Alternative approaches to medical liability reform
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continued on next page
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Surgeons have an inherent drive to serve patients in need. To help the many surgeons who provide care to some of the most vulnerable populations in the world, the American College of Surgeons (ACS) established Operation Giving Back (OGB) in 2004. Over the last year, the ACS leadership has been examining the role of OGB in an era of greater demand for global outreach and continued disparities in access to care in the U.S. After extensive evaluation of the program’s strengths and vulnerabilities, the College has set a fresh course for this important program and has hired a new Medical Director of OGB, Girma Tefera, MD, FACS, who joined the staff of the ACS Division of Member Services in February.

**Role of OGB to date**

OGB was the brainchild of the ACS Board of Governors Committee on Socioeconomic Issues, then chaired by current ACS President Andrew L. Warshaw, MD, FACS, FRCSEd(Hon). The committee conducted a study, which showed that many surgeons were involved in volunteerism and considered giving back to be part of their professional identity. OGB was created to leverage the passion, skills, and humanitarian ethos of the surgical community to effectively meet the needs of medically underserved domestic and international populations. OGB provides the tools necessary to facilitate domestic and international outreach among surgeons of all specialties, at all stages in their careers.

Presently, the OGB website largely serves as a clearinghouse of information, resources, and networks for surgeons who are interested in volunteerism. Through a network of partner organizations, OGB directs surgeons to volunteer opportunities that align with their skills, passions, and beliefs. OGB cultivates innovative models and multi-sector collaborations with academic institutions, corporations, foundations, government, and not-for-profit entities to inform public policy, share information and knowledge, and reduce global health care disparities.

**New leadership, new direction**

Over the last decade, the need for global surgical care and international outreach has continued to rise. Likewise, geographic and socioeconomic disparities in access to optimal care in the U.S. persist. Hence, as the College seeks to move OGB forward, we have developed a broader vision for the program. According to Patricia L. Turner, MD, FACS, Director, ACS Division of Member Services, “We want to actively engage our members—old and young and at every stage of their careers—to become active in these endeavors. In particular, we know that surgeons have different constraints on their time, and we want to build a system that will allow a surgeon to volunteer for a day or for a month, once or on a regular basis, domestically or abroad. The need is great, and we want to connect talented, interested surgeons with the opportunities we know exist for them.”

To expand the breadth of OGB and to make the program more inclusive, we intend to present a wider range of Clinical Congress programs in global surgery, lead coordinated responses to disasters worldwide, develop new programs and opportunities for surgeon volunteers, and better inform the public of the work of OGB. Most importantly, we intend to increase College participation and recognition among other similar global organizations and to redesign the OGB website to more efficiently and effectively match members’ needs with volunteer opportunities.

Dr. Tefera is uniquely qualified to lead these activities and efforts. The recipient of the ACS Surgical Volunteerism Award in 2011, Dr. Tefera is professor of surgery, department of surgery, University of Wisconsin, and vice-chair, division of vascular surgery and chief of vascular surgery, William S. Middleton Memorial Veterans Hospital, Madison. A native of Ethiopia, Dr. Tefera has trained and practiced in a broad range of international environments. He earned his medical degree at the University of Pisa Faculty of Medicine, Italy; completed a clinical fellowship in trauma at Landeskrankenhause Feldkirch, Austria; trained in general surgery at Krankenhouse Friedrichstadt, in Dresden, East Germany; and completed a vascu-
To expand the breadth of OGB and to make the program more inclusive, we intend to present a wider range of Clinical Congress programs in global surgery, lead coordinated responses to disasters worldwide, develop new programs and opportunities for surgeon volunteers, and better inform the public of the work of OGB.

lar surgery fellowship at the University of Wisconsin Hospital and Clinics. Dr. Tefera chairs the board of directors of the Ethiopian-American Doctors Group and is an associate member of the Ethiopian Academy of Sciences. (For more information about Dr. Tefera, see related article, page 40.)

Through these experiences, Dr. Tefera has acquired “a wealth of experience as a practicing, active vascular surgeon, experience gleaned from living all over the world. He also brings with him a commitment to and experience with global health, in the narrow sense of providing surgical care, as well as in a broader sense of building infrastructure and sustainable change or creating educational opportunities that impart long-lasting benefit to patients,” Dr. Turner said.

The work begins
Dr. Tefera said his first priority is to gain a better understanding of ACS member needs and to connect them to available opportunities. “However, as part of my short-term goal, I will focus on developing programs, both domestic and international, that will provide ACS members with opportunities to give back,” he said. “These programs will leverage the existing strengths and infrastructure of the College in education, service, quality, and leadership.”

Dr. Tefera and the rest of the ACS leadership agree that OGB is facing several challenges, including: (1) securing sustainable funding opportunities for programming activities in a sustainable manner; (2) defining priorities and developing action plans at a time when global health care needs are on the rise; and (3) aligning efforts with the many organizations that focus on global surgery.

To help meet these challenges, Dr. Tefera looks forward to partnering with individual ACS members, ACS committees, nongovernment organizations, and government agencies. “In the developing world, trauma and non-communicable diseases, particularly cancer, have reached epidemic proportions. Trauma will be the third leading cause of death in most sub-Saharan countries. I believe the Committee on Trauma and the Commission on Cancer can play a major role in helping to build systems and train the health care workforce that is desperately needed,” he said.

To help cultivate opportunities to foster the expansion of domestic outreach, OGB and the ACS Committee on Optimal Access (COA) will be working closely together, as well. “Almost by definition, there is (and always will be) an indelible link between the Committee on Optimal Access and Operation Giving Back,” said ACS Past-President and COA Chair L.D. Britt, MD, MPH, DSc(Hon), FACS, FCCM, FRCSEng(Hon), FRCSEd(Hon), FWACS(Hon), FRCSI(Hon), FCS(SA) (Hon), FRCS(Glasg)(Hon). “It is the vision of the committee that the priorities in addressing the myriad of health care disparities in the various surgical communities will be appropriately highlighted and underscored, thus providing specific and targeted projects for members of the OGB to consider. There is no greater challenge facing this nation than the widening disparities in health care delivery. With the COA and OGB, the American College of Surgeons will provide a two-prong effort to help address this multifaceted problem,” Dr. Britt added.

Leadership
One significant example of the College’s enhanced visibility and leadership in addressing domestic health care disparities is that we have partnered with the National Institutes of Health (NIH) to host the first State of the Science Meeting on Surgical Healthcare Disparities. This conference will take place May 7–8 at the NIH campus in Bethesda, MD, and will bring together several of the nation’s thought leaders on health care disparities with the goal of creating a national agenda for
EXECUTIVE DIRECTOR’S REPORT

surgical disparities research. The output of this event will enable scientists and funding agencies to prioritize research projects and interventions aimed at mitigating health care inequities and improving access to surgical services. This effort is being led by Dr. Britt and Irene Dankwa-Mullen MD, MPH, director of extramural scientific programs at the National Institutes of Minority Health and Health Care Disparities. Several ACS Past-Presidents, including Carlos A. Pellegrini, MD, FACS, FRCSI(Hon); Regents; Fellows; Dr. Tefera; and senior surgical scientists have been invited to participate in this program. This event will serve as an excellent opportunity to “provide leadership to surgeons across the country to study and address disparities in care,” said COA Vice-Chair Adil H. Haider, MB, BS, FACS, Kessler Director of the Center for Surgery and Public Health at Brigham and Women’s Hospital and Harvard Medical School, Boston, MA, and past-recipient of the Jacobson Promising Investigator Award. We will keep you informed about the upcoming conference and its outcome through reports in the Bulletin.

The ACS, with your help, is well-positioned to help resolve one of the most pressing problems facing our patients throughout the world—inequities in access to surgical care. I encourage you to find out more about how you can get involved in the OGB program by contacting ogb@facs.org. Volunteerism, even at a local level, can be a simple and inspiring experience as demonstrated by Dr. Turner and her children during the most recent Martin Luther King, Jr., holiday in January (see photos, this page). ♦

If you have comments or suggestions about this or other issues, please send them to Dr. Hoyt at lookingforward@facs.org.
Welcome to the 114th Congress:

The implications for surgery

by Sara Morse and Patrick V. Bailey, MD, FACS
Drs. Bera and Benishek both have served as champions for the ACS legislative agenda, including such issues as repeal and replacement of the SGR payment formula, medical liability reform, and repeal of the 96-hour rule for critical access hospitals. Returning as members of Congress are two physicians whose campaigns were actively supported by the ACSPA’s political action committee (ACSPA-SurgeonsPAC)—Ami Bera, MD (D-CA), an internist from the Sacramento area and Dan Benishek, MD, FACS (R-MI), a general surgeon and a Fellow from Michigan’s Upper Peninsula. Drs. Bera and Benishek both have served as champions for the ACS legislative agenda, including such issues as repeal and replacement of the sustainable growth rate (SGR) payment formula, medical liability reform, and repeal of the 96-hour rule for critical access hospitals.

The 2014 elections brought significant changes to the composition of the U.S. Congress, which will likely affect health policy in the coming years. This article summarizes the election results and describes the role that the American College of Surgeons Professional Association (ACSPA) played in ensuring the re-election of two surgical champions. It also highlights the legislative priorities of the ACS.

Electoral wrap-up

Election night 2014 proved to be a very good one for the Republican Party. Most dramatically, control of the Senate flipped from the Democrats to the Republicans, who now hold 54 seats—still six short of the filibuster-proof majority needed to exert maximum control. Previously, the Democrats held 55 seats when accounting for the two independents who caucus with them. In the House, the National Republican Congressional Committee unexpectedly outperformed the goal of their “Drive to 245” initiative by gaining a net of 13 seats to build a 247-member conference and secure the largest Republican majority since 1928.

The implications of this shift are yet to be determined but began to play out early in the first session of the 114th U.S. Congress, which convened on January 6. Speaker of the House John Boehner (R-OH) now has a more comfortable margin with which to operate, and Senate leaders have pledged to work more collaboratively with the House, seeking a return to “regular order” and a restoration of the traditional committee-driven legislative process. For example, House and Senate Republicans combined their respective caucus retreats, providing members and leadership of both chambers with an opportunity to begin the Congress with strategic collaboration. The Republican Congress has an opportunity to address critically neglected and noncontroversial issues, but it will still need to work with a Democratic President.

Returning as members of Congress are two physicians whose campaigns were actively supported by the ACSPA’s political action committee (ACSPA-SurgeonsPAC)—Ami Bera, MD (D-CA), an internist from the Sacramento area and Dan Benishek, MD, FACS (R-MI), a general surgeon and a Fellow from Michigan’s Upper Peninsula. Drs. Bera and Benishek both have served as champions for the ACS legislative agenda, including such issues as repeal and replacement of the sustainable growth rate (SGR) payment formula, medical liability reform, and repeal of the 96-hour rule for critical access hospitals.

One way the ACSPA-SurgeonsPAC contributed to the re-election campaign of both legislators is through what is known as an independent expenditure (IE). The Code of Federal Regulations defines an IE as a paid communication that expressly advocates for “the election or defeat of a clearly identified candidate that is not made in cooperation, consultation, or concert with, or at the request or suggestion of, a candidate, a candidate’s authorized committee, or their agents, or a political party committee or its agents.”*

In October 2014, the ACSPA-SurgeonsPAC Board voted to support the expenditure of $100,000 each in IEs for Representatives Bera and Benishek. For Dr. Bera, the SurgeonsPAC dollars were used for a radio and direct mail campaign as part of a larger effort in which other physician political action committees also participated. For Dr. Benishek, a television ad was produced and run through local cable providers.

On election night, Dr. Benishek was declared the winner with 52.1 percent of the vote. As one of four ACS Fellows who serve as members of Congress, we look forward to continuing to work with “Dr. Dan” and his excellent staff in his third term.

Dr. Bera’s race was much closer. In fact, he actually trailed his opponent with 49.8 percent of the vote when election night closed. Subsequently, with the counting and inclusion of the mail-in ballots specifically targeted by the physician community’s IE effort, Dr. Bera overtook his opponent’s slim margin. Two weeks later, on November 19, 2014, the Associated Press called the election for Dr. Bera with a margin of 1,400 votes. Dr. Bera’s race for the 7th district proved to be the most expen-

As has been the case for many years, the repeal of the flawed SGR remains a primary focus of legislative efforts at the start of the year.

In February 2014, Congress reached a bipartisan, bicameral agreement for repeal of the SGR formula and overhaul of the Medicare physician payment system. The SGR Repeal and Medicare Provider Payment Modernization Act of 2014 (S.2000/H.R.4015), also known as the SGR Repeal Act, was the product of a yearlong collaborative effort between Congress and key stakeholders, including the ACS. In fact, the ACS was the only physician group to testify before all three congressional committees of jurisdiction (House Ways and Means, House Energy and Commerce, and Senate Finance) during the process that culminated in the legislation.

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Congress was subsequently unable to agree on offsets to pay for the cost of the SGR Repeal Act, an example of partisanship trumping good policy. This stalemate is particularly significant when one considers the exemplary bipartisan and bicameral efforts that went into crafting the legislation and the fact that the $170 billion cost of the 17 temporary patches Congress has used over the last 11 years far surpasses the estimated cost of the agreed-upon policy.

Because Congress missed a crucial opportunity to take action in the lame-duck session of the 113th Congress, the ACS is urging legislators to pass the full SGR repeal before March 31, 2015. Congressional action by that date is necessary to preclude the cuts to Medicare physician payment scheduled to take effect April 1. Almost all stakeholders agree that these payment reductions are unlikely to ever be implemented for fear of the political repercussions from Medicare beneficiaries and the physician community. They further agree that short-term patches fail to address the underlying problem. Therefore, full repeal of the SGR remains a top legislative priority for the College, with hopes of averting legislation that implements an 18th temporary patch. Building on momentum among the “rank and file” members of the House, there will be a push for swift reintroduction and passage of the SGR Repeal Act in the 114th Congress.

♦ Global codes
Another issue of imminent importance on the payment front is averting a provision in the November 2014 final rule issued by the Centers for Medicare & Medicaid Services (CMS) that would convert 10- and 90-day global codes to 0-day global codes. The transition for 10-day global codes would begin in calendar year (CY) 2017, and the transition for 90-day global codes would begin in CY 2018. According to CMS, this transition is necessary, in part, to increase the accuracy of payment for these codes. However, CMS has not yet developed a methodology for making the transition.

Prior to the release of the final rule, the ACS sent a detailed letter to CMS asserting that the agency should postpone moving forward with this proposal until a comprehensive analysis of its effect on surgical patients and access to surgical care was completed. The ACS made recommendations on a number of issues that CMS must resolve before moving forward with the proposed policy and stressed, above all, that CMS should not make policy changes that infringe on surgeons’ ability to provide high-quality care to surgical patients.

As the 114th Congress begins, the ACS plans to take a variety of immediate strategic actions on this critical issue, including increased advocacy efforts. Working with key members of Congress, the ACS will continue to oppose implementation of this policy change and will seek congressional intervention to rescind it until such time as CMS can ensure that the transition will not have a negative impact on patients and can be implemented in a way that accurately accounts for the care surgeons provide.

♦ GME
At the start of 2015, the College also has an important opportunity to influence the future of graduate medical education (GME). On December 6, 2014, the House Energy and Commerce Committee released an open letter requesting information on GME. This request indicates a desire on the part of the committee to produce GME reform legislation. The College intends to play an active role in this legislative initiative. ACS leaders and staff are working with key committee leaders to ensure that the ACS, as the premier arbiter of surgical GME programming, is part of the committee’s deliberations and has input on any reform proposal.

Although the issues outlined in this article represent the most pressing of the College’s legislative priorities, the ACS will advocate on other issues as well, including the 96-hour rule mentioned previously, cancer and trauma initiatives, medical liability reform, and other legislation that affects surgeons’ ability to provide the highest quality care to their patients. For a comprehensive catalog of the ACS legislative portfolio, visit www.surgeonsvoice.org. This online resource describes key issues of the day, and provides the necessary tools and information to become a seasoned surgical advocate. ♦
New resources from the College offer alternative approaches to medical liability reform

by Matthew Coffron; Nakul Raykar, MD; Don J. Selzer, MD, FACS; and John G. Meara, MD, DMD, MBA, FACS
Medical liability reform has been a legislative priority for the physician community, including organizations such as the American College of Surgeons (ACS), for decades. The present tort-based system for resolving liability claims is cumbersome and costly for both patients and providers and inhibits the efficient provision of care by encouraging defensive medicine.

Since its passage by the California state legislature in 1975, the Medical Injury Compensation Reform Act (MICRA) has been viewed as the gold standard against which all subsequent reform efforts have been measured.

Over the last decade, when Republicans have been in control of the House, the Speaker has typically reserved bill number H.R. 5 for the Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH) Act, which is modeled on MICRA, speaking to its importance to the Republican Party. Unfortunately, this bill was not introduced in the 113th Congress, which ended in January. The concept has never received significant support in the Democratic Caucus and has recently faced steeper opposition from some Republicans who claim tort reform should remain in the hands of policymakers at the state level. Consequently, despite fervent work in Washington, DC, to pass nationwide liability reform, this legislation has failed to cross the congressional finish line, and much of the legislative focus has turned to seeking enactment of MICRA-type laws at the state level.

ACS develops statement, primer
Noting the shrinking support for tort reform at the federal level and the growing evidence supporting the utility and effectiveness of some alternative reforms, the ACS Division of Advocacy and Health Policy (DAHP) and the ACS Legislative Committee took a comprehensive look at the history of medical liability reform and re-evaluated the current system. The Legislative Committee was created by the ACS Health Policy and Advocacy Group (HPAG) in 2010 and is responsible for identifying, evaluating, and recommending positions on federal legislation and policy issues with the potential to affect the needs, interests, and roles of surgeons and surgical patients that come before the U.S. Congress. The committee, composed of 10 volunteer members and currently chaired by Don J. Selzer, MD, FACS, has played a pivotal role in advising the DAHP on the merits of introduced or proposed legislation over the last five years. Medical liability reform represents the committee’s first major attempt at proactive policy development.

The College convened an ACS Medical Liability Reform Summit in October 2012, which led to the publication of a special issue of the Bulletin in March 2013 featuring 12 articles focused on new approaches to liability reform.¹ The Legislative Committee formed a subcommittee that reviewed the existing resources available to Fellows and the College’s position on these alternatives. The subcommittee determined that additional materials should be developed to better inform Fellows of the current status of medical liability issues, highlight reform prospects, and provide them with a tool kit to navigate the liability arena. The group focused on reforms that accounted for current political realities and new evidence on the efficacy of alternative approaches.

The subcommittee members further noted that although the ACS has submitted testimony and statements to Congress regarding liability reform on many occasions, no official ACS statement had been adopted or released. The committee set to work crafting the statement that the Board of Regents approved at the
2014 Clinical Congress in San Francisco, CA. (See page 30 for the Statement on Medical Liability Reform.)

In December 2014, the Legislative Committee released a new primer—Surgeons and Medical Liability: A Guide to Understanding Medical Liability Reform. This document explores the history and current state of our nation’s inefficient medical liability system and analyzes both traditional and alternative reform proposals. In addition to informing Fellows about ongoing challenges, the primer outlines opportunities for implementation of alternative reforms that have been proposed or studied at the local, state, and federal levels.

The primer is the product of months of effort by the ACS Legislative Committee, DAHP staff, and several research fellows and associates from the Harvard Medical School’s Program in Global Surgery and Social Change; it was overseen by former Legislative Committee Chair and current HPAG Vice-Chair John G. Meara, MD, DMD, MBA, FACS (a co-author of this article). John H. Armstrong, MD, FACS, Surgeon General of Florida, ACS Governor, and HPAG member, also contributed to the document, providing information on the context of reform at the national level. DAHP staff are using this resource to educate congressional offices about the hardships that the existing tort system creates for both patients and providers and to build support for reform on Capitol Hill. Reforms evaluated in the document include traditional tort reform packages such as the HEALTH Act; alternative dispute resolution; health courts; enterprise liability; safe harbors; and communication and resolution programs (CRPs), also known as “disclose and offer” programs. The results of the review are summarized in the table on page 17, which is also available in the primer.

Best practices for the future

After a careful review of the available evidence, the ACS Legislative Committee and HPAG believe that CRPs show the most promise in controlling cost and promoting a culture of patient safety. These programs can be readily implemented without additional legislative action. Moreover, CRPs are in line with the ACS’ mission of improving care of the surgical patient, safeguarding standards of care, and creating an ethical practice environment. CRPs quickly compensate patients who are injured due to adverse events while vigorously defending quality care that, nevertheless, may have resulted in a poor outcome. In addition, lessons learned in the disclosure process reduce future claims and create an environment suitable for continuous quality improvement.

Implementing a CRP requires effort and institutional will. Typically administered at the hospital level, CRPs require a significant culture change for both hospital leadership and health care professionals. However, once introduced, CRPs have shown encouraging results across the country. Although CRPs do not require new legislation, political leaders could facilitate efforts to expand this type of reform through passage of clear and consistent apology laws and changes to the National Practitioner Data Bank reporting requirements.

Safe harbors, which protect physicians who follow accepted practice guidelines, also merit further study, as current supporting evidence for this alternative is small and equivocal. However, renewed interest in this type of reform at the federal level has emerged largely because of the introduction of bipartisan legislation in the 113th Congress. Reps. Andy Barr (R-KY), an attorney, and Ami Bera, MD (D-CA), a primary care physician, introduced the Saving Lives Saving Costs Act in
February 2014. The bill combined elements of both safe harbors and pretrial screening panels. The ACS supported the legislation as a means of increasing bipartisan support for alternative reforms and has had ongoing conversations with the bill’s sponsors to help refine the legislation before it is reintroduced in the 114th Congress.

While certain reform proposals may seem more likely than others to achieve federal enactment, it is clear that the ACS should continue to support a variety of approaches. For example, traditional tort reform, recently “rescored” by the Congressional Budget Office to save the federal government as much as $70 billion over 10 years, must remain an area of continued interest. In addition, targeted reforms, such as Good Samaritan protections for physicians who volunteer across state lines or provide care mandated under the federal Emergency Medical Treatment and Active Labor Act should continue to be discussed.

More to come

The *Surgeons and Medical Liability: A Guide to Understanding Medical Liability Reform* primer and the ACS position statement represent two new tools that the College has developed to assist staff and Fellows as they advocate to improve the medical liability environment. We anticipate that they will serve as a spark to reignite efforts to improve fairness and efficiency in the liability system for physicians and patients alike. The primer is available at www.facs.org/advocacy/practmanagement/primers.

The Legislative Committee will continue to address the issue of medical liability reform and will provide additional resources to Fellows in the coming months. Specifically, the committee plans to publish a practical guide for Fellows on medical liability issues. Topics that will be covered include how to avoid litigation, navigation of the pre-trial and discovery phase of a lawsuit, and what to expect in trial proceedings. At press time, this document was still in development and will require extensive legal review before it is ready for release to Fellows.

### REFERENCES

Report from the Past-Chair of the Board of Regents:
Fostering innovation at the ACS through strategic planning

by Julie A. Freischlag, MD, FACS
“What would you attempt to do if you knew you could not fail?”
—Robert Schuler

It was my distinct honor to serve as Chair of the American College of Surgeons (ACS) Board of Regents from 2012 to 2014 with Mark C. Weissler, MD, FACS, as the Vice-Chair. The two Presidents who served during that time are A. Brent Eastman, MD, FACS, FRCS(Ed)(Hon) (2012–2013), followed by Carlos A. Pellegrini, MD, FACS, FRCS(Hon) (2013–2014). Together the Officers; Board of Regents; Board of Governors; ACS Executive Director David B. Hoyt, MD, FACS; and the staff and volunteers of the ACS accomplished a great deal of work.

Structural changes
At its quarterly meetings, the Board of Regents continued to follow the format changes that J. David Richardson, MD, FACS, had introduced as Chair of the Board of Regents (2011–2012). A key change that Dr. Richardson had implemented was to devote each meeting primarily to one or two key areas of the College, with brief updates from the other division directors and program chairs.

During my first term, six new Regents joined us (all MD, FACS): John L. D. Atkinson, a neurosurgeon from Rochester, MN; Henri R. Ford, a pediatric surgeon from Los Angeles, CA; Enrique Hernandez, a gynecological oncologist from Philadelphia, PA; L. Scott Levin, an orthopaedic surgeon from Philadelphia, PA; Beth H. Sutton, a general surgeon from Wichita Falls, TX; and Steven D. Wexler, a colorectal surgeon from Weston, FL. One new Regent joined us for the 2013–2014 term—James Gigantelli, MD, FACS, an ophthalmologist from Omaha, NE. The energy emanating from this new group of surgical leaders helped us realize that the Board was ready to move quickly in a direction marked by enhanced involvement with current and future members of the ACS.

Marching forward
To help the Board of Regents develop fresh approaches to working with the membership and to encourage other surgeons to join the College, we enlisted the services of Jeffrey DeGraff, PhD, professor of management and organizations, Ross School of Business, University of Michigan, Ann Arbor. Dr. DeGraff worked previously with Dr. Hoyt and the College’s Performance Improvement (PI) team to reenergize and refocus the ACS staff, assisting in the development of the ACS Values of Professionalism, Excellence, Inclusion, Innovation, and Introspection. His research focuses on leading innovation, and he has written several books on the topic, including Creativity at Work: Developing the Right Practices to Make Innovation Happen and Leading Innovation: How to Jumpstart Your Company's Growth Engine.

The Regents agreed to participate in a strategic planning retreat led by Dr. DeGraff. While preparing for this program, I recalled a question my son once asked me when he was younger: “Mom—why would you ever retreat? You should never retreat; you should always march forward!” Keeping that admonition in mind, our “retreat” in July 2014 at the ACS headquarters in Chicago, IL, focused on moving the College forward. The leaders of the Board of Governors, Young Fellows Association, and the Resident and Associate Society attended, along with the ACS Executive Staff.

Innovation though introspection
Dr. DeGraff spoke about the new role of innovation and creativity in fostering change in health care and the need for us all to be creative as leaders to help solve the problems facing the profession. He explained that we use different approaches to solving problems. We can lead as collaborators and lead groups of stakeholders toward meaningful and lasting change. Collaborative activities are usually value-driven. We can...
lead entirely by being creative and doing new things to fulfill a vision. We can lead by being competitive, which encourages us to reach our goals in a timely way. Strategy, organizational culture, competencies, and leadership ability drive these activities. And we can be controlling, which ensures that we complete tasks through process-driven efforts that lead to efficiency and quality.

While leaders often use several or all of these strategies to achieve their goals, we typically use one or two most often. At the retreat, we engaged in exercises to discover how we make decisions and worked in small groups to learn how these different approaches can be used collaboratively. For example, I learned that my dominant behavioral trait is “collaborative” and my secondary is “creative.” It was fun for us to see where each of the Regents landed in their personal and community profile.

Next came some hard work as we looked at the Board of Regents—specifically, at how the board is organized and the processes involved in achieving our goals over the last several years. What needed to change? Could we change? Could we be innovative and creative? Did we need to be controlling and/or collaborative? We worked in groups and listed what we thought we needed to change, and we listened closely to one another.

We then began to brainstorm about how the Regents could be more involved in leading the ACS, and more effective as they serve the more than 80,000 members of the College. The important issues that we discussed included how the Regents are elected and how long they should serve, whether nonsurgeons should have a seat on the Board, how meetings could be conducted to better use the experience and knowledge of the Regents, and how the Regents can play a more active role with ACS committees, Advisory Councils, domestic and international chapters, and other groups.

Following the retreat, Dr. Hoyt and the PI team organized our numerous thoughts and ideas and developed four working groups to further discuss the issues. We continued our discussion at the Regents’ meeting at the 2014 Clinical Congress in San Francisco, CA.

We have already had our first conference calls, and the group that I am in, which is led by ACS Regent Raymond F. Morgan, MD, FACS, has had a tremendously productive call about the involvement of the Regents with committees and chapters of the College. Initial reports from each of the four working groups were presented at the February Regents’ meeting. Final recommendations and proposed changes are scheduled to be submitted for approval at the June meeting.

Enthusiasm for these changes is strong among the leadership of the ACS, and the energy that the Regents have displayed has been exceptional. Following the retreat, we all agreed that it is the perfect time for changes on the Board of Regents, as we want to be able to lead the ACS in the best way possible. By redefining our responsibilities and involvement throughout the College, the Board of Regents will be ready to address the changes occurring in health care, medical education, residency training, Maintenance of Certification, or any other surgery-related matter. I am more excited about my ninth and final year as a Regent than I was even in my first.

As they move on to new places to practice or train, I advise young faculty and residents to always assess how they contributed to the place they are leaving. Will the other surgeons and staff have a party for you before you leave, or will they have a party because you’ve gone? If asked, would they welcome you back? Can you name one or two things that you did to make the place you are leaving a bit better than when you arrived? The members of the Board of Regents involved in this self-assessment process hope to leave it better.

I want to thank all the members of the ACS for the marvelous opportunity to serve as a Regent since 2006 and to serve as the Chair of the Board of Regents from 2012 to 2014—the first woman to do so. It was an amazing time to be in the position as the ACS celebrated its 100-year anniversary. Here’s to the next 100! ♦
To Bangalore and back:

Resident leads software design effort at Indian heart hospital

by Erin Palm, MD, MBA
I was carrying little more than a phone number when I boarded a plane to Bangalore, India, in August 2012. After a day of flying and a memorable first encounter with India’s traffic, I found myself sharing lunch with one of my heroes, cardiac surgeon Devi Shetty, MD, founder and chairman, Narayana Health (NH). The media, including the Wall Street Journal, have compared Dr. Shetty to Henry Ford, and NH has been called the Walmart of hospitals because of their shared mission to mass-produce heart surgery at prices most Indians can afford.*† I would have the privilege of spending the following year helping Dr. Shetty and the staff at NH design a software product that is now being used for patient care at NH. In addition to the project management skills I learned as a result of this experience, I also came to understand some of the difficult realities—and surprising benefits—of operating a health care institution on a limited budget.

A unique opportunity

Many surgery residents spend a year or more doing full-time research. At Stanford University Hospital, CA, we refer to this time away from clinical duties as “professional development” because the program is open to residents pursuing unconventional learning opportunities, rather than strictly conducting bench research. Instead of joining a traditional lab, I went to India.

NH administrators and Dr. Shetty have developed a growing worldwide reputation for providing sophisticated cardiac surgical care at a low cost. Dr. Shetty founded NH with a vision of expanding access to heart surgery to India’s medically indigent population. Seeking a professional development experience that would build on the business administration degree I earned in medical school, I decided to help Dr. Shetty build a customized electronic health record (EHR) for heart surgery patients. I wanted to learn something from his organization that I could bring back home.

During my initial discovery trip to Bangalore, Dr. Shetty and I agreed that I would help create a smart EHR. At this stage, the product existed purely in our imagination, and starting from scratch sounded like a fun challenge. Because this task required deep knowledge of postoperative patient care, I was well-suited to the job.

Between August 2012 and June 2013 I would make half a dozen trips to India, ranging in length from a week to a month. I did not seek outside funding for this endeavor, although NH ultimately reimbursed my travel expenses. During that eventful year, I had the rewarding experience of overseeing the project’s progress from a concept to a working pilot program implemented in the cardiac surgery intensive care unit (ICU) at NH.

The “Silicon Valley of India”
From Dr. Shetty, I became aware of an imminent collaboration between NH and a large technology company that had agreed to supply an experienced team to build a pilot of the clinical software. My first month-long trip to Bangalore involved two main activities: learning how the city’s ICUs functioned and meeting our technology partners.

But first, I had to work out the logistics of life in Bangalore (known as the Silicon Valley of India). I rented a “serviced apartment,” meant for frequent business travelers, with private security and staff available to cook and clean but cheaper and more low-key than a hotel. I selected a neighborhood called Koramangala for its proximity to shops, restaurants, a gym, other educated young professionals, and relative proximity to NH’s 1,000-bed cardiac hospital, where I would be working. From Koramangala, my daily commute was a 20-minute taxi ride on a privately operated toll highway; it was well worth the $1 each way to avoid the traffic gridlock.

To learn how the ICU functioned, I integrated myself with the residents and fellows in the adult cardiac unit. I rounded each morning with the team. I attended the weekly cardiac surgery mortality conference, finding it remarkably similar to our morbidity and mortality conferences. I took note of practices that differed from what I was used to and tried to absorb them so that our software design would reflect the local environment at NH. These differences ranged from basic terms and drug names—they call epinephrine “adrenaline,” in the British tradition—to more fundamental issues like scope of practice for ICU nurses.

At the kick-off meeting with the software engineers, we established objectives and a timeline for our collaboration. I remember feeling intimidated by all the software jargon, but the engineers probably felt the same way about the medical jargon the health care professionals were using.

After that meeting, members of the software team began shadowing health care providers in the ICU. They would stand at a patient’s bedside for an afternoon, watching nurses administer medications, measure vital signs, and remove tubes and drains. This was all new to the software teams, and they found the experience intense. One morning, I had to tell our young business analyst that “his” patient—the one he had been shadowing—had died overnight. It was an emotional but important task for me to break the news to him and debrief the event.

Negotiating what to build
On my third trip to India, NH administrators gave us an office. I arranged desks and chairs in a converted hospital room, with a wall oxygen supply and a sink in the corner. We had to walk through a pediatric ICU to reach our office, so the sounds of the hospital were all around us.

Many other people, departments, and projects were competing for resources at NH, but I figured out ways to get what we needed. It helped being a surgery resident; I could enter the operating theatre and, during a lull in the operation, ask questions of the senior surgeons and anesthesiologists.

Part of my role involved working with the NH clinicians to develop content for the software. As a first step, I documented all of the data we needed in an electronic medical chart. This task was much easier for me than it would have been for the technology team. Using my clinical knowledge and a surgical textbook, I wrote a list of the vital signs, lab values, and the basic items and services necessary for the care of a postoperative cardiac surgery patient. I cross-referenced my list with the paper ICU charts at NH and entered the information into an Excel document. It likely would have taken months for nonmedical personnel to elicit that kind of information from local physicians.

Later, as we began to incorporate more complex medical content, I would gather a group of senior...
anesthesiologists, surgeons, and medical intensivists to decide what clinical data values should trigger warnings in the system and other key features that should be included in the software.

However, after compiling all of this information, we faced a major challenge in defining the scope of our pilot software; we could not do everything immediately. We had to choose which pieces of the medical record were essential to include in the demonstration project—enough to convince NH administrators and our technology partner that it would be a good idea to build a full enterprise product, and to implement that product at a new NH hospital scheduled to open in a year. Multiple factors made narrowing the scope difficult: we measure a significant amount of data in a cardiac ICU, most of which is essential. Additionally, all of the stakeholders—physicians, nurses, engineers, and managers—had ideas about what the software should include. Somewhere, we had to draw the line.

The central event of my fourth sojourn to India was a series of meetings we called “close week.” We organized all of the stakeholders into the NH boardroom, where a sign that reads “Healthcare is all about Process, Protocol and Price” hangs prominently over the head of the table. Our entire team remained in the boardroom until a consensus was reached regarding what to include in the pilot, and, perhaps just as importantly, what to leave out. At the end of close week, the team had compiled hand-drawn illustrations of every screen that we were committed to building. For every screen, we also had an Excel spreadsheet describing each piece of clinical data that would be represented and how the users would interact with those data to perform various tasks.

Determining the scope of our pilot design marked a major accomplishment. From that point forward, the software developers could write code and test it without their clinical partners changing their minds about what to build.

The developers went back to their offices and completed a remarkable amount of work in a few short months. Meanwhile, I turned my attention to planning pilot implementation. Working within the NH facility gave our developers the opportunity to expose the software to real-world clinical demands right away. We wanted nurses using it at the bedside so they could “break it” and give us feedback to make the product better.

The pilot takes off
We identified a cardiac anesthesiologist to lead pilot implementation during my fifth visit to Bangalore, and I helped him outline an action plan. He selected a core group of nurses as “trainers” for the pilot, and one memorable afternoon, I stood by as he handed out tablet computers to the trainers and began their preparation.

By my sixth trip, an early version of the software was ready. We demonstrated it to Dr. Shetty with guarded enthusiasm. A few nurses were trained to use the software, and a few ICU patient stations went live with the system. As expected, it initially crashed, the nurses pointed out errors, and the engineers came back with fixes. We were extremely pleased.

One goal charged our efforts with excitement. We sought to make the software ready in time for the open-
ing of the new NH hospital on Grand Cayman Island, the first in the Western hemisphere.

As we made final preparations for the pilot, I started to make arrangements for my return to clinical residency. The timing worked out well. I had facilitated the design process, but the coding, testing, and implementation would carry on without me. My final trip to India that year centered on ensuring that my successors were fully capable of taking the reins on this project as I transitioned back to clinical residency.

A year later, after a successful pilot, the scaled-up version of the product was available, and it now serves as the primary chart in a Bangalore cardiac ICU. The new NH hospital is open, and we all anticipate the software will be operating there soon, as well.

**What I brought home**

We had dreamed about a “smart” EHR, debated and determined how it should work, revised our plans, made compromises, and then, finally, built a product. My greatest reward was seeing our creation put to use in patient care. Surmounting the day-to-day challenges of creating a definitive product that started out as such a nebulous concept provided me with my greatest learning experience. I also learned a great deal watching firsthand how Dr. Shetty managed his organization.

One major challenge was actually the mirror image of NH’s biggest asset: the leanness of the organization. NH is extremely disciplined about containing costs. There is essentially no waste, no unused resource. As a result, finding personnel and money was difficult, and we succeeded because we had Dr. Shetty’s active support. I do regret, though, that we did not have resources for an impact study to determine whether our software measurably improves patient care. This may be a goal we can pursue in the future.

Eighteen months later, what stands out about working with Dr. Shetty is how a surgeon’s leadership can comprehensively influence the service a hospital delivers. For example, during close week, Dr. Shetty’s main contribution was to simplify our design. He repeatedly asked such questions as, “Do we need that feature? Is that piece of data necessary?” One of the most powerful things he did as a leader was to streamline the process and remove unnecessary and superfluous information and ideas. Dr. Shetty is relentless about cutting processes that require time and money but which fail to enhance patient care. At the same time, he selects important projects like the hospital’s infection control procedures and dedicates his own time and influence in order to advance them. His dual role as chairman and an active surgeon who operates and sees patients on a daily basis enables Dr. Shetty to make these types of decisions.

I believe surgeon leadership can make hospitals better. I have noticed that in addition to his personal leadership, Dr. Shetty selects senior physicians and surgeons to lead new hospitals and other key business units, which I believe is important to their success. Excellence in hospital management boils down to overseeing thousands of details that experienced clinicians uniquely understand.

That first day in the NH boardroom, I took note of the sign mentioned earlier: “Healthcare is all about Process, Protocol and Price.” In the following year, I learned that these words do not signify that NH is perfect. Rather, they keep the organization’s purpose front-of-mind for its leaders, as an aspiration to be pursued every day.

It might serve us well in the U.S. to be similarly focused. The lesson my experience at NH taught me about successfully running a low-cost hospital is that it requires extreme discipline and attention to detail.

I am grateful to Dr. Shetty and to Stanford General Surgery for affording me this opportunity to build a new product and, in the process, to observe NH operations at every level—from the ICU to the executive suite. I anticipate that as a result of this experience, I will be better prepared for a career of shaping organizations to deliver excellent, affordable health care. ♦
Managing burnout: Seek outside help and foster a true work-life balance

Burnout is a clinical syndrome that is characterized by emotional exhaustion, depersonalization, and a decreased sense of personal accomplishment, according to a 2009 article on the subject that appeared in what is now the Journal of the American Medical Association (JAMA) Surgery.* The article’s authors state that burnout affects people whose work involves constant demands and intense interactions with individuals with great physical and emotional needs. As this definition includes surgeons, several of the College’s Fellows spoke about their own experiences with burnout, or how they have avoided it, and offered strategies to help counteract its effects.

The Board of Governors’ Physician Competency and Health Workgroup has been studying burnout for more than a decade. Results of surveys indicate that 40 percent of responding ACS Fellows met diagnostic criteria for burnout.

“The problem with burnout is that people don’t realize it until they are finally over that edge,” Dr. Ketteler said.

To improve her situation, Dr. Ketteler said she made a concerted effort to find time to do things she enjoys. She reinvested in activities such as spinning and yoga and dedicated time to being with her family. She involved her supervisor in what she was experiencing and realized that she didn’t have to say yes to everything that came her way. Dr. Ketteler also found support in social media communities by looking at palliative care blogs, a topic with which she became familiar while in training.

“I gained a lot from sharing and listening and reading about other colleagues who are going through something similar,” Dr. Ketteler said.

At last year’s Clinical Congress, Dr. Ketteler spoke on a panel called My Cup Runneth Over: Surgeon Suffering and Burnout. In feedback from the panel, many surgeons shared that the topic of burnout is often seen as an end-of-career event, Dr. Ketteler said. However, surgeons actually felt that burnout and near-burnout occurs throughout surgical residency, fellowship, and surgical practice. Surgeons on the panel emphasized the importance of changing the culture of surgery to prevent burnout before it occurs.

Using technology to help surgeons connect has been a goal of Philip R. Caropreso, MD, FACS, Communications Chair, ACS Advisory Council for Rural Surgery. Dr. Caropreso is a general surgeon and clinical professor of surgery, University of Iowa Carver College of Medicine (UICCM), Iowa City.

Now retired from active practice, Dr. Caropreso previously maintained solo surgical practices in Keokuk, IA, and Carthage, IL, for 37 years. He wanted to find a way to address the surgeon shortage in rural areas, so he started the College’s rural surgery e-mail listserv almost three years ago. Dr. Caropreso described this effort in the “Dispatches from rural surgeons” that appeared in the July 2014 issue of the Bulletin. This electronic forum offers surgeons who may sometimes feel professionally...
isolated due to their practice location a space to discuss cases in an objective, non-confrontational way, he said.

Dr. Caropreso added that he was fortunate during his career to develop positive relationships and maintain contact with other surgeons at UICCM—about 100 miles from Keokuk—where he still teaches two trauma courses. His connection with the university helped to ensure his techniques stayed current and his knowledge was sufficient, despite his isolation, Dr. Caropreso said.

In his own experience, Dr. Caropreso said, he has felt support from the community of Keokuk, and that sense of belonging has kept him from feeling burned out. His involvement around town, including serving as president of Friends of the Animal Shelter and on his church council, has earned him respect from the people who live in the area. Even in the case of a complication or a death, Dr. Caropreso said, most people understand that humans make mistakes.

Staying enthusiastic about surgery

For some surgeons, variety at work helps ward off burnout. Dr. Ketteler said the mix of operating, working with residents, and teaching courses makes for a better environment than doing the same thing every day. Carol-anne Moulton, MB, BS, FRACS, MEd, PhD, agreed that variety has been helpful in maintaining her enthusiasm for her work. For Dr. Moulton, that has meant following her interest in surgical qualitative research.

“I think I’ve kept moving. I’m somebody who’s always looking out for something new,” Dr. Moulton said. Dr. Moulton is staff surgeon and associate professor of surgery, University of Toronto, ON, and scientist, University of Toronto Donald R. Wilson Centre for Research in Education. She joined Dr. Ketteler and Gregory R. D. Evans, MD, FACS, at last year’s Clinical Congress to speak on the panel on burnout. Dr. Moulton has researched and studied burnout extensively, which she thinks has helped her to avoid succumbing to the syndrome so far.

“We can’t be brave and all-knowing all the time,” Dr. Moulton said. “Because I study [burnout], I’m very aware of that pressure within me to fit into that stereotype.” Dr. Moulton said she has developed a group practice so that the workload is distributed among several surgeons, and everyone can have some time off without carrying a pager. She added that finding challenges in her work has helped her maintain an enthusiastic attitude.

Changes in health care

One factor that contributes to burnout, according to Dr. Perry, is the unpredictability of how our health care system will evolve. Dr. Perry said that the implementation of electronic health records and administrative requirements, as well as the changing rules of insurance companies, add to the pressures surgeons are already under, which is very unsettling.

Dr. Caropreso agreed that the environment outside clinical practice was a big source of stress during his career, and external influences still affect surgeons today, because nonphysicians are telling doctors what to do.

“I’ve recognized that so much of it is outside of our control, and I try not to get upset about things that are out of my control,” Dr. Perry said.
Taking time for family and hobbies

It has taken Dr. Perry time to learn and implement the strategies that can be useful in avoiding burnout. Earlier in his career, if he had the opportunity to leave work early, he used to feel guilty. If he had time to read, he would only read things related to surgery, he said. “We are so focused on our patients; we will do whatever it takes,” Dr. Perry observed. “Sometimes that comes at the cost of ignoring our own health.”

Now, Dr. Perry said, he tries to spend more time at home and not feel guilty about it. He exercises two or three times each week, and he reads material that is not always related to surgery.

Dr. Caropreso said his supportive family, including his children and grandchildren, were factors that helped mitigate his stress. He also took up running, and has since competed in half and full marathons.

According to Dr. Evans, when he started practicing surgery more than 20 years ago, burnout was not a term he heard very often. “It wasn’t something you talked about. You got your work done, and if you were in the hospital 100 hours a week, that’s how it was,” said Dr. Evans, chair, department of plastic surgery, University of California, Irvine, and member of the panel on burnout at last year’s Clinical Congress.

Today, according to Dr. Evans, residents are required to participate in webinars and lectures on the dangers of fatigue and substance abuse. He added that residents are more aware of the importance of abiding by work-hour limits.

Dr. Evans said the traveling he does once or twice a month for his job helps prevent feelings of burnout. He tries to go running, biking, out to the movies, or spend time with his wife and kids when he can. Dr. Evans added, “If I can organize my time and be very efficient at it, that helps me with the stress,” he said.

Raymond R. Price, MD, FACS, a general surgeon at Intermountain Medical Center in Murray, UT, said his faith, family, and work are the foundations in his life, and the key for him is not to get pushed too far in any one direction.

In addition to practicing surgery for approximately 22 years, Dr. Price is the associate director of the Center for Global Surgery at the University of Utah, Salt Lake City. He earned an ACS International Volunteer Award in 2012 for his efforts to improve surgical care in resource-poor countries. This work has “kept me pretty well-grounded,” Dr. Price said. “I can provide the care that I wanted to provide when I went into medicine,” which sometimes can be obstructed in the U.S. because of all the necessary documentation and regulations, he added. “There are people that you see that are very grateful for what they get. It gives you a real sense of accomplishment,” he said of his work with patients in countries like Mongolia, Nigeria, and Indonesia. When he practices surgery in Utah, Dr. Price limits himself to no more than four nights of call per month. He said he learned how to keep a work-life balance from his father, who is also a surgeon and will tell him if he’s doing too much.

Despite the stresses that are typically associated with the profession, the surgeons interviewed for this article said that they are able to stay involved and excited about their role as physicians because of their patients. Dr. Caropreso said that not feeling burned out was a mindset. “For me, it’s been a privilege to be a doctor and a surgeon. People trust me enough to put their lives in my hands, and I’ve always kept that in focus. That has helped a lot.” ♦
The following statement was developed by the American College of Surgeons (ACS) Legislative Committee and was approved by the Board of Regents at its October 2014 meeting.

The nation’s medical liability system is broken; it fails both patients and physicians. Less than 3 percent of patients who sustain medical injury sue for monetary compensation, and in 37 percent of all closed liability claims no error was discovered.\(^1,2\) In addition, the current liability system costs the U.S. an estimated $55.6 billion annually (including $45.6 billion for defensive medicine).\(^3\) The system is costly and inefficient, and the process of compensating injuries related to medical errors is inaccurate.

The mission of the ACS is to improve the care of the surgical patient, safeguard standards of care, and create an ethical practice environment.\(^4\) The ACS is a proven leader in patient safety through initiatives such as the ACS National Surgical Quality Improvement Program (ACS NSQIP\(^6\)) and the Inspiring Quality campaign.\(^5,6\) The failing medical liability process jeopardizes the public’s trust in the health care system and threatens to undermine the successes that the ACS has achieved. Therefore, the ACS must continue to lead the way by advancing practical reforms that improve patient safety and provide quality health care.

Traditional liability reforms, such as caps on noneconomic damages and collateral source reform, may have market-stabilizing effects.\(^7\) The ACS has long supported these reforms and will continue to do so as a means of addressing skyrocketing liability insurance premiums. However, for decades, attempts to generate bipartisan political support for new tort reform have proven challenging, particularly at the federal level. In addition, reforms that focus on alleviating the financial impact of medical liability on health care professionals frequently do little to improve patient safety or to re-establish the trust patients place in the system.\(^5\)

Beyond traditional legislative remedies, the medical liability system is in need of transformative change that focuses less on monetary reparations and more on the ACS mission centered on patient safety, quality health care, and provider accountability.\(^7,8\) Adverse events should be approached with open communication and recognition that an unfortunate outcome is not synonymous with negligence. Compensation for injured patients, monetary or otherwise, should be fair and timely without the unnecessary delay commonly associated with the current tort process. Hospitals should pursue system-level changes that assure patients of quality care and that prevent event recurrences. Ultimately, negligent providers should be held accountable.

Alternative, patient-centered solutions to liability reform have received varying degrees of attention.\(^9,10\) Health courts, enterprise liability, and alternative dispute resolution can be crafted around patient-centered principles and also provide excellent opportunities for reform.\(^9,10\) However, on balance, disclosure and offer programs, otherwise known as communication and resolution programs (CRPs), show the most promise for promoting a culture of safety, quality, and accountability; restoring financial stability to the liability system; and requiring the least political capital for implementation.\(^11,12\) All of these alternatives may be improvements over the status quo for both patients and providers and should be explored through additional research and advocacy. Structural barriers to their implementation, however, such as obsolete reporting requirements to the National Practitioner Data Bank (NPDB) and inconsistent apology protections, must be addressed.
REFERENCES


The College actively supports:

• Reforms based on safety, quality, and accountability

• Continued advocacy of traditional reforms where appropriate and feasible

• Legislation that eases structural barriers to implementation of patient-centered reforms, specifically as it pertains to NPDB reporting requirements and apology laws

• Culture change among hospitals and providers to embrace swift adoption of alternative patient-centered reforms, including CRPs

Beyond traditional legislative remedies, the medical liability system is in need of transformative change that focuses less on monetary reparations and more on the ACS mission centered on patient safety, quality health care, and provider accountability.
The ACS motto: What does it really mean?

by Frederick K. Weber, MD, JD, FACS

Editor’s note: The following is an edited version of the Presidential Address that Fred Weber, MD, JD, FACS, delivered at the 63rd annual Clinical Symposium of the New Jersey Chapter of the American College of Surgeons, which took place December 6, 2014.

The American College of Surgeons (ACS) was founded in 1913 to foster the highest ideals in the practice of surgery. The College continues with this mission today, inspiring quality, providing education, maintaining the highest standards in surgery, and thereby providing better outcomes for our patients.

Origins of the ACS seal and motto
In establishing the organization, the founders of the ACS sought to develop a logo for the College that would also contain a short sentence or phrase that would express a rule guiding the behavior of the Fellows. In 1915, the first Director of the ACS, John G. Bowman, MD, FACS, urged the Regents and the ACS Secretary, Franklin H. Martin, MD, FACS, to authorize a competition among Chicago, IL, artists to develop the seal for the College. Paul Frederick Volland, who ran a publishing company in Chicago, IL, entered the contest, and his seal containing the Latin phrase, *Omnibus per artem fideaque prodesse*, was selected.

Translations
So what does *omnibus per artem fideaque prodesse* mean? What is the literal translation? What does it signify? Why is this motto still important to us today? The traditional translation has been “to serve all with skill and fidelity.” My version is slightly different. To understand the full interpretation of the motto, though, it is helpful to consider each Latin word separately.¹,²

*Prodesse*: Latin places the verb at the end of the sentence, so the reader is held in suspense until the last word. At the end of the motto is *prodesse*. It is the present infinitive of the
The Latin flows easily: Omnibus per artem fidelisque prodesse. But, as with many translations, the literal English is somewhat awkward: To heal all through the art and fidelity. My translation is “to heal all with skill and trust.”

verb prosum, meaning to be helpful, to be useful, and to heal. It is related to the Latin verb sum I am, with its infinitive esse. In his Latin grammar class, young Hamlet might have contemplated esse non esse. “To be or not to be.”

I like to translate this word as “to heal” and put it in the beginning of the English version.

Omnibus: Omnibus is the plural of the noun omnis, meaning “all” and is in the accusative case. In English this would be the objective case. Interestingly, our word “bus” is derived from this word; the ending -bus signifies transportation for everyone. This word can be seen on New Jersey taxi and bus license plates. Additionally, a power strip is a power bus. With prodesse this is the main thrust of the motto “to heal all.” We are not to discriminate among whom we heal—we treat all comers.

Per: The preposition per means “through,” “by,” or “by means of.” NPO is a standard medical abbreviation for nil per os: nothing by mouth, not even ice chips. Putting this into English is an awkward construction, so the ACS and I translate this as “with.”

-que: The conjunction -que is added to the second word of a construction, substituting for the English “and.” For example, senatus populusque Romanus translates as “equality between the Senate and the citizens of Rome.”

Artem: The art in artem fidelisque refers to the art of medicine and surgery. Translators try not to transliterate a word into English. The practice of medicine and surgery requires skill and this is the primary definition of the Latin word. Translating artem as “skill” makes the English flow more effortlessly.

Fidem: The College has traditionally translated fidem as “fidelity,” but, in my opinion, this translation conveys only a partial meaning of the word. The primary definition is “trust,” and I prefer to translate the word as such. Patients put their trust and lives in our hands. We are entrusted with the surgical care of our patients. As surgeons, we carry the burden of the outcome of our procedures.

The Latin flows easily: Omnibus per artem fidelisque prodesse. But, as with many translations, the literal English is somewhat awkward: To heal all through the art and fidelity. My translation is “to heal all with skill and trust.” Physicians stand in a long line of healers, dating from the dawn of civilization to the present. Our patients put their trust in us.

Ties to the Hippocratic Oath
Hippocrates lived and practiced on the island of Kos in the third and fourth centuries before the Common Era. He penned his eponymous oath—which we all swear to uphold as physicians—late in his practice. The Hippocratic Oath, with its 253 words, contains the formula for a successful medical and surgical practice. The Affordable Care Act, with its 234,812 words, does not even come close.

I would like to discuss two parts of the Hippocratic Oath as it relates to us, the ACS motto, and the College today. I will not cut for stone, even for patients in whom the disease is manifest; I will leave this operation to be performed by practitioners, specialists in this art.

In antiquity, surgeons were not part of the Hippocratic medical community. Surgeons were “practitioners, specialists in this art.” The dorsal lithotomy position is a common placement of a patient. I prefer to call this position the “childbirth position,” recalling the birth of my daughters. It is literally the “stone cut” position. I suspect that the stone being cut is a bladder stone, as this position would give access to the bladder just superior to the pubic ramus. This must have been a truly horrific procedure, such that it is the only operation specifically proscribed in the oath.

We became physicians when we graduated from medical school. We became “practitioners, specialists in this art” when we completed our surgical residency. We are physicians first and specialists second.

In purity and holiness I will guard my life and my art.

Here, the oath emphasizes the high calling of the healing art.
The physician’s life should be one of restraint from wrongdoing, which will reflect positively on the art of medicine and surgery. The trust patients place in us produces a burden that we carry as surgeons and physicians. This burden is the worry we have when we start an operation, when we have a patient with a complication, when we have to deal with the death of a patient. The ACS unites the surgical community with the healing art through its high standards. We are both physicians and surgeons, aspiring to the highest standard of our practice.

The surgeon’s burden

The painting by Sir Luke Fildes, titled The Doctor, exemplifies the trust our patients place in us (see image, this page). Sir Henry Tate commissioned the painting in 1890. The artist was left to his own discretion in choosing the subject matter. Mr. Fildes chose to recall a personal tragedy of his own—the death of his first son, Philip, who died at one year old in his Kensington home in 1877. Mr. Fildes’ surviving son wrote a biography of the artist in which he stated, “The character and bearing of their doctor throughout the time of their anxiety made a deep impression on my parents.” When viewing the painting, one notes the anguish of the wife, the stoicism and trust of the husband, the sick child arranged on two chairs, and what I call the “burden” upon the physician caring for the life of the couple’s precious daughter. In this pre-antibiotic era, one could only hope for the dawn to break, the crisis to pass, and for the recovery of the child.

Four days before my graduation from New Jersey Medical School, Newark, an elderly woman knocked at my apartment door. She was a retired physician, and wanted to give me her framed print of this painting. She had watched me for four years, studying in my ground floor studio, and wanted me to have it as it had been with her throughout her practice. Five days after graduation, a massive heart attack claimed her life. In her memory, I have carried The Doctor with me over the last 40 years.

This painting links the motto of the ACS with the trust our patients place in us and the skill we possess as surgeons. Membership in the College and the letters “FACS” that follow our names guarantee that the public can be sure of this trust and skill.

REFERENCES

Setting standards of efficiency

by David L. Nahrwold, MD, FACS

Editor’s note: This essay is part of a series of historical vignettes that the Bulletin is publishing as part of the regular “From the Archives” column. These brief articles center on key individuals and events in the history of the American College of Surgeons (ACS) and are written by members of the ACS Surgical History Group, chaired by ACS Past-President LaMar S. McGinnis, Jr., MD, FACS.

Franklin H. Martin, MD, FACS, acting as the General Secretary of the ACS, gave a talk to the Fellowship titled Problems of the College at the annual meeting of Fellows in October 1916, four years after the organization was founded. The following is a brief excerpt from that presentation:

But we are face to face with grave problems. Let me enumerate some of them: First, the discrepancies in the standards of efficiency among hospitals in which recognized leaders in surgery do their work. Second, the wide range of difference[s] in surgical training of graduates of medical schools of like classification. Third, the great difference in the surgical training received by interns in hospitals of comparable equipment. Fourth, the confusion in estimating the value of an assistantship to recognized surgeons. Fifth, the lack of a standardized system of case-histories through which we may estimate the merit of work as submitted by candidates to the Committee on Examinations. Sixth, lack of uniformity among graduate courses in surgery as offered by educational institutions which control the great clinical centers.*

The “efficiency movement” was central to the Progressive Era of the early 20th century. Waste, inefficiency, and incompetence festered in hospitals and the medical education system, weakening the effects of the modernization that was occurring in surgery. Dr. Martin and others believed that standards of efficiency were needed to elevate the quality of surgery and surgeons. The variance in quality among hospitals, the surgical training of medical students and surgical interns, assistantships, and postgraduate courses in surgery responsible for inferior surgical care could be eliminated by setting standards. Even the systems for writing, submitting, and evaluating the 50 case histories required for admission to the College needed standardization so that better judgments could be made regarding the admittance of Fellows.

The first standardization programs

College leaders quickly responded to these inefficiencies by establishing the Hospital Standardization Program, which created standards and required hospitals to meet them. This program lives on through The Joint Commission.

The American Medical Association (AMA) stepped in to create standards for internships in 1920, and both the College and the AMA set standards for residency programs in the 1930s—programs that continue through the Accreditation Council for Graduate Medical Education. Standards for individual physician competency were established through the certifying boards, beginning in 1916 with the American Board of Ophthalmology. Today, there are 24 certifying boards, and they also establish standards for continuing competency through their Maintenance of Certification programs.

The College’s response to Dr. Martin’s frank assessment led to the high standards with which surgery is practiced today. And the efficiency movement lives on, with many organizations and the government now setting standards for care and how medicine should be practiced. Standards of efficiency are now so ubiquitous that health care policymakers and the profession are confronted with the need to support standards that actually improve care, while casting aside those that make us wasteful, less efficient, and do nothing to improve care for our patients.

As the demand for health care institutions to provide safe, high-quality, and cost-effective and efficient care continues to increase, so too has the presence of ambulatory surgery centers (ASCs). ASCs present an opportunity for surgeons to focus on various aspects of performing safe and efficient operations, including medication management.

**A priority issue for surgeons**

Surgeons should make medication management a priority at their ASC. Developing an effective and safe medication management system is critical in eliminating any potential patient harm that medications might cause. A drug management system addresses an institution’s medication processes based on the care, treatment, or services it provides. A reliable system requires that multiple services and disciplines within an ASC work together, especially when it comes to maintaining safe, efficient, and orderly medication administration.

According to an article in the June 2014 issue of *Outpatient Surgery Magazine*, medication carts should be organized for easy access by separating look-alike and sound-alike medications, and pre-drawn syringes should include appropriate industry-standard required labeling and expiration dates and comply with Joint Commission standards. Surgeons also should ensure that single-dose vials are used only on one patient and that the proper policies and procedures are in place for discarding unused/unneeded medications.* Complying with these standards can help staff to more easily and efficiently prepare and administer medications, especially during surgical procedures or emergencies, potentially reducing errors, delays in administration, and misuse.

**Framework for managing medications**

In addition to these precautions, The Joint Commission outlines several medication management (MM) standards in its ambulatory health care accreditation manual to help ASCs develop a framework for a safe and effective MM system. ASCs may incorporate the following standards into their system:
Developing an effective and safe medication management system is critical in eliminating any potential patient harm that medications might cause.

- **Planning:** The ASC plans its medication management process and safely manages high-alert and hazardous medications.

- **Selection and procurement:** The ASC selects and procures medications.

- **Storage:** The ASC safely stores medication and manages emergency medications. It also safely controls medications that patients, families, or licensed independent practitioners bring into the facility.

- **Ordering:** Medication orders are clear and accurate.

- **Preparing and dispensing:** The organization reviews the appropriateness of all orders for pharmaceuticals to be dispensed in the ASC and safely prepares medications. The facility safely obtains and dispenses medications when it does not operate a pharmacy and safely manages returned medications.

- **Administration:** The ASC safely administers medications and safely manages investigational medications.

- **Monitoring:** The ASC monitors patients to determine the effects of their medications and responds to actual or potential adverse drug events, significant adverse drug reactions, and medication errors.

- **Evaluation:** The organization evaluates the effectiveness of its medication management system. This evaluation includes reconciling medication information.†

As surgeons increasingly perform operations at ASCs, it is important to focus efforts on making patient safety a top priority. Establishing a MM system is invaluable in reducing and eliminating the potentially devastating consequences that could result from medication errors.

For more information regarding The Joint Commission’s Ambulatory Health Care Accreditation Program, go to www.jointcommission.org/accreditation/ambulatory_healthcare.aspx.

Affordable trauma care?

by Richard J. Fantus, MD, FACS

Traumatic injuries are devastating in more than one way. The physio- and psychological consequences of major trauma can last a lifetime, depending on the constellation of injuries and organ systems affected. In addition, trauma patients may experience significant financial burdens because of hospital bills, physician fees, lost income, and loss of future insurability. This month’s column looks at how provisions in the Affordable Care Act (ACA) are affecting access to care for Americans as a whole and considers the potential effects on trauma care.

Expanded access to care
In 2010, six months after enactment of the ACA, a Patient’s Bill of Rights went into effect, which prohibits insurance companies from denying health care coverage to children based upon preexisting conditions, eliminates lifetime limits on coverage, regulates annual limits on insurance coverage, and provides an appeal process for insurance company denials. Additional changes include payment relief for senior citizens affected by the Medicare prescription “donut hole,” adds preventive service coverage in new plans, cracks down on health care fraud, and extends coverage for young adults.

In 2012, ACA regulations targeted improving quality and outcomes, and in late 2013 came the much-anticipated increase in access to health care insurance coverage under the ACA. Some glitches occurred in the process of enrolling millions of patients in insurance plans, but the goal of bringing affordable and qualified health plans to individuals and small businesses was largely realized.* In 2008, Gallup and Healthways began tracking the percentage of Americans without health insurance. In that first year, the rate started out at 14.6 percent, and it peaked at 18 percent in mid-2013. When the requirement for most Americans to have health insurance went into effect in the early part of 2014, however, this percentage decreased sharply.†

Self-pay in trauma care

The National Trauma Data Bank® (NTDB®) Annual Report is based upon trauma admission for the preceding year. This year’s Annual Report is based on 2013 admissions. When looking at the most recent five years, which include 2009 through 2013 admission years, the percentage of self-pay patients remained consistent at 15.12, 15.56, 15.10, 14.9, and 14.4, respectively. These percentages are compared by year with the U.S. population of uninsured in the figure on this page.

The 2014 percentage of uninsured Americans is the lowest it has been since tracking began in 2008. It will be interesting to see what happens to the percentage of trauma admissions that are self-pay when reviewing the 2014 admission records to be included in the 2015 Annual Report. Will we see a comparable drop in the self-pay percentage and the start of affordable trauma care?

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/trauma/ntdb/index.html.

In addition, information about how to obtain NTDB data for more detailed study is posted on the website. If you are interested in submitting your trauma center’s data, contact Melanie L. Neal Manager, NTDB at mneal@facs.org.
Girma Tefera, MD, FACS, joined the American College of Surgeons (ACS) Division of Member Services in February as the new Medical Director of Operation Giving Back (OGB). OGB is a comprehensive resource that helps surgeons find volunteer opportunities worldwide that match their expertise and interests.

Dr. Tefera is a vascular surgeon and professor of surgery, department of surgery, University of Wisconsin (UW) Hospital and Clinics, Madison. He is also vice-chair, division of vascular surgery and chief of vascular surgery, William S. Middleton Memorial Veterans Hospital, Madison. Dr. Tefera specializes in minimally invasive vascular interventions, including stent grafts for complex aneurysm treatment, as well as percutaneous treatments of carotid arteries and vascular diseases of the lower extremity.

Educational path
In pursuing a surgical career, Dr. Tefera took the road less traveled. He grew up in Chencha, a small town of fewer than 5,000 people in southern Ethiopia, as one of seven children. At the age of 12, he left home to enroll in high school 22 miles away, and at age 15, he was admitted to a college preparatory school 400 miles from home. After graduating at the top of his class, he was one of six Ethiopian students offered a full scholarship at the University of Pisa Medical School, Italy. After graduating in 1982, he returned to war-torn Ethiopia, where he worked for five years as a general practitioner, primarily in the Armed Forces General Hospital, department of surgery, Addis Ababa, Ethiopia, and Asmara, Eritrea. These experiences with treating injuries on the battlefield strengthened his surgical skills as well as his resolve as a surgeon.

As war continued to ravage his homeland, the Ethiopian government resisted his efforts to leave. In 1988, he seized an opportunity for a surgical residency at Krankenhouse Friedrichstadt in Dresden, East Germany. After the Berlin Wall fell in 1989, he continued with his surgical training, where he gained a general surgery certification in 1992. He emigrated to the U.S., where he sought refuge from the conflicts of his homeland. This move proved to be deeply challenging. “It is hard to relate the difficulties a foreign graduate faces to get into surgical residency,” he said. He persisted and was admitted into a residency program at Howard University Hospital, Washington, DC, and in 1999, began a vascular surgery fellowship at the UW School of Medicine and Public Health, followed by his work as a faculty member.

Surgical Volunteerism Award
Dr. Tefera is taking the reins of a program that in 2011 honored him with the ACS Surgical Volunteerism Award. OGB, in conjunction with the ACS Board of Governors, oversees the annual award that pays tribute to one Fellow for exceptional volunteer work, either domestically or abroad. The award to Dr. Tefera recognized his significant contributions to improving the delivery of surgical and emergency care in Ethiopia. He was acknowledged for the strategic partnerships he developed to strengthen health care delivery, focused on systems development and building workforce capacity to train local partners. In 2010, Dr. Tefera and his local partners celebrated the opening of an emergency medical training center and the start of a training program for emergency medical specialists at Addis Ababa University. The center has since trained more than 4,000 health care professionals in medical emergency care.
In the past five years, more than 100 volunteers from Wisconsin and other U.S. partner schools have traveled to Ethiopia, and more than 15 residents have graduated in emergency medical care. The partnership has created a foundation for developing comprehensive trauma and emergency care for the entire country.

Giving back to OGB
Dr. Tefera looks forward to directing OGB. “It is such a privilege for me to ‘give back’ to a program that has given so much to me,” he said. “I am delighted to have this opportunity to direct such an important global volunteer program and to have an impact on its future.” In his new role, Dr. Tefera will turn his attention to the range of global surgical programs offered at the ACS Clinical Congress. He also will coordinate the College’s response to disasters worldwide, develop new programs and opportunities for surgeon volunteers, communicate the work of OGB, and increase College participation and recognition among other similar global organizations.

In addition, he will oversee a redesign of the OGB website to match members’ needs with volunteer opportunities.

Dr. Tefera has been involved in giving back to his country of origin together with his diaspora colleagues. He chairs the Board of Directors of the Ethio-American Doctors Group, a diaspora organization that is striving to build the first Joint Commission International-accredited hospital in Ethiopia.

Dr. Tefera is married to Rahel, and they have two children, Daniel and Eden.

“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.
M. Margaret (Peggy) Knudson, MD, FACS, professor of surgery at the University of California, San Francisco (UCSF), and trauma surgeon at San Francisco General Hospital and Trauma Center, has joined the Division of Member Services of the American College of Surgeons (ACS) as Medical Director of the Military Health System Strategic Partnership (MHSSPACS). This three-year partnership was officially launched with the signing of a charter during the ACS Clinical Congress 2014 in San Francisco. The partnership will enable the sharing of training and educational platforms, research endeavors, quality improvement programs, and combat readiness and disaster preparedness efforts. Ultimately, the work of the partnership is intended to benefit surgical patients in both the civilian and combat arena in the U.S. and throughout the world.

For Dr. Knudson, this new responsibility is a natural progression in a career dedicated to trauma care. “These are activities I have been doing all along and this new partnership is really an extension of the Senior Visiting Surgeon exchange program in Landstuhl, Germany, supported by the ACS Committee on Trauma (COT), the American Association for the Surgery of Trauma, and the U.S. military,” she said. “The U.S. war in Iraq has been a training ground for combat casualty care, resulting in the fewest number of deaths ever recorded as a result of wartime wounds.” Many lessons regarding the care of trauma patients have been learned during the 13-year military involvement in Iraq and Afghanistan, the longest war in U.S. history, she said. “This is a very important time in history. What a shame it would be if we couldn’t study the treatment of battlefield injuries in a more controlled setting in the civilian world.

“The military surgeons are really looking for a surgical home for medical students and residents who are training at military facilities, as well as for active duty and reserve surgeons and those who have separated. Much of this effort will be focused around the ACS Clinical Congress,” Dr. Knudson added.

The new partnership will provide a mutually beneficial exchange of educational, quality of care, and research efforts between military and civilian surgeons.

Dr. Knudson brings to her new role with the College years of experience serving on the front lines of trauma care. She treated victims of major disasters, including the 2010 earthquake in Haiti, and the crash of Asiana Airlines Flight 214 in San Francisco in July 2013. In 2007, as Vice-Chair of the ACS COT, Dr. Knudson participated in the first Verification Review Committee (VRC) site visit outside the U.S., at Landstuhl Regional Medical Center (LRMC) in Germany. LRMC, a permanent U.S. military installation and the largest American military hospital outside the U.S., was seeking verification as a Level II trauma center. Dr. Knudson and the other VRC members performed a site visit as they would for any other trauma center. They evaluated the medical center’s resources, interviewed hospital personnel, toured the facilities, and reviewed...
selected medical records and performance improvement materials to determine the quality of care provided. In the end, the reviewers praised the medical center for its high quality of care and encouraged administrators to pursue a Level I verification. In 2011, LRMC became a Level I trauma center.

In 2008, Dr. Knudson traveled with a team of physicians to Iraq’s Balad Air Force Base to share information about operations at their hospitals and how their collective knowledge might improve the delivery of trauma care on the battlefield. The trauma system in Iraq, similar to those established in civilian hospitals, helps ensure that wounded service members have the optimal opportunity to survive and recover from battlefield injuries. Patients are transported to military treatment facilities based upon the level of care that the facility is able to provide. Many patients, service members, and U.S. and Iraqi civilians are transported to the Balad hospital for severe injuries. At the conference, Dr. Knudson raised the issue of the delivery of injured patients and the complications and challenges faced by individuals who fly severely injured patients to care. Conference participants discussed issues regarding resources, adherence to clinical practice guidelines, and the medical evacuation of critically ill or injured patients to another facility with the needed services.

Dr. Knudson eventually served the maximum number of years allowed on the national level of the COT. Although she remains involved in the activities of the COT in both Region 7 and Region 9, she is pleased that her involvement in the partnership will extend her association with the COT nationally.

Dr. Knudson served as Chair of the ACS Prevention and Control Committee (2003–2009) and as COT Vice-Chair (2006–2010). Dr. Knudson is the director and a principal investigator of the San Francisco Injury Center, funded by the Centers for Disease Control and Prevention. She attended medical school and completed her general surgical residency at the University of Michigan in Ann Arbor. After a fellowship in pediatric surgery at Stanford University, she became involved with the development of trauma systems in California, with a special interest in pediatric trauma. She joined the teaching faculty at the UCSF in 1989.

Dr. Knudson and her husband, Stephen A. DeLateur, PhD, live in Los Altos, CA, and have twin daughters who are now young adults. ♦

“The military surgeons are really looking for a surgical home for medical students and residents who are training at military facilities, as well as for active duty and reserve surgeons and those who have separated. Much of this effort will be focused around the ACS Clinical Congress.” —Dr. Knudson

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Sir Murray F. Brennan, MD, FACS, was named a Knight Grand Companion of the New Zealand Order of Merit on January 1, for his service to medicine as part of the Queen’s New Year Honours. A native New Zealander, Dr. Brennan is the Benno C. Schmidt Chair in Clinical Oncology, vice-president for international programs, and director of The Bobst International Center, Memorial Sloan Kettering Cancer Center (MSKCC), New York, NY. Dr. Brennan adds knighthood to a long list of accolades that he has received throughout his distinguished career as a cancer surgeon. In 2000, he received the American College of Surgeons’ (ACS) highest honor—the Distinguished Service Award.

Crowning achievements in cancer care
Born in Auckland, Dr. Brennan received a degree in mathematics from the University of Otago, Dunedin. He performed advanced laboratory and clinical work at Peter Bent Brigham Hospital, Harvard Medical School, and the Joslin Research Laboratories, Boston, MA. After residency, Dr. Brennan joined the National Cancer Institute, where he led the surgical metabolism section. He began his career at the MSKCC in 1981 as chief of gastric and mixed tumor service. From 1985 to 2006, Dr. Brennan chaired the department of surgery at MSKCC. In 1994, MSKCC established the Murray F. Brennan Chair in Surgery. Throughout his career at MSKCC, he also has served as a professor of surgery at Cornell University in New York.

Dr. Brennan is recognized around the world for his extraordinary achievements in enhancing the medical and scientific communities’ understanding of tumor biology, in evaluating the proper role of surgery and other therapies in caring for patients with cancer, and for training young surgeons and serving as a mentor to developing surgical scientists. Dr. Brennan’s clinical and research interests have centered on surgical oncology, endocrinology, metabolism, and nutrition. He has designed and conducted numerous clinical trials, which have produced significant findings in the management of patients with soft tissue sarcomas and pancreatic cancer, and played a leading role in creating the world’s largest database of more than 10,000 sarcoma patients.

Leader of surgical organizations
An ACS Fellow since 1977, Dr. Brennan has served the College in numerous capacities. He served as ACS Second Vice-President (2004–2005) and is a former Chair of the Commission on Cancer, the Surgical Forum Committee, and the International Relations Committee. In 2012, the Fellows Leadership Society of the ACS presented the Distinguished Philanthropist Award to...
Dr. Brennan is recognized around the world for his extraordinary achievements in enhancing the medical and scientific communities’ understanding of tumor biology, in evaluating the proper role of surgery and other therapies in caring for patients with cancer, and for training young surgeons and serving as a mentor to developing surgical scientists.

Dr. Brennan in recognition of his philanthropic endeavors, his service to the surgical profession, and his all-encompassing support of the College. Also in 2012, the Murray F. Brennan International Scholarship was endowed through the ACS Foundation with the support of more than 100 donors.

Dr. Brennan has played an active leadership role in many other surgical organizations. He has served as director of the American Board of Surgery and president of the Society of Surgical Oncology, the James IV Association, the Society of Clinical Surgery, the International Gastric Cancer Association, and the American Surgical Association.

Dr. Brennan is an Honorary Fellow of the Royal College of Surgeons in Ireland, Edinburgh, England, and Australasia; the Brazilian and Chilean Surgical colleges; the Royal College of Physicians and Surgeons of Glasgow and Canada; a number of international surgical societies; and the Association of Surgeons of Great Britain and Ireland.

He has received honorary doctorates from the Universities of Edinburgh, Otago, and Gothenburg, and the University College of London. In 1995, he was honored with membership in the Institute of Medicine of the National Academy of Sciences.


NAPBC to co-host best practices session at NCBC Breast Conference

The American College of Surgeons National Accreditation Program for Breast Centers (NAPBC®) and the National Consortium of Breast Centers (NCBC®) will co-host a post-conference session, Best Practices in Breast Centers: Quality from NAPBC and NQMBC® (National Quality Measures for Breast Centers), 7:45 am–5:30 pm, March 17. Speakers at the post-conference session, which will follow the NCBC’s 25th Annual Interdisciplinary Breast Cancer Conference, in Las Vegas, NV, will convey best practices for breast centers. These practices, successfully adopted by breast centers worldwide, include accreditation, survivorship, genetics and risk assessment, and the role of navigators. Cary S. Kaufman, MD, FACS, associate clinical professor of surgery, University of Washington, Seattle, and medical director, Bellingham Regional Breast Center; Randy E. Stevens, MD, radiation oncologist, White Plains Hospital Center, NY; and Claudia Z. Lee, MBA, president, C. Z. Lee & Associates, Hudson, NY, serve as course directors.

The conference, featuring a clinical track from NCBC and the American Society of Breast Disease, will provide continuing education to oncologists, surgeons, nurses, clinicians, and administrators to advance the delivery of treatment options and quality of care. Nathalie Johnson, MD, FACS, a surgical oncologist and medical director, Legacy Cancer Institute and the Legacy Breast Health centers, Portland, OR, and a cancer survivor, will deliver the conference’s keynote address.

View the syllabus for the NAPBC-NQMBC post-conference session at https://mlsvc01-prod.s3.amazonaws.com/b59f4183201/38804c6c-fb2a-44ea-bdbb-c034de25273d.pdf. Obtain more information and register online for the NCBC conference at www2.breastcare.org/ncbc-conference-tickets.
Members in the news

Brooke M. Buckley, MD, FACS, emergency surgeon and medical director, Anne Arundel Medical Center, Acute Care Surgeons, Annapolis, MD, was recently elected 2015–2016 president of the Maryland State Medical Society (MedChi). Dr. Buckley served as co-chair of the MedChi legislative council, 2011–2013, and has been on the board of the MedChi political action committee since 2010.

Luther F. Cobb, MD, FACS, was installed as the 147th president of the California Medical Association (CMA). Dr. Cobb has dedicated many years to the betterment of health care in California and formerly served as chair of the CMA Council on Legislation and president of the Humboldt-Del Norte County Medical Society. Over the course of the last year, he played a significant role in the successful campaign to defeat Proposition 46, with 67 percent of the California electorate voting against it. This proposal would have increased California’s $250,000 cap on noneconomic damage awards in medical liability lawsuits to $1.1 million. Read Dr. Cobb’s president’s message in the January 14, 2015, issue of CMA News at www.cmanet.org/m/news/detail.dT/presidents-message-the-coming-year-and-beyond.

Alvin Crawford, MD, FACS, co-director of the Crawford Spine Center, Cincinnati Children’s Hospital, and professor emeritus at the University of Cincinnati College of Medicine, OH, has received a number of awards in recent months. He was among four individuals honored as 2014 Great Living Cincinnatians by the Cincinnati USA Regional Chamber. Since 1967, the Regional Chamber has honored more than 135 residents with the annual Great Living Cincinnatian Awards, based on such criteria as community service; business and civic attainment at a local, state, national, or international level; leadership; awareness of the needs of others; and distinctive accomplishments that have brought favorable attention to their community, institution, or organization. Dr. Crawford also received the Distinguished Achievement Award from the Pediatric Orthopaedic Society of North America in 2014, its highest honor. In addition, he received the Lifetime Achievement Award from the Scoliosis Research Society, the premier organization for spinal deformities. On February 12,
Brandon Snook, MD, FACS, Mike O’Callaghan Federal Medical Center, Las Vegas, NV, graduated as a categorical active duty resident in acute care surgery from the University Medical Center (UMC) of Southern Nevada, Las Vegas, the state’s only Level I trauma and burn center, in July 2013. He is part of a program called Sustained Medical and Readiness Trained, which helps medical officers stay current with the latest medical and surgical techniques used on the battlefield. In January, Lieutenant General Thomas W. Travis, MD, U.S. Air Force (USAF) Surgeon General, toured the UMC’s emergency department and formally announced the expansion of the medical center’s two-year training program, in partnership with the USAF and Nellis Air Force Base, NV. John Fildes, MD, FACS, department of surgery, University of Nevada School of Medicine, Las Vegas, and Past Medical Director of the American College of Surgeons Trauma Programs, has been an active participant in the embedding of active duty residents into emergency medicine. As a result of this partnership, more USAF medical specialists from around the country will expand their acute care training at the UMC.

55 hospitals represented at first semi-annual ISQIC meeting

More than 200 representatives from 55 Illinois hospitals participated in the first semi-annual meeting of the Illinois Surgical Quality Improvement Collaborative (ISQIC) in January. The Illinois and Metropolitan Chicago Chapters of the American College of Surgeons (ACS) formed the collaborative last year with the ACS National Quality Improvement Program, using several innovative approaches, including mentors, coaches, formal process improvement training, annual statewide projects, pilot grants, and many other initiatives. At the meeting, hospital representatives shared their experiences with implementing a variety of surgical quality improvement projects. Attendees at the meeting continued their formal quality and process improvement training with lectures and group exercises. The group also spent time planning their first statewide quality improvement initiative.

Keynote speaker Oscar D. Guillamondegui, MD, FACS, associate professor of surgery and trauma medical director, Vanderbilt Multidisciplinary Traumatic Brain Injury Clinic, Nashville, TN, addressed the challenges and successes of the Tennessee Surgical Quality Collaborative in enhancing surgical care in their state. View ISQIC’s website at www.isqic.org/.
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ACS-0814 CA#OF76076 AR#1322
The American College of Surgeons (ACS) Division of Education and the International Relations Committee are now accepting applications for two international scholarships focused on surgical education. These awards, in the amount of $10,000 each, allow young faculty members from countries outside the U.S. and Canada to participate in a variety of educational opportunities for faculty development. The end result will be the acquisition of new knowledge and skills meant to enhance surgical education and training in the scholar’s home institution and country.

All applications and supporting documentation must be received at the office of the International Liaison no later than May 1, 2015, for attendance at this year’s Clinical Congress.

The two scholars selected for 2015 will participate in the ACS Clinical Congress, October 4–8, in Chicago, IL, including the course Surgical Education: Principles and Practice, as well as other plenary sessions and courses that address surgical education and training across the continuum of professional development. There may be a focus on the needs of practicing surgeons, surgery residents, medical students, and members of the surgical team, or on building knowledge and skills in evaluating and adopting new surgical technologies.

Following the Clinical Congress, the scholars will visit appropriate Level I ACS-Accredited Education Institutes or similarly recognized and established centers with a plan of study and interaction tailored to their particular education-based focus. These centers are typically located in large academic medical centers, which may also allow the scholar exposure to areas of clinical interest. At the conclusion of the Clinical Congress and their visits to these institutions, each scholar will send a brief report to the ACS Division of Education and to the International Relations Committee, which will summarize the outcomes achieved as a result of the scholarship, specifically focusing on achievement of the objectives outlined in the application. Applicants must supply evidence of support of the scholar’s objectives from the leadership at their home institutions.

The scholarship will facilitate the scholar’s involvement in subsequent collaborative ventures in education and training under the aegis of the ACS Division of Education.

Each scholarship provides a stipend of $10,000, supporting travel and per diem in the U.S., and the cost of courses undertaken at the Clinical Congress and at the centers to be visited. Clinical Congress registration will be provided gratis, and assistance in reserving economical housing in the Clinical Congress host city will also be provided. Chicago, IL, is the host city for Clinical Congress 2015.

Requirements
To qualify for the scholarships, the following criteria must be met:

• Applicants must be medical school graduates.

• Applicants must be at least 30 years old but younger than 45 years of age on the date that the completed application is filed.

• Applications must be submitted from the applicants’ intended permanent location.

• Applicants must be in surgical practice and teaching for at least five years following completion of all formal training (including fellowships and scholarships).

• Applicants must submit a fully completed application form, which is available on the College website at www.facs.org/member-services/scholarships/international/issurged. The application and accompanying materials must be in English. Submission of a curriculum vitae only is unacceptable.

• Applicants must submit independently prepared letters of recommendation from three of their colleagues. One letter...
must be from the chair of the department in which they hold an academic appointment and must provide evidence of support of the scholar’s objectives from the leadership at the home institution. Letters of recommendation should be submitted directly by the persons making the recommendations.

- The International Scholarships for Surgical Education must be used in the year for which they are designated. The scholarships cannot be postponed.

- Awardees must provide a written report upon their return home, specifically focusing on the value of the visit to the awardee and the potential benefits to patients in the country of origin.

- Unsuccessful applicants may reapply only twice and only by completing and submitting a current application form provided by the College together with new supporting documentation.

Questions and supporting materials should be directed to Kate Early, Administrator, International Liaison Section, at scholarships@facs.org, or 633 N. Saint Clair St., Chicago, IL, 60611-3211.

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<td>#S30 Hand embroidered</td>
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V100 No 3 BULLETIN American College of Surgeons
SCHOLARSHIPS

Apply now for 2015 Claude H. Organ, Jr., MD, FACS, Traveling Fellowship

The American College of Surgeons (ACS) is now accepting applications for the 2015 Claude H. Organ, Jr., MD, FACS, Traveling Fellowship. This fellowship is supported through an endowment that the family and friends of the late Dr. Organ, a Past-President of the College, established with the ACS Foundation. The award is presented annually to an outstanding surgeon from the Society of Black Academic Surgeons, the Association of Women Surgeons, or the Surgical Section of the National Medical Association and serves as a lasting memorial to the extraordinary life and work of Dr. Organ. Applications for the 2015 award are due June 1, 2015.

The Organ Fellow is required to make travel arrangements to and from the selected meeting.

Basic requirements
The Organ Fellowship is available to a U.S. or Canadian member of the ACS in any of the surgical specialties who meets the following requirements:

- Is a member of the Society of Black Academic Surgeons, the Association of Women Surgeons, or the Surgical Section of the National Medical Association
- Is a Fellow or Associate Fellow of the ACS
- Is 45 years of age or younger on the date the application is filed

Applications must comprise the following items submitted as a PDF in this order:

- An essay of up to two pages describing why the applicant is interested in receiving the Organ Fellowship and his or her plans for using it
- The applicant’s current curriculum vitae
- One letter of nomination/recommendation from the applicant’s chair or mentor

Submissions should be labeled with the applicant’s last name, followed by their first initial. Send application materials to the attention of the ACS Scholarships Administrator at scholarships@facs.org. Questions may also be submitted to the Scholarships Administrator.

One awardee will be selected, and all applicants will be notified of the outcome of the selection process by July 31, 2015. Requirements for the Organ Traveling Fellowship are also posted at www.facs.org/member-services/scholarships/research. For information on donating to this fund, contact the ACS Foundation at 312-202-5376 or mwojcik@facs.org.
Calendar of events

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

**MARCH**
Alaska Chapter
March 14
Anchorage, AK
Contact: Danny Robinette, drrobinette@gmail.com

Peru Chapter
March 25–27
Lima, Peru
Contact: Jaime Herrera-Matta, juanjaimehpe@yahoo.com

**APRIL**
Japan Chapter
April 16
Nagoya, Japan
Contact: Katsuhiko Yanaga, kyanaga@jikei.ac.jp

Indiana Chapter
April 17–18
Indianapolis, IN
Contact: Carolyn Downing, cdowning@ismanet.org, www.infacs.org

ACS Leadership & Advocacy Summit
April 18–21
Washington, DC
Contact: Donna Tieberg, dtieberg@facs.org, www.facs.org/advocacy/participate/summit

Chile Chapter
April 19–22
Valparaiso, Chile
Contact: Celia Aldana, presidente@acschile.cl, www.acschile.cl

Egypt Chapter
April 29–May 2
Cairo, Egypt
Contact: Mohey Elbanna, moheyelbanna@yahoo.com, www.egyptacs.net

Innovation and Controversies: Montreal Colorectal Symposium
April 29–30
Centre Mont-Royal, Montreal, QC
Contact: Dr. Carol-Ann Vasilevsky, carol-ann.vasilevsky@mcgill.ca, www.montrealcolorectalsymposium.com

**MAY**
North Dakota Chapter & South Dakota Chapter
May 1–2
West Fargo, ND
Contact: Terry Marks, tmarks@sdmsa.org

Virginia Chapter
May 1–3
Richmond, VA
Contact: Susan McConnell, smcconnell@ramdocs.org, www.virginiaacs.org

West Virginia Chapter
May 7–9
Sulphur Springs, WV
Contact: Sharon Bartholomew, sbartholomew@hsc.wvu.edu

Ohio Chapter
May 8–9
Dayton, OH
Contact: Jennifer Starkey, ocacs@ohiofacs.org, www.ohiofacs.org

Michigan Chapter
May 13–15
East Lansing, MI
Contact: Angela Kemppainen, akemppainen@msms.org, www.michiganacs.org

Northern California Chapter
May 16
Monterey, CA
Contact: Christina McDevitt, nccacs@att.net, www.nccacs.org

Metropolitan Philadelphia Chapter
May 18
Philadelphia, PA
Contact: Maria Elias, melias@pamedsoc.org, www.metrophilasurgeons.org

**FUTURE CLINICAL CONGRESSES**

2015
October 4–8
Chicago, IL

2016
October 16–20
Washington, DC

2017
October 22–26
San Diego, CA