately evident. Table 1 on this page provides an overview of characteristics with which to become familiar while transitioning to ICD-10-CM.

The expanded code format of ICD-10-CM means that coders will have the ability to include greater details within the code, and greater detail means that the code can provide more specific information about the diagnosis.

Is ICD-10 currently being updated?
A code freeze has been placed on both the ICD-9 and ICD-10 code sets while the transition to ICD-10 occurs. The code freeze will end when implementation of ICD-10 takes effect October 1, 2015. Regular updates to ICD-10 will begin on October 1, 2016. No updates have been made to ICD-9 since October 1, 2013, as the code set is no longer being maintained.

The ICD-10 Coordination and Maintenance Committee, the Centers for Medicare & Medicaid Services (CMS) committee responsible for approving code changes to the ICD, has continued to meet twice a year during the

---

**TABLE 1. DIFFERENCES BETWEEN ICD-9-CM AND ICD-10-CM CODE SETS**

<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 to 5 characters in length</td>
<td>3 to 7 characters in length</td>
</tr>
<tr>
<td>Approximately 13,000 codes</td>
<td>Approximately 68,000 current codes</td>
</tr>
<tr>
<td>First character may be alpha (E or V) or numeric; characters 2–5 are numeric</td>
<td>Character 1 is alpha; characters 2 and 3 are numeric; characters 4–7 are alpha or numeric</td>
</tr>
<tr>
<td>Limited space for new codes</td>
<td>New codes can be added</td>
</tr>
<tr>
<td>Limited code detail</td>
<td>Specific code detail</td>
</tr>
<tr>
<td>No laterality</td>
<td>Includes laterality</td>
</tr>
</tbody>
</table>

---

*All specific references to CPT codes and descriptions are © 2014 American Medical Association. All rights reserved. CPT and CodeManager are registered trademarks of the American Medical Association.
TABLE 2. ICD-10 CROSSWALK FOR GENERAL SURGERY

This crosswalk has been developed by the ACS and may be used as a basic guide for comparing a selection of frequently reported general surgery procedures between ICD-9 and ICD-10. Note that accurate coding is the responsibility of the provider. This crosswalk is intended only as a resource to assist in the billing process.

<table>
<thead>
<tr>
<th>ICD-9 (non-specified)</th>
<th>ICD-9</th>
<th>ICD-9 description</th>
<th>ICD-10</th>
<th>ICD-10 description</th>
</tr>
</thead>
<tbody>
<tr>
<td>569.0</td>
<td></td>
<td>Anal and rectal polyp</td>
<td>K62.0</td>
<td>Anal polyp</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>K62.1</td>
<td>Rectal polyp</td>
</tr>
<tr>
<td>569.1</td>
<td></td>
<td>Rectal prolapse</td>
<td>K62.2</td>
<td>Anal prolapse</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>K62.3</td>
<td>Rectal prolapse</td>
</tr>
<tr>
<td>569.2</td>
<td></td>
<td>Stenosis of rectum and anus</td>
<td>K62.4</td>
<td>Stenosis of anus and rectum</td>
</tr>
<tr>
<td>569.3</td>
<td></td>
<td>Hemorrhage of anus and rectum</td>
<td>K62.5</td>
<td>Hemorrhage of anus and rectum</td>
</tr>
<tr>
<td>569.4</td>
<td></td>
<td>Other specified disorders of the rectum and anus</td>
<td></td>
<td></td>
</tr>
<tr>
<td>569.41</td>
<td></td>
<td>Ulcer of anus and rectum</td>
<td>K62.6</td>
<td>Ulcer of anus and rectum</td>
</tr>
<tr>
<td>569.42</td>
<td></td>
<td>Anal or rectal pain</td>
<td>K62.89</td>
<td>Other specified diseases of anus and rectum</td>
</tr>
<tr>
<td>569.43</td>
<td></td>
<td>Anal sphincter tear (healed) (old)</td>
<td>K62.81</td>
<td>Anal sphincter tear (healed) (nontraumatic) (old)</td>
</tr>
<tr>
<td>569.44</td>
<td></td>
<td>Dysplasia of anus</td>
<td>K62.42</td>
<td>Dysplasia of anus</td>
</tr>
<tr>
<td>569.49</td>
<td></td>
<td>Other</td>
<td>K62.49</td>
<td>Other specified diseases of anus and rectum</td>
</tr>
<tr>
<td>569.5</td>
<td></td>
<td>Abscess of intestine</td>
<td>K63.0</td>
<td>Abscess of intestine</td>
</tr>
<tr>
<td>569.6</td>
<td></td>
<td>Colostomy and enterostomy complications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>569.60</td>
<td></td>
<td>Colostomy and enterostomy complications, unspecified</td>
<td>K94.00</td>
<td>Colostomy complication, unspecified</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>K94.10</td>
<td>Enterostomy complication, unspecified</td>
</tr>
<tr>
<td>569.61</td>
<td></td>
<td>Infection of colostomy or enterostomy</td>
<td>K94.02</td>
<td>Colostomy infection</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>K94.12</td>
<td>Enterostomy infection</td>
</tr>
<tr>
<td>569.62</td>
<td></td>
<td>Mechanical complication of colostomy and enterostomy</td>
<td>K94.03</td>
<td>Colostomy malfunction</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>K94.13</td>
<td>Enterostomy malfunction</td>
</tr>
<tr>
<td>569.69</td>
<td></td>
<td>Other complications</td>
<td>K94.09</td>
<td>Other complications of colostomy</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>K94.19</td>
<td>Other complications of enterostomy</td>
</tr>
<tr>
<td>569.7</td>
<td></td>
<td>Complications of intestinal pouch</td>
<td></td>
<td></td>
</tr>
<tr>
<td>569.71</td>
<td></td>
<td>Pouchitis</td>
<td>K91.850</td>
<td>Pouchitis</td>
</tr>
<tr>
<td>569.79</td>
<td></td>
<td>Other complications of intestinal pouch</td>
<td>K91.858</td>
<td>Other complications of intestinal pouch</td>
</tr>
</tbody>
</table>

continued on next page
### ICD-10 CROSSWALK FOR GENERAL SURGERY (CONTINUED)

<table>
<thead>
<tr>
<th>ICD-9 (non-specified)</th>
<th>ICD-9</th>
<th>ICD-9 description</th>
<th>ICD-10</th>
<th>ICD-10 description</th>
</tr>
</thead>
<tbody>
<tr>
<td>553.0</td>
<td>Femoral hernia</td>
<td></td>
<td>K41.90</td>
<td>Unilateral femoral hernia, without obstruction or gangrene, not specified as recurrent</td>
</tr>
<tr>
<td>553.00</td>
<td>Unilateral or unspecified (not specific as recurrent)</td>
<td></td>
<td>K41.00</td>
<td>Unilateral femoral hernia, without obstruction or gangrene, not specified as recurrent</td>
</tr>
<tr>
<td>553.01</td>
<td>Unilateral or unspecified, recurrent</td>
<td></td>
<td>K41.91</td>
<td>Unilateral femoral hernia, without obstruction or gangrene, recurrent</td>
</tr>
<tr>
<td>553.02</td>
<td>Bilateral (not specified as recurrent)</td>
<td></td>
<td>K41.20</td>
<td>Bilateral femoral hernia, without obstruction or gangrene, not specified as recurrent</td>
</tr>
<tr>
<td>553.03</td>
<td>Bilateral, recurrent</td>
<td></td>
<td>K41.21</td>
<td>Bilateral femoral hernia, without obstruction or gangrene, recurrent</td>
</tr>
<tr>
<td>553.1</td>
<td>Umbilical hernia</td>
<td></td>
<td>K42.9</td>
<td>Umbilical hernia without obstruction or gangrene</td>
</tr>
<tr>
<td>553.2</td>
<td>Ventral hernia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>553.20</td>
<td>Ventral (unspecified)</td>
<td></td>
<td>K43.9</td>
<td>Ventral hernia without obstruction or gangrene</td>
</tr>
<tr>
<td>553.21</td>
<td>Incisional</td>
<td></td>
<td>K43.2</td>
<td>Incisional hernia without obstruction or gangrene</td>
</tr>
<tr>
<td>553.29</td>
<td>Other</td>
<td></td>
<td>K43.9</td>
<td>Ventral hernia without obstruction or gangrene</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>K46.9</td>
<td>Unspecified abdominal hernia without obstruction or gangrene</td>
</tr>
<tr>
<td>553.3</td>
<td>Diaphragmatic hernia</td>
<td></td>
<td>K44.9</td>
<td>Diaphragmatic hernia without obstruction or gangrene</td>
</tr>
<tr>
<td>459.0</td>
<td>Postphlebitic syndrome</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>459.10</td>
<td>Postphlebitic syndrome without complications</td>
<td></td>
<td>I87.009</td>
<td>Postthrombotic syndrome without complications of unspecified extremity</td>
</tr>
<tr>
<td>459.11</td>
<td>Postphlebitic syndrome with ulcer</td>
<td></td>
<td>I87.019</td>
<td>Postthrombotic syndrome with ulcer of unspecified lower extremity</td>
</tr>
<tr>
<td>459.12</td>
<td>Postphlebitic syndrome with inflammation</td>
<td></td>
<td>I87.029</td>
<td>Postthrombotic syndrome with inflammation of unspecified lower extremity</td>
</tr>
<tr>
<td>459.13</td>
<td>Postphlebitic syndrome with ulcer and inflammation</td>
<td></td>
<td>I87.039</td>
<td>Postthrombotic syndrome with ulcer and inflammation of unspecified lower extremity</td>
</tr>
<tr>
<td>459.19</td>
<td>Postphlebitic syndrome with other complications</td>
<td></td>
<td>I87.039</td>
<td>Postthrombotic syndrome with ulcer and inflammation of unspecified lower extremity</td>
</tr>
</tbody>
</table>
freeze. At these meetings, the public is allowed to comment on whether new diagnosis and procedure codes should be created in order to capture new technology or disease. New code requests will be evaluated for implementation in ICD-10 on or after October 1, 2016. The ACS has representation every step of the way and is already working to improve ICD-10.

What steps should I take to begin implementing ICD-10 in my practice?
The implementation of ICD-10 will require coordination of multiple aspects of a surgical practice. An important first step in the ICD-10 implementation process is to conduct a practice impact assessment, which will be useful in bringing awareness to the areas of the practice that will be most affected by the transition to ICD-10. It includes an analysis of how the practice will accept, process, and translate coded data under the ICD-10 system. An impact assessment may evaluate how ICD-10 will affect the following aspects of your practice:

- Systems and vendor contracts: Ensure vendors can accommodate ICD-10 needs
- Additional ICD-10 resources:
  - The American Health Information Management Association ICD-10 website: www.ahima.org/topics/icd10
  - The American Hospital Association central office ICD-10 website: www.ahacentraloffice.org/codes/ICD10.shtml
  - Online tool for converting ICD-9 codes to ICD-10: www.icd10data.com/
and find out how and when the vendor plans to update existing systems; review new and existing vendor contracts and evaluate vendor offerings and capabilities against the organization’s expectations

• Business practices: Once ICD-10 is implemented, determine how the new codes will affect processes for referrals, authorizations/pre-certifications, patient intake, physician orders, and patient encounters

• Productivity: Train staff to accommodate the substantial increase and specificity in code sets, physician workflow and patient volume changes, and the amount of time needed for testing

• Reimbursement structures: Coordinate with payors on contract negotiations and new policies that reflect the expanded code sets

What resources are available to aid in this transition?
The ACS has developed an ICD-9-CM to ICD-10-CM crosswalk of the most frequently reported general surgery diagnosis codes to assist surgeons with the transition to ICD-10. Table 2, pages 36–37, can help determine how a particular ICD-9 code will translate to ICD-10.

The crosswalk was published in the February issue of the Bulletin. Surgeons should continue to monitor the ACS ICD-10 website leading up to the October 1 implementation date for more ICD-9-to-ICD-10 coding examples and other important information. Additional ICD-10 resources are located in the sidebar on page 38.

While ICD-10 may seem more burdensome than ICD-9, the system has its benefits. It will be more specific, more compatible with electronic health record systems, and will help clarify the true diagnosis for the surgical patient. ♦

Editor’s note
Accurate coding is the responsibility of the provider. This article is intended only as a resource to assist in the billing process.

REFERENCES
Big data and GME: Expanding the scope of patient safety and QI training

by David C. Chang, PhD, MPH, MBA; Jordan D. Bohnen, MD, MBA; John T. Mullen, MD, FACS; and Bob S. Carter, MD, PhD

In 2012, the Accreditation Council for Graduate Medical Education (ACGME) mandated that training programs “engage residents in patient safety and quality improvement [QI] activities” and created the Clinical Learning and Environment Review, a national program to oversee efforts to engage residents in these and other key areas.1-3 Subsequently, many discussions among medical educators have centered on how to integrate training in patient safety and QI into residency programs.4,5 Most current QI curricula are delivered in the form of didactic lectures or hands-on clinical QI projects at the local hospital level.6

The increasing availability of “big data” generated through electronic health records, large health care outcomes databases, and so on, has created a new and potentially complementary approach to engage surgical residents, in addition to the more common approach of classroom lectures or other clinical didactics about quality and patient safety. The value of big data in clinical care and in research has been well documented, but the application of these modern, evolving tools to GME training has received far less attention.7,8 This column summarizes some of the important skills and lessons these new tools offer to GME.

Ownership over QI and decision making

Accessing and studying big data can increase residents’ sense of ownership over the development and exploration of a QI hypothesis and provide important insights into the decision-making processes that underlie QI priorities. Residents may be asked to select a QI project from a list of existing project ideas, but they often are not privy to the internal organizational decisions that lead to the prioritization of one QI effort over another—they are only tasked with designing, implementing, and studying a QI intervention. Reviewing pertinent literature may improve the understanding of the quality problem at hand, but without access to the initial data, residents may not appreciate the assumptions and calculations used to frame the problems. Providing access to large data sources and the training necessary to use them shifts ownership of a QI question to the individuals designing the interventions.

For example, when asked to investigate readmission to their own hospitals, residents using big data may first ask, “What is the scale of the problem that I am considering? Is it a problem of variation across practitioners, hospitals, or regions? If so, are there indicators that suggest what might correlate with this variation, and are any of the covariates potentially modifiable in a way that improves quality broadly?” Residents engaged in big data QI research will learn the decision-making processes for initial data abstraction and analysis necessary to refine QI questions and to propose meaningful solutions. This training will enhance the ability of future physician leaders to further prioritize and advocate for the collection of the granular data necessary to test QI hypotheses and strategic improvement initiatives. The Quality In-Training Initiative, launched by the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP®), is an example of a step in this direction.9

Gaining perspective

By providing population-level perspectives, big data can also be used to identify new targets for QI, as well as elucidate
The value of big data in clinical care and in research has been well documented, but the application of these modern, evolving tools to GME training has received far less attention.

potential limitations. Until the past decade, most health care quality and outcomes research was confined to single institutions or small multi-institutional series, limiting both their inferential power and generalizability.

However, with the availability of large health care datasets—such as those found in ACS NSQIP, the Healthcare Cost and Utilization Project’s Nationwide Inpatient Sample (NIS), as well as specialty-specific registries—we can now aggregate data across large numbers of health care organizations to identify new opportunities for QI. For example, the Cystic Fibrosis Foundation’s national registry has been used to identify outliers in care, prompting some of the best health care institutions to identify potential areas of improvement. In much the same way as the appeal of fine art can be appreciated at a slight distance—if the viewer stands too close, all they might see are the brushstrokes and miss the point of the art work—so too can health care quality be more fully appreciated when viewed on a broader scale.

The population-level perspectives gained from big data also lend important insights into the potential limitations of QI work. An important concept in QI is the observed-to-expected (O/E) ratio. Although health care professionals aim to prevent all patient harm, the limitations in scientific knowledge and the often unpredictable nature of disease and treatment suggest that a certain percentage of imperfect outcomes may be unavoidable. Big data provides a lens through which we can better appreciate and develop evidence-based standards, allowing us to quantify the degree to which a particular outcome may have been avoidable. This concept of “expected outcomes”—or essentially a principle of “acceptability of negative outcomes”—is difficult to appreciate at the local hospital level. We can identify poor outcomes and use root-cause analyses to determine why they occurred, but it is difficult to know which outcome was “expected” for a given case. By identifying and comparing “apples to apples” through such processes as risk adjustment and propensity score matching, residents can begin to appreciate the concept of acceptability behind the O/E ratios.

A better understanding of this acceptability principle can have important systemic implications in helping to increase the national acceptance of QI policies. For instance, the goal of a recent Centers for Medicare & Medicaid Services (CMS) policy to penalize hospitals for readmissions is sometimes misinterpreted as CMS wanting to penalize all hospitals for all readmissions, when this policy will only target hospitals with readmissions that are “higher than expected,” a metric that can only be discerned when big data is analyzed.

Generating new ideas for interventions

By analyzing different physician practice patterns, care pathways, and hospital organizational structures across hundreds or even thousands of different surgeons, hospitals, and regions of the country, big data may provide novel ideas for QI initiatives that extend beyond patient selection or technical refinement issues. For example, surgical outcomes have been shown to vary widely between surgeons with different experience levels, or between surgeons from different subspecialties. At the local level, QI efforts may focus on studying the differences in technique or resource utilization. However,
Big data provides a lens through which we can better appreciate and develop evidence-based standards, allowing us to quantify the degree to which a particular outcome may have been avoidable.

Promoting rigorous evaluation
A successful QI initiative must include an evaluation component, and big data provides a platform to teach trainees about data-driven QI process evaluation. Important concepts such as risk adjustment and O/E ratios are best taught with actual data. Residents can learn to identify and capture data that are necessary for project evaluation, design evidence-based evaluation strategies, and critically analyze and interpret the data. This process is a logical extension of the evidence-based medicine concept into QI. Rather than assuming that a given QI intervention will work, big data enables and encourages the trainee to rigorously evaluate the data both before and after the intervention to determine whether it did or could work.

Conclusion
Big data has important implications for the tripartite mission of academic medical centers to support excellent clinical care, research, and education. We should recognize the value that big data offers for our educational mission and design specific offerings within the context of our education programs to allow trainees to learn about big data research tools and their applications to QI and patient safety. Though big data and the tools used in their systematic analysis have historically been reserved for dedicated health services researchers, they are increasingly available to our trainees and warrant increased attention as a means to engage learners in lifelong QI endeavors, which our nation’s health care system so desperately needs.

REFERENCES
Surgical resection of solid tumors remains the cornerstone of multidisciplinary care for patients with early-stage and advanced malignancies. Although organizations such as the National Cancer Institute and National Comprehensive Cancer Network publish guidelines and treatment algorithms for the care of cancer patients, none of these protocols addresses the fundamental question of what constitutes the critical elements of an operative procedure for cancer resection. Overall, standards for oncologic resections are surprisingly lacking. Quality control in clinical trials involving surgery has been inconsistent and makes comparison across studies inaccurate or impossible.

To address the technical aspects of standardizing surgical care, the American College of Surgeons Clinical Research Program, a program of the Alliance for Clinical Trials in Oncology and the College, formed the Cancer Care Standards Development Committee. For the last three years, the committee, led by Kelly K. Hunt, MD, FACS (co-author of this article), worked to develop a manual that details the critical elements of cancer surgery as first envisioned by Heidi Nelson, MD, FACS (co-author of this article). The resulting textbook, *Operative Standards for Cancer Surgery*, is now complete and will be available for purchase in July at the Wolters Kluwer website, www.lww.com/acrs.

**Development of the manual**
The manual was conceived in response to the need for a standardized description of “minimum standards” for various cancer operations to serve as a reference for clinical trials that include surgical interventions. More specifically, the idea was to create a standards manual that could serve as a reference in the development of clinical trials that include operations such as breast-conserving surgery, pancreaticoduodenectomy, or lobectomy, rather than require investigators to establish or re-establish the basic principles of these operations with the development of each new trial. The goal was to minimize variability across study sites and improve adherence to minimum standards for patients treated both on and off a clinical trial. As the project matured, it became clear that this manual could serve many purposes, ranging from surgical education to providing a basis for operative report templates and quality improvement databases.

The committee chose to focus on four specific disease sites for the first edition of the manual—breast, colon, lung, and pancreas. For each disease site, several common operative procedures that the committee agreed were important to describe were chosen. The manual is not a surgical atlas; rather, the emphasis is on oncologic fundamentals and the critical elements in the conduct of an operation and intraoperative decision making.

In addition, the committee participants who developed the manual identified areas of controversy and posed several key questions that were then analyzed using a systematic review of current literature. These may serve as the basis for a new clinical trial within each disease site.

A leadership committee was assigned to address each disease group. This leadership group included a section editor, a methodologist, and an art/illustrations editor. Surgeons
with expertise in each disease site were recruited from all of the national societies and cooperative groups for the broadest possible representation. International experts also were invited to participate in each section. Much of the initial work was done on conference calls, followed by collaborative writing over the next year and a half. This work culminated in the completed textbook, which will also be available as an online resource.

The final product
The manual provides concrete recommendations on the proper conduct of operations and detailed information on the oncologic principles, avoidable pitfalls, and quality of the evidence on which these recommendations are based. The manual is focused on the decisions that are made from skin incision to skin closure, and the recommendations are based on the strongest available evidence. Because randomized trials have not addressed all of the components of operations within each disease site, it was important to draw on the experience and consensus of the experts writing the individual chapters. Identifying the lack of evidence on certain topics has been an unintended consequence of writing this manual and has galvanized the authors into establishing standards where none currently exist. With the participation of more than 120 surgeons in this first edition, it is perhaps the best resource currently available on the proper conduct of an operation for cancer of the breast, colon, lung, and pancreas.

In anticipation of continued evolution in surgical oncology, these initial four disease site sections will be updated every two to three years. Planning is already under way for the second edition of the manual and will include procedures in melanoma, gastric cancer, esophageal cancer, rectal cancer, and thyroid cancer.

Frank Detterbeck, MD, FACS, FCCP, professor of surgery (section of thoracic surgery); chief, thoracic surgery; surgical director, thoracic oncology; and associate director, clinical affairs, Yale Cancer Center, New Haven, CT, described the role of the manual best in the introduction to the chapter on lung cancer:* The purpose of this section is to describe a minimal standard for the actions that should be taken in the surgical care of [lung] cancer patients, with the ultimate goal of improving the quality of care these patients receive. In this way, the aim...is to “raise the floor” rather than define the absolute ceiling of what can be achieved; further improvement is always possible. This standard should serve as a guide for surgeons who are focused on delivering high-quality care to achieve the best outcomes for their patients. ♦

The Surgeon Specific Registry and the ACS Member Profile enhance your practice

by Bianca Agregado and Connie Bura

The American College of Surgeons’ (ACS) top priority is providing value for its Fellows, Associate Fellows, and Resident and Medical Student Members. Current member benefits provide opportunities and resources in the areas of education, research, quality, advocacy, publications, scholarships, networking, committees, and communities. The ACS Division of Member Services has developed this new “Your ACS benefits” column to provide members with updates every other month on the member perquisites. This inaugural column looks at two ACS member databases: the Surgeon Specific Registry (SSR) and the ACS Member Profile.

The SSR
The SSR is a web and mobile software application and database that allows surgeons to track their cases and outcomes in a convenient, easy-to-use manner. The SSR builds on the ACS Case Log system, enabling surgeons not only to log and keep track of their cases, but also participate in an increasing number of regulatory programs for the individual health care professional. Examples include the following:

• Submit surgical measures to the 2015 Centers for Medicare & Medicaid Services (CMS) Physician Quality Reporting System (PQRS). In 2017, health care providers will be subject to penalties based on 2015 data. Options for CMS PQRS participation in the SSR include the following:
  – 2015 PQRS General Surgery Measures Group
  – 2015 PQRS individual measures
  – 2015 ACS SSR Qualified Clinical Data Registry (QCDR)—Trauma measures

• Meet American Board of Surgery Maintenance of Certification Part 4, which requires surgeons to participate in an outcomes registry or quality assessment program.

• Use the SSR as an individual health care provider case log.

• Enter and edit cases online and via a mobile device (iPhone, iPad, and Android).
Many members who have used the SSR have found that the registry is a valuable benefit; in fact, according to a member survey conducted in November 2014 of 2,232 members, 64 percent of the Fellows who reported using the SSR rated it as highly valuable.

- Enter cases in the registry within a matter of minutes based on key clinical data variables.

- Review benchmark and real-time online reports.

ACS members can access and use the SSR free of charge. Many members who have used the SSR have found that the registry is a valuable benefit; in fact, according to a member survey conducted in November 2014 of 2,232 members, 64 percent of the Fellows who reported using the SSR rated it as highly valuable. The College anticipates that surgeons will find the SSR of increasing value as regulatory requirements continue to mount.

To use this member resource, members will need to register for the system by logging in with a user name and password. Participants will then be taken to an account creation page. If you have already registered for the SSR, log in to the system and enter your cases. For more information about the SSR, contact SSR@facs.org.

**My Profile and the Find a Surgeon Site**

The new ACS website, launched in the summer of 2014, allows members to access and update their online profiles more easily. These data feed into the Find a Surgeon site that your colleagues and, most importantly, patients who are searching for a qualified surgeon use to connect with you. Members who log in to the website and then access the Find a Surgeon site can search for colleagues and retrieve their contact information, including their e-mail addresses. E-mail addresses are not displayed to the public. In addition, members can search for colleagues through the ACS Communities.

To date, more than 10,000 members have updated some component of their Member Profile. Updating your profile is quick and easy. There are eight profile sections, some of which are pre-populated with information provided as part of your Fellow or Associate Fellow application. You can use key features of the member profile to do the following:

- Edit your contact information and specify whether you want patients to be able to contact you through the site.

- Upload your photo. If you don’t have a current photo available to upload, visit the My Profile booth at the annual Clinical Congress to get a professional photo taken and where staff will upload it directly to your profile. The photo will be provided to you on a flash drive, free of charge.

- Inform patients about yourself and your practice philosophy.

- Identify and select your subspecialties and areas of clinical concentration from a comprehensive list.

- Display information about your hospital and/or academic appointments and society memberships.
YOUR ACS BENEFITS

• Edit your pre-populated training and society membership information as well as update your specialty and board certification information.

• Select options to display your birth date, gender, and/or race.

• Choose how you want the information displayed—to the public, to members only, or kept private.

The ACS will send you a weekly e-mail indicating how many individuals have viewed your profile.

The ACS is working on your behalf to raise awareness and help patients understand the meaning of ACS membership—that Fellows pledge to place the welfare and rights of their patients above all else, to respect each patient’s autonomy and individuality, and to work to advance their professional knowledge and skills throughout their careers.

Patients who enter a search such as “need a qualified surgeon” or “looking for a surgeon” in a search engine such as Google will be presented with the ACS Find a Surgeon site as one of their top search returns. The facs.org website is also promoted by the National Institutes of Health, the National Cancer Institute, and the American Cancer Society.

Most patients are either looking for surgeons to perform a specific procedure or a health care professional within their geographic area. However, patients can also search by a range of variables, including name, state/city/zip code, country, distance, specialty, subspecialty, areas of clinical concentration, and gender. The results will display all of the information you have requested as “public” in your Profile; from that point, patients can send you a direct e-mail communication.

Monthly page views on the Find a Surgeon site range between 12,000 to 18,000 searches, making it one of the most visited pages on the ACS website.

To update your profile, go to facs.org and click on “Member Login,” located in the upper right-hand corner of the Web page. Enter your user name (your member ID) and password. If you do not have this information available, contact ms@facs.org and a College staff member will send it to you. Once logged in, the “Member Login” tab will read, “Welcome Dr. [Your Name].” Click on “Welcome” and select “My Profile.” From here you can click on the pencils in the right hand corner of each section to begin editing and adding information to your profile. Users have the ability to save content as they work within the tool, and have the option of reviewing the finished product by logging out and searching for his or her name in the Find a Surgeon site. Members are encouraged to visit his or her profile at least once a year and whenever contact information requires updating. While logged in, users have the opportunity to review all of the other exclusive members-only benefits that are available, such as My CME, the Affinity Program offerings, and the FACS logo that is available for download.
For quite some time now, this column has brought Joint Commission-related news and information to surgeons. In the last year, the column has covered a variety of relevant topics, including guidelines related to the prevention of retained surgical items, surgical site infections, and wrong site surgery, as well as the important role of surgeons in standards development and on-site survey processes.

**Expanded topics**

As a new member of The Joint Commission’s Board of Commissioners, appointed by the American College of Surgeons (ACS), I have come to believe that the connection between The Joint Commission and surgeons could be expanded beyond these topics. With that in mind, I would like “A look at The Joint Commission” to take a new direction over the coming year. My intention is to continue to keep Bulletin readers informed of relevant developments in surgical care, patient safety, and related Joint Commission initiatives and resources but, at the same time, I also plan to contribute my own thoughts and opinions with regard to those topics as they affect surgeons and to add perspectives on other topics, such as surgeon fatigue and sleep deprivation, enhanced patient recovery after surgery, and the effect of accountable care organizations on surgeons.

Since joining the Board of Commissioners, I have had the opportunity to become more familiar with The Joint Commission and its initiatives to improve patient safety and quality of care—issues that are top priorities for surgeons. Through this column, I look forward to identifying additional ways that The Joint Commission and surgeons can work together to ensure optimal patient safety and reach the goal of zero harm.

**Insider’s perspective**

In addition to covering topics related to patient safety and quality care, I look forward to informing ACS members about my responsibilities and activities as a member of The Joint Commission’s Board of Commissioners. As the commission’s governing body, the board provides policy leadership and oversight. Board members serve three-year terms, renewable for up to nine years. Each member of the board governs with a dedication to The Joint Commission’s mission to continuously improve health care for the public in collaboration with other stakeholders by evaluating health care institutions and inspiring them to excel in providing safe and effective care.

A total of 21 Commissioners are appointed by The Joint Commission’s five member organizations: the ACS, American Hospital Association, American Medical Association, American College of Physicians, and American Dental Association. Representatives from six additional groups serve as public members and four as at-large members representing behavioral health care, home care, long-term care, and nursing care. As health care continues to expand, it is increasingly important for members of the health care community to strengthen their relationships with one another and to work collaboratively to bring about positive change for patients.

I hope you’ll enjoy the new direction of “A look at The Joint Commission” and find this column to be a valuable resource in your everyday practice. I invite your questions, comments, and suggestions on topics related to The Joint Commission, and can be reached at cpellegrini@facs.org.
Road rash is an alliteration that is entrenched in American slang and heard with frequency on spring and summer trauma rounds. The term is distinct, descriptive, and diagnostic, but it refers to more than an allergic reaction to asphalt. It is unclear whether the term was born in the hospital or is rooted in the motorcycle, skate, or some other speed-loving subculture. Nevertheless, any activity that involves speed, skin, and asphalt has a potential for road rash.

Factors affecting degree of injury
The word “asphalt” derives from the Greek “asphaltes,” which is actually of Phoenician origin. Homer gave the name Asphaltites to a lake in Palestine, now known as the Dead Sea, which had been an ancient source of asphalt or bitumen.* Asphalt provides the maximum amount of traction between tires and other road-bound surfaces. Unfortunately, the same tractive forces used to generate motion between a body and a tangential surface can wreak havoc on exposed dermal areas. The degree of injury ultimately depends on the bodies in motion, the speed of the skin when it hits the road, the texture and condition of the surface, and the sliding distance. In the spring and summer months, the frequency of kinematic activities prone to road rash tend to increase. The activity that comes to mind first would be motorcycling. Even with an entire industry based on apparel designed to protect motorcyclists, no federal laws or regulations mandate their use—and only 19 states and the District of Columbia require all motorcyclists to wear helmets.

Road rash injuries, as with thermal injuries, classify in terms of depth. These wounds can include a combination of deep abrasions, avulsions, and lacerations. Patients may require hospital admission for adequate pain control, assistance with wound care, and therapies if the injuries span joints. Deeper injuries that fail to heal may require excision and grafting. Healed injuries also are prone to hypertrophic changes. Other considerations would be tattooing that occurs when bituminous particles become embedded in the dermis after re-epithelialization and produce discolorations of the skin.† After Advanced Trauma Life Support® protocols are applied, principle tenets of wound care should be used to obtain the best functional and cosmetic outcomes.

Outcomes
To examine the occurrence of motorcycle-related road rash injuries in the National Trauma Data Bank® (NTDB®) research dataset for 2013, hospital admissions records were searched using the International Classification of Diseases, Ninth Revision, Clinical Modification diagnoses codes. Specifically searched were records for motorcycle-related injuries containing an external cause of injury code (E-code) E810–816 and E818 (motor vehicle traffic related) and either a post-decimal value of 0.2 for injured motorcyclist, or 0.3 for injured passenger on a motorcycle. These records were then searched for a diagnosis code 910.0–917.0 and 919.0 (abrasion or friction burn for varying parts of the body). A total of 20,407 records were found; 17,054 records contained a discharge status, including 13,554 patients discharged to home, 1,974 to acute care/rehab, and 1,126 to skilled nursing facilities; 400 died. These patients were 88.5 percent male, typically 40.1 years of age, had an average hospital length of stay of 5.8 days, an average intensive care unit length of stay of 5.8 days, an

*Transactions of the American Institute of Mining Engineers, Volume XVIII. New York, NY. American Institute of Mining Engineers; 1890.
average injury severity score of 13.1, and were on the ventilator for an average of 7.1 days. Of those tested for alcohol (12,235) or drugs (7,466), 29.5 percent were positive for alcohol and more than half (52.1 percent) were positive for drugs. (See figures, this page.)

Motorcycle rallies will be in abundance between Memorial Day and Labor Day, and bike enthusiasts have many options when it comes to scale and locale. The population of Sturgis, SD, for example, will soar from roughly 7,000 to potentially 600,000 during the first week of August as bikers from across the nation attend the annual rally commemorating the event’s 75th anniversary. Riding a two-wheeled, high-performance transportation device is challenging in and of itself; this summer, don’t hit the road jacked if you want to avoid spilling and sliding your way to road rash.

Throughout the year, we will be highlighting these data through brief reports in the Bulletin. The NTDB Annual Report 2014 is available on the ACS website at www.facs.org/quality-programs/trauma/ntdb.

In addition, information is available on the website about how to obtain NTDB data for more detailed study. If you are interested in submitting your trauma center’s data, contact Melanie L. Neal, Manager, NTDB, at mneal@facs.org. ♦

Acknowledgement
Statistical support for this article has been provided by Chrystal Caden-Price, Data Analyst, NTDB.
ACS declares victory with passage of law repealing the SGR

The landslide vote in Congress to pass H.R. 2, the Medicare Access and Children’s Health Insurance Program Reauthorization Act of 2015, this spring ushered in much-needed Medicare reforms. Especially noteworthy is the repeal of the flawed sustainable growth rate (SGR) formula used to calculate Medicare physician pay. The American College of Surgeons (ACS) led a multi-year campaign to garner lawmakers’ support to permanently repeal the SGR. H.R. 2 passed in the Senate 92–8 and in the House 392–37. President Obama signed it into law on April 16.

The new law stopped implementation of a 21 percent SGR cut that was scheduled to take effect April 1. The hard-fought victory was achieved through the advocacy efforts of the ACS and other medical associations, as well as through Fellows’ participation in meetings with lawmakers and thousands of letters and calls to Capitol Hill.

The College is committed to working with Centers for Medicare & Medicaid Services officials on the implementation of the policies authorized in the legislation that stress quality of care for Medicare beneficiaries. Details regarding the legislation and what surgeons can expect in the future will be published in the July issue of the Bulletin.
Hartford Consensus III focuses on empowering the public to serve as first responders

The Joint Committee to Create a National Policy to Enhance Survivability from Intentional Mass-Casualty and Active Shooter Events, founded by the American College of Surgeons (ACS), held its third Hartford Consensus meeting April 14, 2015, in Hartford, CT. Chaired by ACS Regent Lenworth M. Jacobs, Jr., MD, MPH, FACS, professor of surgery; director, Trauma Institute; and vice-president of academic affairs, Hartford Hospital, the meeting focused on implementation of strategies for effective hemorrhage control.

The full Hartford Consensus III report will be published in the July issue of the Bulletin. Briefly, however, the Hartford Consensus III centers on strategies for preparing individuals at the scene of a mass-casualty event to serve as immediate responders using the group’s THREAT system. THREAT involves the following:

- 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 from the following groups:

- Immediate responders: Individuals present at the incident
- Professional first responders: Law enforcement, emergency medical service personnel, fire fighters, and rescue workers
- Trauma professionals: Hospitalists; emergency department physicians, nurses, and technicians; and trauma surgeons

Empowering immediate responders

An emphasis of the Hartford Consensus III is on empowering the public to provide lifesaving, first-line care. The Hartford Consensus III also calls for educating individuals and communities about the use of effective external hemorrhage control techniques and for ensuring access to bleeding control bags in public places in the same way that automatic external defibrillators are now accessible to the public. For example, the document calls for extending Good Samaritan protections to individuals who use tourniquets and lifesaving devices to control the bleeding of victims at mass-casualty events.

A number of ACS Fellows in addition to Dr. Jacobs participated in the Hartford Consensus III, a list of whom can be found in the sidebar.

ACS FELLOW PARTICIPANTS IN HARTFORD CONSENSUS III

Richard Carmona, MD, MPH, FACS, 17th U.S. Surgeon General
Alasdair K. T. Conn, MD, FACS, FRCSC, chief emeritus, department of emergency medicine, Massachusetts General Hospital, Boston
Alexander Eastman, MD, MPH, FACS, Major Cities Police Chiefs Association; chief of trauma, Parkland Memorial Hospital, University of Texas Southwestern Medical Center, Houston
Lenworth M. Jacobs, Jr., MD, MPH, FACS, professor of surgery; director, Trauma Institute; and vice-president of academic affairs, Hartford Hospital
John Holcomb, MD, FACS, chief, division of acute care surgery, University of Texas Health Science Center at Houston
Norman McSwain, MD, FACS, medical director, prehospital trauma life support, Tulane University, New Orleans, LA
Peter Rhee, MD, MPH, FACS, professor of surgery, department of surgery, University of Arizona, Tucson
Ronald Stewart, MD, FACS, Chair, ACS Committee on Trauma; chair, department of surgery, University of Texas Health Science Center at San Antonio
ACS President Andrew L. Warshaw, MD, FACS, FRCSEd(Hon), surgeon-in-chief emeritus, Massachusetts General Hospital, and the W. Gerald Austen Distinguished Professor of Surgery, Harvard Medical School, Boston
Leonard Weireter, MD, FACS, Vice-Chair, ACS Committee on Trauma; Arthur and Marie Kirk Family Professor of Surgery, Eastern Virginia Medical School, Norfolk
Jonathan Woodson, MD, FACS, Assistant Secretary of Defense for Health Affairs, U.S. Department of Defense, Washington, DC

V100 No 6 BULLETIN American College of Surgeons
North American surgery lost one of its great leaders last winter. **Lloyd Douglas MacLean, MD, PhD, FACS, FRSC, Past-President of the American College of Surgeons (ACS),** died in his sleep on January 14 at age 90.

Dr. MacLean was an outstanding clinician whose investigative interests touched on all of the important surgical developments that occurred in his lifetime. Early studies in gastric physiology, transplant immunology, infection, and nutrition preceded his interests in septic shock and organ failure, clinical transplantation, host resistance, and the physiologic evaluation of the critically ill surgical patient. His evaluations of the clinical results of bariatric surgery were leading edge and established the bar for others in this currently relevant clinical field. He was one of Canada’s leading academic surgeons and a wonderful role model for all of the surgeons in his department.

---

**Early promise**

Born in Calgary, AB, in 1924, Dr. MacLean achieved an exceptional academic record, and he financed his undergraduate and medical school education at the University of Alberta, Edmonton, on scholarships. Following a rotating internship in Alberta, he entered the surgical training program at the University of Minnesota, Minneapolis, where he thrived in the intellectual and investigative atmosphere promulgated by Owen H. Wangensteen, MD, PhD, FACS, chief of surgery.

By the completion of his residency and after earning a doctorate in physiology in 1957 as a Markle Scholar in Medical Sciences, Dr. MacLean had authored 32 papers, many of which were published in the *New England Journal of Medicine,* *The Lancet,* and basic science journals. Board-certified in general and thoracic surgery, he was promoted from the residency program to chief of surgery at the Ancker Hospital in St. Paul, MN, where his clinical and academic career flourished.

In 1962, he was recruited to McGill University, Montreal, QC, to serve as professor of surgery and chief of surgery at the Royal Victoria Hospital. In his 27 years in that position, Dr. MacLean established what was considered the premier academic surgery program in Canada. He achieved universal recognition, becoming the Archibald Professor of Surgery at McGill, a Fellow of the Royal Society of Canada, an Officer of the Order of Canada, and the 1988 Sims Commonwealth Travelling Professor. He received the Canada Gairdner Wightman Award, along with honorary degrees from McGill and the University of Alberta and visiting professorships to most Canadian medical schools, as well as many U.S. and international institutions.

---

**Leadership in fractious times**

Dr. MacLean held high office in many surgical associations. He was president of the American College of Surgeons, the American Surgical Association, the Canadian Association of General Surgeons, and the Canadian Association of Thoracic Surgeons. He was a member of the ACS Board of Directors, where he was instrumental in the development of the National Resident Educational Improvement Program (NREIP), and was the long-time chair of the NREIP Committee. He was also a member of the ACS Committee on Accreditation of Training Programs and the ACS Committee on Organ Transplantation.

---

**In memoriam:**

**Dr. Lloyd MacLean, ACS Past-President and “The Chief” at McGill**

by Jonathan L. Meakins, MD, FACS
Dr. MacLean (left) accepting the Surgical Forum Volume XL dedication from Douglas W. Wilmore, MD, FACS, then-Chair of the Committee for the Forum on Fundamental Surgical Problems, at the 1989 Clinical Congress.

Surgical Association, the Central Surgical Association, the International Surgical Group, and the James IV Association of Surgeons.

Much of his energy dedicated to surgical organizations, though, was focused on the ACS. In the 1960s, Dr. MacLean was heavily involved with the Pre- and Post-Operative Care Committee and the writing of the first ACS Manual of Preoperative and Postoperative Care. For the next six years, he served on the Committee on Fundamental Surgical Problems, the Surgical Forum Committee, of which he served as Vice-Chair. In 1989, his 29th year of participation, the Surgical Forum was dedicated to him. Additionally, he was ACS Secretary (1982–1983) and served three consecutive three-year terms on the ACS Board of Regents (1983–1992), culminating in his service as Vice-Chair of the Board of Regents (1991–1992). He also served on the Honors Committee (1981–1987); Organization Committee (1981–1985); Central Judiciary Committee (1983–1990); Executive Committee (1987–1992); the Member Services Liaison Committee (1990–1992); and Health Policy and Reimbursement Committee (consultant, 1984–1986, and member, 1993–2000).

Dr. MacLean was Chair of the ACS Clinical Congress Program Committee from 1985 to 1992. These were fractious years due to an increase in specialization and surgical disciplines seeking more program time and independence. His diplomatic skills were evident as the College’s meetings were always successful, and peacefully evolved into the 1990s.

He was elected ACS President in 1993, and his Presidential Address, “Wangensteen’s Surgical Forum: A legacy of research,” is worth reexaming. The speech outlined Dr. Wangensteen’s career, explaining how a restless intellect that constantly questioned the causes of the clinical problems facing his patients would find solutions. Dr. MacLean believed surgeons were physicians who operated—not simply technicians. None of us heard, “What do you mean, you got a medical consult?” more than once.

Influence on McGill’s culture

The Surgical Forum was an integral component of the residency program in Minnesota and, under Dr. MacLean’s leadership, participation in the forum became a significant part of serving and training in the department of surgery at McGill. For residents and junior staff, meeting the March 15 deadline for submitting abstracts for the Surgical Forum was integrated into the rhythm of the year. Presentation and participation were a part of the department’s culture. In the late 1970s, more than half of the Canadian Forum papers were from McGill staff.

Dr. McLean was a leader whose integrity, scholarship, and devotion to the physiological approach to patient care and outcomes data epitomized the caring academic surgeon. A key characteristic that surfaced in morbidity and mortality...
conferences was Dr. MacLean’s ability to be chair one minute and a regular surgeon with a complication the next. When he had a patient who experienced a complication, as happens to all of us, he could relinquish the chair and allow himself to be quizzed about the case, accepting that there might have been a better approach, as we all had to do from time to time. And when it was time to move on to the next case, he resumed his authority as chair. Thus, he created a level playing field.

“The Chief”
There was never any doubt that Dr. MacLean was “The Chief”—and was referred to as such. The winter issue of the department of surgery’s newsletter, The Square Knot, recorded the reflections of his residents and their interactions with him.* Aside from his acknowledged qualities as department chair, a number of common themes emerged, including his modesty, quick sense of humor, decision-making skills, and a remarkable ability to crystallize a problem, paper, or situation into an often-hilarious sentence.

His wit was situational and difficult to translate out of context, but examples from the operating room include: “Let me introduce my opponents for this operation” and, “Here, let me help you…just kidding.” Following a difficult meeting with the other department heads, he was known to burst into the office with, “I have made enough enemies for one day, I am going home.” When we were offered a position in the department, the conversation was brief: “You will start ___(date) and share an office with ___. Now see ___about the details.” Before you could say “thank you,” he was dictating the letter to the dean and a funding source.

His modesty came through in many ways. We always learned of his awards or presidencies indirectly, if at all. Following receipt of an international award, he repeatedly refused to be nominated for any further recognition, saying, “Let’s spread them around.” He said that he did not get paid after 6:00 pm and would return home with his boundless energy and extraordinary sense of humor, but also with a full briefcase of work to be completed after dinner. His personal life was full with golf, tennis, gardening, cycling, hiking, skiing, and photography of the children and grandchildren as they grew and prospered.

Dr. MacLean leaves his wife of 60 years, Eleanor Colle, MD, four sons, a daughter, and 10 grandchildren, along with extraordinary memories for those of us who had the good fortune to have worked for and with him. ♦

---

Spend Your Time Learning, Not Searching

Selected Readings in General Surgery (SRGS®) is the premier literature review for general surgeons.

• Explore an expert summary of the latest published research.
• Study a variety of topics, including specialty areas like pediatrics, breast, and vascular diseases.
• Earn a substantial number of self-assessment credits for MOC Part II.*
• Expand your knowledge when it’s convenient for you. Read SRGS on any platform at home, in the office, or while traveling.

* The American College of Surgeons (ACS) is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians. The ACS designates this enduring material for a maximum of 80 AMA PRA Category 1 Credits™ annually. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Subscribe today!
www.facs.org/publications/srgs or call 800-631-0033
In the summer of 2014, the American College of Surgeons (ACS) launched an online platform for members of the organization to share their interests and concerns. Nearly a year later, more than 100 ACS Communities are now active. In the coming months, the Bulletin will periodically publish a brief message from the Editor of a community. To begin this series, this article focuses on the ACS Diversity Community.

Fellows of the ACS Diversity Community are thought leaders who are committed to engaging in collaborative discussions informed by their unique experiences and ongoing exposures in diversity with the intent of maximizing our capabilities as surgeon leaders. The members of this community are dedicated to creating a transformative online community by expanding the traditional concepts of diversity beyond gender, religion, race, and ethnicity to include sexual orientation, disability, body shape, and all differences that may be embodied in our families, friends, patients, co-workers, and colleagues.

The community is engaged in a continuous, reaffirming conversation focused on the value proposition of diversity in all of its forms. A multidisciplinary social media framework including social science, business management, psychology, entertainment, leadership development, and diversity science are used to stimulate conversations. Leadership is a consistent theme that permeates most discussions. The goal of our community is to create value for each Fellow by sharing our perceptions of the human experience, so that our privilege of performing surgery is magnified as we embrace the humanity of each of our patients. Through enhanced awareness and empathy, we seek to inspire quality in both our surgical practices and health care organizations and therefore better position ourselves as surgeon leaders to serve our patients with skill and fidelity.

I invite you to join the Diversity Community. Simply log in to ACS Communities, hover over “Communities” on the blue bar, and select “Browse All Communities.” When the list of communities appears, click the green “Join” button next to the Diversity Community.
Retired Brigadier General John E. Hutton, Jr., MD, FACS, was buried with full military honors at Arlington National Cemetery April 1. He died December 19, 2014, of complications from Parkinson’s disease and Lewy body dementia at a military retirement facility in Washington, DC, at age 83.

Distinguished service to country
Dr. Hutton was born in New York, NY, September 9, 1931, the son of John and Antoinette Hutton. He graduated from Wesleyan University, Middletown, CT, in 1953, and in September of that year was commissioned as an Officer in the U.S. Marine Corps. He served primarily as an Infantry Officer, with a secondary specialty as a Naval Aviation Tactical Observer, and served in both the Mediterranean and far eastern theaters.

In 1957, then-Captain Hutton resigned his regular commission and entered Columbia University, New York, NY, to complete pre-medical education. After graduating from the George Washington School of Medicine, Washington, DC, in 1963, he entered the U.S. Army and completed a rotating internship, general surgery residency, and vascular surgery fellowship at Walter Reed National Military Medical Center, Bethesda, MD. Military assignments included a tour in Vietnam as the Chief of Surgery and Professional Services at the 91st Evacuation Hospital; Chief of General and Vascular Surgery and Residency Program Director, Letterman Army Medical Center; Chief, Department of Surgery, Walter Reed National Military Medical Center; Vascular Consultant to the Surgeon General; Commander of the 47th Field Hospital, Honduras; and Commanding General, Madigan Army Medical Center, Tacoma, WA.

His military awards include the Distinguished Service Medal; Bronze Star; Meritorious Service Medal with oak leaf cluster; the Joint Services, Army, and Navy Commendation Medals; the Vietnam Cross of Gallantry; the Vietnam Honor Medal 1st Class; and various theater and campaign medals. He held the “A” prefix, which refers to a very high level of competency in a critical specialty, as a teaching chief and was awarded the Order of Military Medical Merit. He was a diplomat of the Diploma in the Medical Care of Catastrophes under the auspices of The Worshipful Society of Apothecaries of London.

Physician to President Reagan
Dr. Hutton was White House physician and was appointed Physician to President Ronald Reagan in January 1987. He also was director of the White House Medical Unit, which comprised several physicians, nurses, and other health care professionals. He provided emergency care to the President and First Lady, as well as approximately 1,500 White House staff and visiting dignitaries. He had an office in the Old Executive Office Building, plus a small office in the White House. He visited the Reagans a number of times in their home near Los Angeles, CA, after President Reagan left office, and Dr. Hutton served as a pallbearer at the President’s funeral.

Dr. Hutton held a variety of academic positions, including...
[Dr. Hutton] was a Fellow of the ACS; he delivered the Opening Address, On a President’s Health, at the 1989 Clinical Congress under the ACS Presidency of Oliver H. Beahrs, MD, FACS.

Dr. Hutton’s major interests were in the field of vascular and trauma surgery, with publications in both fields. He was a Fellow of the American College of Surgeons (ACS); he delivered the Opening Address, On a President’s Health, at the 1989 Clinical Congress under the ACS Presidency of Oliver H. Beahrs, MD, FACS. He also was a member of the American Association for the Surgery of Trauma, the Society for Vascular Surgery, the Society for Clinical Vascular Surgery, the Bay Surgical Society (Honorary), the Chesapeake Vascular Society, and the Military Vascular Society.

Outside interests

He had many interests, including photography. Several of his photos were featured on the cover of Yachting Magazine and in a series of yachting calendars. While in San Francisco, CA, he sang in the Grace Cathedral Choir. He also was a second degree black belt in karate.

Survivors include his wife of 53 years, Barbara Joyce Hutton of Silver Spring, MD; four children—John E. Hutton III of Jacksonville, FL; Wendy Little of Olympia, WA; James Hutton of Phoenix, MD; and Beth Shiau of Aiea, HI—and eight grandchildren.

“Your Lung Operation” provides patients with the knowledge and training to support full participation and optimal recovery. Safety measures such as site marking, ID band checks, and pneumonia prevention strategies are demonstrated to support the surgeon and health care professional in meeting all CMS and Joint Commission guidelines for safe surgical procedures and optimal recovery.

The program is free to members and contains:

- A 20-page booklet and 30-minute DVD with information on preoperative prep, cancer staging, procedure overview, potential risks, discharge, and home care.
- Information sheets, including lung images, medication lists, exercise and pulmonary rehab activity guides, quit smoking resources, and survivorship plans.
- Additional resources, including a patient evaluation form.
- For nonmembers, this program can be purchased individually, or bulk pricing is available.
- Hospital broadcast rights are also available for purchase.

To order, visit www.facs.org/education/patient-education.

This Surgical Patient Education Program is a collaborative by the American College of Surgeons with the Society of Thoracic Surgery, the American Association for Thoracic Surgery, the Association of periOperative Registered Nurses, and the Commission on Cancer.

Print or digital Bulletin? The choice is yours

For the last three years, the American College of Surgeons (ACS) has offered an online version of the Bulletin, which can be accessed at bulletin.facs.org or from the ACS website (facs.org) under “Publications.” One advantage of reading the Bulletin online is that you can read it as early as a week before you would receive the print edition. And each month, we will send you a direct link to the latest issue when it appears online.

In light of a recent survey of ACS members that revealed that a number of you would prefer to read the Bulletin online rather than continue to receive the print version, the staff in the ACS Division of Integrated Communications are now in the process of developing an even more reader-friendly design for the online edition. The new design will make the publication easily read on mobile devices and is expected to be completed this summer.

As more of you move toward reading the digital version of the Bulletin, you may be interested in ending your subscription to the print edition. To stop receiving the print version, go to the ACS website and log in. Once you have logged in, go to “My Profile” and select edit (the pencil icon) at the top of your profile. Scroll down to “Subscription Preferences.” There you can indicate your preferred delivery method for the Bulletin.

You can also opt-in to the online version of the Journal of the American College of Surgeons (JACS) by following the same steps. JACS articles go online almost immediately after they have been accepted for publication and weeks before they appear in print.

If you still want to receive the print version of the Bulletin and/or JACS, no action is needed on your part. Keep in mind that even if you select the online versions, you may still receive one or two print publications before the changes go into effect. ♦
Dr. Turner is first woman SBAS president-elect

Patricia L. Turner, MD, FACS, Director, Division of Member Services, American College of Surgeons (ACS), was recently elected the first woman president-elect of the Society of Black Academic Surgeons (SBAS). The election took place at the SBAS Annual Scientific Assembly, in Chapel Hill, NC, cohosted by the University of North Carolina Chapel Hill department of surgery, and chaired by Anthony A. Meyer, MD, PhD, FACS, FRCS, Governor of the ACS North Carolina Chapter.

Dr. Turner’s one-year term as president of the SBAS will begin at next year’s annual meeting, which will be cohosted with The Ohio State University and chaired by Robert S. D. Higgins, MD, MSHA, FACS, program director, The Ohio State University Medical Center, Columbus.

Dr. Turner will preside at the 2017 SBAS annual meeting in Chicago, IL, cohosted by the University of Chicago and chaired by Jeffrey B. Matthews, MD, FACS, Dallas B. Phemister Professor of Surgery, and chair, department of surgery, University of Chicago Medicine.

Dr. Turner is an adjunct associate professor in surgery at Northwestern University Feinberg School of Medicine, Chicago, and a clinical associate professor of surgery at the University of Chicago. SBAS nurtures the involvement and development of academic surgeons, providing a robust and research-oriented annual scientific forum. View the SBAS website at www.sbas.net/.

Commission on Cancer to hold two educational programs in June

The American College of Surgeons Commission on Cancer (CoC) will sponsor two educational programs at the Swissôtel Chicago, IL. A half-day workshop on June 17 will focus on the National Cancer Data Base (NCDB) quality tools. Participants in Maximizing NCDB Data to Improve Your Cancer Program Today will learn how cancer program administrators and oncologists can use the registry data for clinical decision making. NCDB staff will present examples of tool development, expectations, and current uses of the NCDB quality tools. The registration fee is $350. Find more information and register online at www.facs.org/quality-programs/cancer/coc/events/survey-savvy/ncdb-workshop.

The second program, Survey Savvy, June 18–19, will offer an in-depth review of the information that an institution’s cancer committee needs to coordinate a high-quality, patient-centered, multidisciplinary cancer program. Developed by CoC staff and committee leadership, this program addresses a cancer program’s common questions and concerns regarding CoC standards and compliance.

This conference will examine the following:

- Chapter 3 in the CoC’s Cancer Program Standards 2012: Ensuring Patient Centered Care, Continuum of Care Services. Participants will gain clarification on the standards, learn how to demonstrate compliance, and distinguish how each of the 2015 phase-in standards will be evaluated for compliance during the survey process.

- Chapter 4 in the CoC’s Cancer Program Standards 2012: Ensuring Patient Centered Care, Patient Outcomes. Attendees will learn to identify the components of successful prevention and screening programs (Standards 4.1 and 4.2), as well as differentiate what are appropriate and compliant studies of quality and quality improvements (Standards 4.7 and 4.8).

The registration fee is $850. Find more information and register online at www.facs.org/quality-programs/cancer/coc/events/survey-savvy.
**Becker’s Hospital Review** names Dr. Ko one of 50 patient safety experts

Clifford Y. Ko, MD, MS, MSHS, FACS, Director, American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP®), and Director, ACS Division of Research and Optimal Patient Care, has been named one of 50 experts leading the field of patient safety in the U.S. by the 2015 Becker’s Hospital Review. This third edition of the list includes individuals at national organizations, universities, and health care systems working to improve patient safety. The 2015 list includes names of advocates, professors, researchers, administrators, and health care providers who have won awards, published articles, and led initiatives to reduce medical injuries and ensure patient safety. In addition to his role with ACS NSQIP, Dr. Ko is a practicing colon and rectal surgeon and a professor at the University of California, Los Angeles (UCLA) Schools of Medicine and Public Health and holds the Robert and Kelly Day Chair in Surgical Outcomes at UCLA. He is also a research affiliate at the RAND Corporation.

The Becker’s Hospital Review editorial team considered nominations and selected leaders through an editorial review process. See the full list of recipients on the Becker Hospital Review website at [http://goo.gl/X5Eetm](http://goo.gl/X5Eetm), and view Dr. Ko’s profile on the website at [http://goo.gl/IwriLC](http://goo.gl/IwriLC).

---

**Dr. Ellner receives inaugural Roger Schenke Award from AAPL**

The American Association for Physician Leadership (AAPL) presented the inaugural Roger Schenke Award to Scott J. Ellner, DO, MPH, FACS, at its annual meeting April 18 in Las Vegas, NV. Dr. Ellner is president of the Saint Francis Medical Group, vice-chairman of the department of surgery, and director of surgical quality at Saint Francis Hospital and Medical Center, Hartford, CT.

Dr. Ellner has implemented training for all perioperative teams and instituted evidence-based protocols to virtually eliminate the risk of human error in the operating rooms at Saint Francis and was instrumental in founding the Connecticut Surgical Quality Collaborative (CtSQC). The CtSQC is a statewide group of 22 hospitals that meets regularly to share quality outcomes, including successes and best practices for the benefit of all patients in the state. Many of the CtSQC hospitals use the American College of Surgeons National Surgical Quality Improvement Program to improve outcomes in key areas of surgical care and provide the best value—health outcomes achieved per dollar spent—to patients, hospitals, and health plans.

The Roger Schenke Award, created in 2014 for the 40th anniversary of the AAPL, honors individual vision, commitment, and innovation in creating education and training programs to improve patient safety and enhance physician leadership. It is named for Roger Schenke, who in 1975 founded the American Association for Physician Leadership, which has grown to more than 11,000 members and serves physicians at all stages of their careers through leadership education, career support, and policy advocacy. Learn more online at [www.physicianleaders.org](http://www.physicianleaders.org).
The American College of Surgeons (ACS) Committee on Trauma (COT) announced the 15 winners of the 38th annual Residents Trauma Papers Competition at its Annual Meeting, March 12–14, in Chicago, IL. Each winner received $500, with an additional $500 awarded to the second-place winners in each category, and an extra $1,000 awarded to the two first-place winners.

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

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

The 2015 competition winners are as follows:

**First Place, Basic Laboratory Research:** Simone M. Langness, MD, University of California, San Diego, postgraduate year (PGY)-4 (COT Region 9): The Vagus Nerve Mediates the Neural Stem Cell Response to Intestinal Injury

**First Place, Clinical Investigation:** Deepika Nehra, MD, Massachusetts General Hospital, Boston, PGY-7 (COT Region 10): Acute Rehabilitation after Trauma: Does It Really Matter?

**Second Place, Basic Laboratory Research:** Michaela C. Kollisch-Singule, MD, State University of New York at Stony Brook Medical University, Syracuse, PGY-4 (COT Region 2): Impact of Chest Wall Recruitment in Prevention of Acute Respiratory Distress Syndrome

**Second Place, Clinical Investigation:** Cherisse Berry, MD, University of Maryland, Baltimore, PGY-9 (COT Region 4): Acute Rehabilitation after Trauma: Does It Really Matter?
Region 3): Prospective Evaluation of Post-Traumatic Vasospasm (PTV) and Post-Injury Functional Outcome Assessment: Is Cerebral Ischemia Going Unrecognized in TBI Patients?

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

Elizabeth King, MD, Boston University Medical Center, PGY-5 (COT Region 1): Valproic Acid Mitigates the Inflammatory Response in Murine Acute Lung Injury at the Expense of Bacterial Clearance

Samuel W. Ross, MD, MPH, Carolinas Medical Center, Charlotte, NC, PGY-4 (COT Region 4): Hemodilution: Fact or Fiction? A Prospective, Randomized Control Trial to Quantify the Effect of Blood Loss and Crystalloid Resuscitation on Hemoglobin

Ihab Halaweish, MD, University of Michigan, Ann Arbor, PGY-5 (COT Region 5): Early Resuscitation with Fresh Frozen Plasma for Traumatic Brain Injury Combined with Hemorrhagic Shock Improves Neurological Recovery

Melody R. Saeman, MD, University of Texas Southwestern Medical School, Dallas, PGY-5 (COT Region 6): Alteration of the Circadian Network following Traumatic Brain Injury

Haniee Chung, MD, Barnes Jewish Hospital, St. Louis, MO, PGY-5 (COT Region 7): The Problem of Age: The Role of the Immune Response to Severe Injury in the Elderly

Hunter B. Moore, MD, University of Colorado, Denver, PGY-3 (COT Region 8): Hyperfibrinolysis Is Driven by Hemorrhagic Shock and Attenuated by Plasma Resuscitation: The Role of Plasma First Resuscitation in Critically Injured Patients

Timothy J. Rice, MD, Hamilton General Hospital, ON (COT Region 12): A Randomized, Double-Blinded, Placebo-Controlled Pilot Trial on the Efficacy of Early Enoxaparin: The Optimal Timing of Thromboprophylaxis in a Traumatic Intracranial Hemorrhage Study

Captain Jonathan J. Sexton, MD, Johns Hopkins Community Physicians Suburban Hospital, Bethesda, MD (COT Region 13): Administration of FTY720 during Tourniquet-Induced Hind Limb Ischemia-Reperfusion Injury Attenuates Morbidity and Mortality in a Rodent Model

Eduardo Rissi Silva, MD, Hospital das Clinicas, Sao Paulo, Brazil (COT Region 14): Prospective Evaluation of a Protocol of Whole-Body CT Based Only in Mechanism of Injury in Major Trauma Patients

Jacqueline van Laarhoven, MD, Ratboud University, Netherlands (COT Region 15): Associated Thoracic Injury in Patients with a Clavicle Fracture: An Analysis of 1478 Polytrauma Patients

Felix Che-Lok Chow, MB, BS (HK), MHKICSBCS, University of Hong Kong, Queen Mary Hospital (COT Region 16): Clinical Parameters Predicting In-Hospital Mortality in Geriatric Patients following Severe Trauma: A 15-Year Experience ♦
Wall Street Journal article features enhanced recovery protocols

Enhanced recovery protocols are changing surgical patients’ perioperative care and improving outcomes, according to an article in the March 30 The Wall Street Journal (WSJ). Laura Landro, who writes the WSJ column “The Informed Patient,” interviews Traci Hedrick, MD, FACS, co-author of a study in the February online edition of the Journal of the American College of Surgeons. Dr. Hedrick’s team at the University of Virginia Health System, Charlottesville, found that when used in colorectal surgery patients, enhanced recovery contributed to reducing length of hospital stay by 2.2 days compared with a control group. Furthermore, complications were reduced by 17 percent, patient satisfaction with pain control increased by 55 percent, and overall estimated cost savings was $7,129 per patient. View an American College of Surgeons (ACS) press release reporting on the study results at www.facs.org/media/press-releases/facs/colorectal0205.

Enhanced recovery protocols are designed to achieve early recovery after surgical procedures by maintaining organ function and minimizing the stress caused by the procedure. The key elements include preoperative counseling, nutritional guidance, painkilling and anesthetic medication, and early mobilization.

The ACS National Surgical Quality Improvement Program (ACS NSQIP®) is pursuing an initiative for increased acceptance of enhanced recovery protocols throughout surgery. Profiled in the article is a positive patient care enhanced recovery experience at Duke University Medical Center, Durham, NC. In addition, “Kaiser Permanente Northern California is currently introducing the enhanced recovery protocol in its 21 medical centers, focusing first on colorectal surgery and hip fracture patients. It plans to expand the program soon to total joint replacement,” Ms. Landro reports.

Ms. Landro writes of this “national initiative led by experts including Julie Thacker [MD, FACS], assistant professor of surgery at Duke University School of Medicine and medical director of the enhanced recovery program at Duke University Hospital, which has been able to reduce hospital stays and readmissions with the approach.”

For details on ACS NSQIP’s role in enhanced recovery, contact acsnsqip@facs.org. Read the full text article and view the news video online at http://goo.gl/JHQXWW.

Each month, rely on the ACS advocacy e-newsletter:

★ To keep you informed
★ To learn the College’s position on pertinent issues
★ To see how your involvement can make a difference.

Downloadable from most digital communications devices
Visit www.facs.org/publications/newsletters/acs-advocate
Louisiana Chapter annual meeting features mock oral exam

The Louisiana Chapter of the American College of Surgeons (ACS) held its annual meeting January 16−18 at the InterContinental Hotel in New Orleans. This year’s event featured opening remarks by Louisiana Chapter President Barry Landry, MD, FACS. ACS President Andrew L. Warshaw, MD, FACS, FRCSEd(Hon), provided an update on College activities and commented on the strengths of the chapter.

Also in attendance from the College was James Wadzinski, Director of Operations, ACS National Surgical Quality Improvement Program (ACS NSQIP®), and Susan Chishimba, Business Development Associate, ACS NSQIP. Mr. Wadzinski shared the podium with Scott J. Ellner, DO, MPH, FACS, who spoke on Identifying and Sustaining Surgical Quality Improvement. In addition, Tara Leystra-Ackerman, State Affairs Associate, and Frank G. Opelka, MD, FACS, Medical Director for Quality and Health Policy, ACS Division of Advocacy and Health Policy, spoke about issues under their purview in the College’s Washington office.

This year’s annual meeting included many educational sessions, Resident Paper Awards, a Poster Competition, and the Sixth Annual Surgical Jeopardy Bowl, moderated again by Donnie F. Aultman, MD, FACS, assistant vice-chancellor, graduate medical education designated institutional official, Louisiana State University Health Sciences Center, Shreveport. The grand prize winner of the 2015 Resident Jeopardy Bowl was Tulane University School of Medicine, New Orleans.

A mock oral exam was offered the day before the Louisiana Chapter annual meeting. The event was open to Fellows and postgraduate year (PGY)-4 residents; 20 examiners and 14 residents participated, and 10 chapter members donated the use of their hotel rooms for the four-and-a-half-hour program. The event ended with a social hour for meeting participants.

Commission on Cancer groups each held meetings, as did the Louisiana Chapter Women in Surgery (WIS) Committee. The WIS Committee Chair, Eliana A. Soto, MD, FACS, welcomed meeting attendees. WIS member Rachel L. Moore, MD, FACS, chief, section of metabolic surgery, Louisiana Health Sciences Center, New Orleans, introduced featured speaker Kathleen Zuniga, partner with Carr, Riggs & Ingram, LLC, who spoke on balancing a demanding full-time career with raising a family.

Participants of the WIS Breakfast at the Louisiana Chapter Meeting, including (from left): Ms. Zuniga; Samire Almeida, resident at Universidad Federal do Pard; Dr. Moore; and Dr. Soto.
**Participants, College staff, and some chapter members.**

**Jordan Chapter holds first council meeting as a new chapter**

The Jordan Chapter of the ACS hosted its first official council meeting February 18 at the Jordan Hospital in Amman. The meeting followed the chartering of the chapter by the Board of Regents on February 7. Presiding officers at the meeting were Abdalla Yunis Bashir, MB, BCh, FACS, ACS Governor, and Chapter President Mahmoud Abu-Khalaf, MB, BCh, FACS. Also discussed at the council meeting were activities planned by the chapter for the upcoming year and the formation of standing committees in the areas of education, membership finance, communications, issues and social events, and Resident and Associate members. All Jordan Chapter members will be encouraged to volunteer for the proposed new committees based on personal interest.

Abdul Naser Al Shunaigat, MB, BS, FACS, Chapter Treasurer, introduced a discussion of chapter dues during the council meeting. Osama Hamed, MB, BS, FACS, Chapter Secretary, encouraged all present to attend the first annual meeting of the chapter, which took place April 25.

**North Texas Chapter meeting offers travel awards**

The 2015 ACS North Texas Chapter meeting took place February 20–21 at the Cityplace Conference Center in Dallas, with more than 150 surgeons, residents, and medical students participating. Assisting the Chapter Council with annual meeting preparations was new Chapter Administrator Carrie Steffen.

This year the North Texas Chapter offered financial assistance to 12 resident surgeons and medical students traveling to the meeting from institutions outside Dallas. Each recipient was compensated for up to two nights hotel accommodations and given $200 to offset the cost of travel.

Representing the College at the meeting was Kenneth L. Mattox, MD, FACS, ACS Second Vice-President, who offered an update on ACS activities along with an overview on best practices for using the online ACS Communities.

In addition, the North Texas Chapter meeting...
Dr. Robinette (at podium) addresses chapter members and ACS staff at the first annual meeting of the revitalized Alaska Chapter.

A view of the Cook Inlet, from the top of the Hotel Captain Cook in Anchorage. Most of the population of Alaska surrounds Cook Inlet.

featured the annual Resident Paper Competition, a Poster Exhibition, and a Resident Jeopardy Competition. The 2015 Winner for Best Overall Paper was Jeffrey R. Watkins, MD, a PGY-4 general surgery resident at Methodist Dallas Medical Center. Dr. Watkins was awarded $250 for his paper “Keyhole Mesh in Large Paraeosophageal Hernias: A Safe Technique with Low Rates of Dysphagia.” Best Poster was awarded to Bharti Jasra, MD, PGY-5, at the University of Texas, Southwestern Medical Center, Dallas, for “Failure of a Breast Density Notification Law to Impact the Screening of Women with Dense Breasts.” A trophy was given to the Resident Jeopardy Competition winners, the team from the department of surgery at Texas Tech University, Lubbock.

Connecticut Chapter holds 2015 Lobby Day in Hartford
The Connecticut Chapter of the ACS, in conjunction with the Connecticut State Medical Society, sponsored a Lobby Day March 11 in Hartford. Several ACS Fellows were in attendance and advocated on legislation being debated in the statehouse, including bills that would establish a legal definition of surgery, increase coverage for bariatric surgery, and mandate truth in advertising. The day opened with Connecticut Chapter members commenting on the activities of the Connecticut Surgical Quality Collaborative and the Enhanced Recovery after Surgery initiative, and a national legislative update from Patrick V. Bailey, MD, FACS, Medical Director of Advocacy, ACS Division of Advocacy and Health Policy. The day’s activities also included a conversation with State Comptroller Kevin Lembo. Chapter members were briefed on the current legislative environment, and then adjourned to attend individual meetings with state legislators, including Senate Majority Leader Bob Duff (D). The day concluded with a luncheon featuring leaders from both sides of the Connecticut General Assembly.

Revitalized Alaska Chapter elects officers, holds first annual meeting
On March 14, the Alaska Chapter held its first meeting since the mid-1980s, with newly elected Chapter President Danny R. Robinette, MD, FACS, presiding over the day’s educational and social events. The meeting took place at Hotel Captain Cook in Anchorage, named for Captain James Cook, who was the first person credited with mapping the state’s jagged coastline. A total of 20 Fellows attended the meeting, and a combined total of 28 Fellows, guests, sponsors, and College staff participated in an evening reception and dinner.

Patricia L. Turner, MD, FACS, Director, ACS Division of Member Services, provided an update on ACS activities and gave a presentation on Abdominal Wall Reconstruction. Meg Gilley, Congressional Lobbyist, ACS Division of Advocacy and Health Policy, offered an overview of the College’s legislative activities. Also in attendance was Donna Tieberg, ACS Chapter Services
Manager, who worked with Dr. Robinette as administrator for the Alaska Chapter meeting and chapter activities during the revitalization period.

In addition, guest speaker Mika N. Sinanan, MD, FACS, ACS Governor and professor of surgery, University of Washington, Seattle, spoke on Managing the Complex Referral Patient. Frank D. Sacco, MD, FACS, a general surgeon at Alaska Native Medical Center, Anchorage, gave an Update on the State of Alaska Trauma System. A lively Town Hall discussion involving chapter members and guests focused on future chapter goals. The chapter council, including officers and councilors-at-large, met to further solidify and outline the goals discussed at the Town Hall session.

Over the past 18 months, a small yet active core group of Fellows in Alaska has been instrumental in reviving interest in the chapter. Significant motivating factors for bringing Alaska Fellows together include changes to medical reimbursements, the evolving political climate, and threats to both national and state trauma funding. The chapter plans to work closely with Jon Sutton, Manager of State Affairs, ACS Division of Advocacy and Health Policy, to obtain funding for a state lobby day.

**ACS Chapter Services announces new webinar series**

ACS Chapter Services is now offering a new free chapter webinar series for ACS members and chapter administrators/staff. The webinars focus on best practices and important issues in ACS chapter management. This series is aimed at anyone involved in ACS chapter management. The 45-minute webinars are presented live, with time for questions at the end of each session. These brief but informative sessions are being recorded and are accessible online after the webinars.

The series kicked off March 18 with “Protect Your Chapter’s History: Archiving 101,” hosted by Adam Carey, MA, MLIS, ACS Archivist. Other titles and presenters included When Board Members Go Bad: Practical Aspects of Hard Problems, featuring ACS legal counsel Paula Goedert, Esq., Barnes & Thornburg, LLP; and Governors 101: Building a Partnership, hosted by Betty A. Sanders, MBA, PMP, Senior Administrator, ACS Board of Governors.

To register and view a full list of webinars, go to the ACS Chapter Services webinar page at www.facs.org/member-services/chapters/webinars. For questions regarding registration or accessing webinar recordings, contact Vivian Ross, Chapter Services Program Coordinator at vross@acs.org.

---

**R. Phillip Burns Surgical Society established in Tennessee**

A large crowd of friends and colleagues were on hand to celebrate the establishment of the R. Phillip Burns Surgical Society February 23 in Chattanooga, TN. This new society recognizes the contributions that Dr. Burns, a Fellow and Past First Vice-President of the ACS, has made to surgical education and provides “a forum for the advancement of surgical training in Tennessee as well as to promote collegiality among surgeons.”

*Left:* Attendees at the inaugural meeting included (from left): Kenneth W. Sharp, MD, FACS, Vanderbilt University Medical Center; Laura E. Witherspoon, MD, FACS, University Surgical Associates, Chattanooga; Dr. Burns, University Surgical Associates; ACS President-Elect J. David Richardson, MD, FACS; and Harold (David) Head, MD, FACS (retired), Signal Mountain, TN.
American College of Surgeons Members can save up to $358 on annual premiums

Current 10-Year Level Term Life Rate Chart

<table>
<thead>
<tr>
<th>Age</th>
<th>Base Rate</th>
<th>Your Rate*</th>
<th>Your Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>35</td>
<td>$340</td>
<td>$272</td>
<td>$68</td>
</tr>
<tr>
<td>40</td>
<td>$430</td>
<td>$344</td>
<td>$86</td>
</tr>
<tr>
<td>45</td>
<td>$650</td>
<td>$520</td>
<td>$130</td>
</tr>
<tr>
<td>50</td>
<td>$1,060</td>
<td>$848</td>
<td>$212</td>
</tr>
<tr>
<td>55</td>
<td>$1,790</td>
<td>$1,432</td>
<td>$358</td>
</tr>
</tbody>
</table>

Rates shown are for male, super preferred, non-smoker meeting the highest underwriting standards.

With your many obligations as a surgeon, you certainly know how important it is to protect your family. Life insurance can help protect your family in the event you become terminally ill or die suddenly.

You can save even more on all your coverages if you are covered under a Group Term Life, a Group Disability and Group Accidental Death & Dismemberment Insurance at the same time. 20-Year Level Term Life and Traditional Term Life plans are also available. Our package discount will save you an additional 25%!
2015 Health Policy Scholars announced

A total of 17 surgeons will participate in the Leadership Program in Health Policy and Management in June at the Heller School for Social Policy and Management, Brandeis University, Waltham, MA, in June.

Each year, the American College of Surgeons (ACS) partners with 16 surgical specialty groups to help design the course and award scholarships to surgeons who are ACS Fellows and members in good standing of these organizations. The scholarships pay for participation in the week-long, intensive course. Each scholar is then expected to provide a year’s service in a health policy-related capacity to the College and the cosponsoring surgical specialty society. For details about the scholarship program and past participants, see www.facs.org/member-services/scholarships/health-policy. This year’s awardees are as follows:

- ACS Health Policy Scholar for General Surgery: **Quyen D. Chu, MD, FACS**, Louisiana State University Health Sciences Center, Shreveport
- ACS Health Policy Scholar for General Surgery: **Anathea C. Powell, MD**, Phoenix Indian Medical Center, AZ
- ACS Health Policy Scholar for General Surgery: **Sujana S. Chandrasekhar, MD, FACS**, New York Otology, NY; New York Head and Neck Institute, NY
- ACS Health Policy Scholar for General Surgery: **Robert J. Winchell, MD, FACS**, University of Texas Health Sciences Center, Houston
- ACS Health Policy Scholar for General Surgery: **Mike K. Chen, MD, FACS**, University of Alabama, Birmingham

Sandi Lam, MD, FACS, Baylor College of Medicine/Texas Children’s Hospital, Houston

• ACS/American Academy of Otolaryngology–Head and Neck Surgery Health Policy Scholar: **Sujana S. Chandrasekhar, MD, FACS**, New York Otology, NY; New York Head and Neck Institute, NY

• ACS/American Association for the Surgery of Trauma Health Policy Scholar: **Robert J. Winchell, MD, FACS**, University of Texas Health Sciences Center, Houston

• ACS/American Pediatric Surgery Association Health Policy Scholar: **Mike K. Chen, MD, FACS**, University of Alabama, Birmingham

JUN 2015 BULLETIN American College of Surgeons
Each year, the ACS partners with 16 surgical specialty groups to help design the course and award scholarships to surgeons who are ACS Fellows and members in good standing of these organizations.

- ACS/American Surgical Association Health Policy Scholar: Daniel B. Jones, MD, MS, FACS, Beth Israel Deaconess Medical Center, Boston, MA
- ACS/American Society of Breast Surgeons Health Policy Scholar: Veronica Shim, MD, FACS, Kaiser Permanente, Berkeley, CA
- ACS/American Society of Colon and Rectal Surgeons Health Policy Scholar: Fabio Potenti, MD, MBA, FACS, Cleveland Clinic Florida, Weston
- ACS/American Society of Plastic Surgeons Health Policy Scholar: Bernard T. Lee, MD, MBA, MPH, FACS, Beth Israel Deaconess Medical Center
- ACS/American Urogynecologic Society Health Policy Scholar: Tanaz R. Ferzandi, MD, Tufts Medical Center, Boston, MA
- ACS/American Urological Association Health Policy Scholar: Norm D. Smith, MD, University of Chicago, IL
- ACS/Eastern Association for the Surgery of Trauma Health Policy Scholar: Michelle R. Brownstein, MD, University of North Carolina, Chapel Hill
- ACS/New England Society of Surgery Health Policy Scholar: Neal E. Seymour, MD, FACS, Tufts University School of Medicine, Springfield, MA
- ACS/Society for Surgery of the Alimentary Tract Health Policy Scholar: KMarie Reid Lombardo, MD, MS, FACS, Mayo Clinic, Rochester, MN
- ACS/Society of Thoracic Surgeons Health Policy Scholar: Jeremy Conklin, DO, MPH, MBA, Albany Medical Center, NY
- ACS/Society for Vascular Surgery Health Policy Scholar: Evan C. Lipsitz, MD, FACS, Montefiore Medical Center, Albert Einstein College of Medicine, Bronx, NY
The American College of Surgeons (ACS) has awarded five Faculty Research Fellowships for 2015. These two-year fellowships are offered to surgeons entering careers in surgery or a surgical specialty and carry awards of $40,000 per year from July 1, 2015, through June 30, 2017.

Three of the Faculty Research Fellowships are named in honor of past ACS leaders and sponsored by the Scholarship Endowment Fund of the College. The Franklin H. Martin, MD, FACS, Faculty Research Fellowship of the American College of Surgeons honors the founder of the College. The C. James Carrico, MD, FACS, Faculty Research Fellowship for the Study of Trauma and Critical Care honors the late Dr. Carrico. The new Thomas R. Russell, MD, FACS, Faculty Research Fellowship is provided by the Thomas R. Russell Fund, and supports research aimed at improving surgical outcomes. The award honors the late Dr. Russell, who served as ACS Executive Director from 2000 to 2010.

The recipients of these fellowships are as follows:

- **Franklin H. Martin, MD, FACS, Faculty Research Fellow:** Bryan M. Burt, MD, FACS, assistant professor of surgery, Baylor College of Medicine, Houston, TX. Research project: Allogeneic Antibody Therapy for Non-Small Cell Lung Cancer

- **C. James Carrico, MD, FACS, Faculty Research Fellow:** Steven J. Schwulst, MD, FACS, assistant professor of surgery, Northwestern University, Chicago, IL. Research project: The Role of Infiltrating Myeloid Cells in Traumatic Brain Injury-Induced Immune Suppression

- **Thomas R. Russell, MD, FACS, Faculty Research Fellow:** Kathleen B. To, MD, FACS, assistant professor of surgery, University of Michigan, Ann Arbor. Research project: Emergency General Surgery—Catalyst for Change: Outcomes, Models of Care and Performance Improvement

Additional undesignated Faculty Research Fellowships for 2015–2017 were awarded to the following individuals:

- **Stephen H. McKellar, MD, FACS,** assistant professor of surgery, University of Utah, Salt Lake City. Research project: Genomic and Metabolomic Analysis of Energy Metabolism in Right Heart Failure and Recovery

- **Bedabrata Sarkar, MD, PhD,** assistant professor of surgery,
Boston University School of Medicine, MA. Research project: Mitochondrial DNA Regulates Cytokine mRNA Stability in Sepsis

Applications
The description and requirements for this program are posted at www.facs.org/member-services/scholarships/research/acsfaculty. The next application deadline for the 2016 Faculty Research Fellowships will be November 2, 2015. These awards are funded through the ACS Scholarship Endowment Fund, which was established to provide income to fund scholarships and fellowships awarded by the ACS Board of Regents. Direct contributions to support the Scholarship Endowment Fund are welcome.

Fellows who are interested in making tax-deductible gifts to fund these vital programs via the Scholarship Endowment Fund or the Thomas R. Russell Fund are encouraged to contact the ACS Foundation at 312-202-5338.

American College of Surgeons Official Jewelry & Accessories designed, crafted and produced exclusively by Jim Henry, Inc.

Tie Tac/Lapel Pin
#S1 Gold-Filled $60
#S2 Solid 14K Gold $350

Cuff Links
#S3 Gold-Filled $200
#S4 Solid 14K Gold $150

Key (shown actual size of 5/8")
#S5 Gold-Filled $85
#S6 Solid 14K Gold $700

Miniature Key (Not Shown)
#S7 Gold-Filled $70
#S8 Solid 14K Gold $450

Charm (Not Shown)
#S9 Gold-Filled $85
#S10 Solid 14K Gold $550

Miniature Charm
#S11 Gold-Filled $60
#S12 Solid 14K Gold $350
#S13 Sterling Silver w/ 18 *Sterling Silver Necklace $65
#S13-1 Sterling Silver Charm $50

Ring
#S14 Solid 14K Gold $2250
#S14.1 Solid 10K Gold $1675 (Indicate finger size)

Tie Bar
#S15 Gold-Filled Emblem $75

Necktie
#S16A Dark Blue $35
#S16B Light Blue $35
#S17 Maroon Extra long add $5.00

Diploma Plaques*
#S18 Satin Gold Finish $380
#S19 Satin Silver Finish $380
8-1/2 x 12" metal plaque on 11x14-1/2 walnut. Specify name, day, month, year selected.

Men’s Bow Tie (Untied) (Not Shown)
#S22 Dark Blue $35
#S23 Maroon $35

Women’s Scarf - Silk (Not Shown)
#S24 36" x 36" cream w/ dark blue and maroon border

Rollerball Pen - Chrome
#S26 Cross Townsend Medalist w/ 23/K Gold Plated Emblem $135

Money Clip (Not Shown)
#S26 With Gold-Filled emblem $75

Desk Set (Not Shown)
#S27 Solid Walnut with Cross Gold-Filled Pen & Pencil/Gold-Filled emblem; name and year elected a Fellow engraved on gold polished plate $325

Wallet (Not Shown)
#S28 Black cowhide with Gold-Filled emblem $90

Blazer Buttons (Not Shown)
#S29 Gold Electroplated (set of 9) $35

Blazer Patch
#S30 Hand embroidered $35

Shipping/Handling/Insurance
Domestic (48 contiguous states) $15
Alaska, Hawaii, Puerto Rico $30
Foreign $40
*Foreign (Diploma Plaques) $60

Jim Henry, Inc., 435 Thirty-Seventh Avenue St. Charles, Illinois 60174 phone 630-584-6500 fax 630-584-3036 www.jimhenryinc.com e-mail: kcredille@jimhenryinc.com

Designers expressly for the American College of Surgeons, these emblematic items are crafted to perfection in the Jim Henry tradition of excellence. The American College of Surgeons receives a royalty for authorizing Jim Henry, Inc. to use the American College of Surgeons marks and other intellectual property.

Please use model # and item description when ordering
Include payment with order
VISA, American Express, & MasterCard accepted
Price subject to major changes in gold prices
Send order directly to Jim Henry, Inc.
Illinois residents add 8% sales tax

SCHOLARSHIPS
The American College of Surgeons (ACS) has awarded six Resident Research Scholarships for 2015–2017. The scholarships are offered to encourage residents to pursue careers in academic surgery and carry awards of $30,000 for each of two years, beginning July 1, 2015. The recipients of the 2015–2017 Resident Research Scholarships are as follows:

- **Madhukar S. Patel, MD**, postgraduate year (PGY)-3, at Massachusetts General Hospital, for research to be performed at Beth Israel Deaconess Medical Center, Boston. Projected specialty: Surgery. Research project: Preventing Device Associated Infections Using Slippery Liquid-Infused Porous Surfaces.

- **Jacob K. Olson, MD**, PGY-3, Loma Linda University Medical Center, CA, for research to be performed at Nationwide Children’s Hospital, Columbus, OH. Projected specialty: Pediatric surgery. Research project: Probiotics and Heparin-Binding-Like Growth Factor: A Novel Therapy for Necrotizing Enterocolitis.


- **Gabriella Grisotti, MD**, PGY-3, Yale University, New Haven, CT. Projected specialty: Pediatric surgery. Research project: Determining the Role of Lymphotoxin-a in the Lymphangiogenesis of Wound Healing.

- **Clement Marshall, MD**, PGY-2, Stanford University, CA. Projected specialty: Transplant surgery. Research project: Inhibition of Tumor Growth by Healing Wounds.

**Applications**
The description and requirements for this scholarship are posted at [www.facs.org/member-services/scholarships/resident/acsresident](http://www.facs.org/member-services/scholarships/resident/acsresident). The application deadline for the 2016 Resident Research Scholarships is **September 1, 2015**.

The Scholarship Endowment Fund of the College sponsors these scholarships.

The Scholarship Endowment Fund was established to provide income to fund scholarships and fellowships awarded by the ACS Board of Regents. Direct contributions to support the Scholarship Endowment Fund are welcome. Fellows who are interested in making tax-deductible gifts to fund these vital programs are encouraged to contact the ACS Foundation at 312-202-5338.
# MEETINGS CALENDAR

## Calendar of events*

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

### JUNE

**Austria-Hungary Chapter**  
June 3–5  
Linz, Austria  
Contact: Albert Tuchmann, albert.tuchmann@wienkav.at

**Alabama & Mississippi Chapters**  
June 4–6  
Point Clear, AL  
Contact: Lisa Beard, alcollegesurgeons@yahoo.com, www.alabamaacs.org and www.mschap-acs.com

**Brooklyn-Long Island Chapter**  
June 9  
Garden City, NY  
Contact: Teresa Barzyz, acsteresa@aol.com, www.bliacs.org

**Lebanon Chapter**  
June 11–13  
Beirut, Lebanon  
Contact: Muhammad Younis, drmhy@yahoo.com, www.facs-lebanon.org

**Northeast Mexico Chapter**  
June 11–13  
Nuevo León, Mexico  
Contact: Raul Lozano-Quiroga, facsnoreste@gmail.com

**Washington & Oregon Chapters**  
June 11–14  
Cle Elum, WA  
Contact: Harvey Gail, harvey@spiremanagement.com, www.wachapteracs.org and www.oregonchapteracs.org

**Illinois Chapter**  
June 18–20  
Peoria, IL  
Contact: Luann White, llwhite26@gmail.com, www.ilchapteracs.org

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

### 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

### AUGUST

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

**FUTURE CLINICAL CONGRESSES**

- **2015**  
  October 4–8  
  Chicago, IL

- **2016**  
  October 16–20  
  Washington, DC

- **2017**  
  October 22–26  
  San Diego, CA