Surgeons help with recovery after earthquake in Nepal
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Letters to the Editor should be sent with the writer’s name, address, e-mail address, and daytime telephone number via e-mail to dsschneidman@facs.org, or via mail to Diane S. Schneidman, Editor-in-Chief, Bulletin, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611. Letters may be edited for length or clarity. Permission to publish letters is assumed unless the author indicates otherwise.
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Looking forward

by David B. Hoyt, MD, FACS

The “Looking forward” column in the April Bulletin focused on the importance of delivering coordinated, team-based perioperative care. That column delineated the actions that the American College of Surgeons (ACS) and other organizations are taking to improve the quality and safety of perioperative care. As previously noted, the perioperative phase of care begins with the decision to operate and intensifies 24 to 48 hours before an operation.

That column also indicated that the ACS and other stakeholders were in the process of developing recommendations on how best to ensure patients receive safe, high-quality surgical care. As an example, I noted that the American Society of Anesthesiologists (ASA) had been working to establish a perioperative surgical home.

Since then, the ASA and the College have been collaborating to develop mutually agreed-upon principles of team-based surgical care. In addition, a number of professional societies, including the Society of American Gastrointestinal and Endoscopic Surgeons (SAGES), American Surgical Association, and Central Surgical Association, have started to look more closely at the issue.

The ACS and ASA work toward consensus

At a meeting in August, several ACS Regents and leaders of the ASA joined forces to develop a joint “Statement on Team-Based Surgical Care,” which, at press time, was scheduled for review at the October ACS Board of Regents meeting. This statement articulates that perioperative care is focused on consistent, efficient, safe, high-quality, patient-centered medical care, with timely access and full recovery being the ultimate goal.

We further determined that optimal care is best provided by a coordinated, multidisciplinary team in which each health care professional recognizes and respects the expertise each specialty brings to the operating table. This type of care leads to better outcomes, lower costs, and greater patient satisfaction.

Several approaches to coordinated care involving a patient’s surgeon, anesthesiologist, primary care physician, medical specialist, hospitalist, nurses, and other health care professionals are in development. These models emphasize consistency, high reliability, and effective communication and handoffs.

The participants in these meetings agree that redesigned perioperative care models should be based on what best meets the needs of the individual patient, and of the institution and health care practitioners that are providing the care. Perioperative care also should apply the following principles:

- Patient involvement with shared decision making, patient education and engagement, and alignment of expectations, including risk-based informed consent
- Risk stratification, risk reduction, and optimization of patients prior to surgery, including medication reconciliation
- Standardized adherence to high-reliability and safety standards
- Evidence-based care to reduce variability and perioperative complications
- Effective coordination of care among all health care providers involved in the perioperative care of the patient

ACS activities

Optimal team-based care involves a range of health care providers, including physicians, nurses, technicians, and other health care professionals. The contributions of each group will vary by practice and local environment. With this knowledge in mind, each organization continues to develop programs and guidelines that will enable its members to deliver high-quality perioperative care.

Examples of what the College has accomplished in recent months to establish standards for the provision of perioperative care to specific patient populations include the launch of the four-year Coalition for Quality in Geriatric Surgery Project. The aim of this
Examples of what the College has accomplished in recent months to establish standards for the provision of perioperative care to specific patient populations include the launch of the four-year Coalition for Quality in Geriatric Surgery Project.

program, which is supported with funding from the John A. Hartford Foundation, is to improve care of older patients. This project has seven key deliverables: set the standards, engage key stakeholders, develop meaningful measures, establish a verification program, educate providers and patients, pilot the program, and launch the Geriatric Surgery Quality Campaign.

Leading this effort are Clifford Y. Ko, MD, MS, MSHS, FACS, Director of the ACS Division of Research and Optimal Patient Care; Ronnie Rosenthal, MD, FACS, professor of surgery, Yale School of Medicine, and surgeon-in-chief, [Veterans Affairs] Connecticut Healthcare System, West Haven; and Julia Berian, MD, an ACS Clinical Scholar in Residence and a surgery resident at the University of Chicago, IL. The core team also includes five experienced surgeons in elder patient care, a geriatrician, and a gerontology nurse.

The College also continues its involvement with Washington State’s Strong for Surgery initiative. This program uses evidence-based checklists that surgeons and other health care professionals can use in the perioperative setting to assist in patient screening, preparation, and education in an effort to improve clinical outcomes. This effort is currently being led by David R. Flum, MD, FACS, professor of surgery and director of the Surgical Outcomes Research Center, department of surgery, University of Washington Medical Center, Seattle, and medical director of the Surgical Care and Outcomes Assessment Program Comparative Effectiveness Research Translation Network, which created the Strong for Surgery programs.

At the other end of the patient spectrum, the Children’s Surgery Verification Program continues to develop, with a focus on improving care for pediatric patients. The ACS Task Force for Children’s Surgery developed the first draft of Optimal Resource Standards with support from the Society of Pediatric Anesthesia and the American Pediatric Surgical Association. The program is set to formally launch next spring.

The Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program’s Decreasing Readmissions through Opportunities Provided project got under way this spring. At press time, more than 120 centers were participating in this interventional effort to decrease 30-day postoperative readmissions.

Furthermore, the College continues to make progress in developing the quality manual for surgical quality officers to use in ensuring that the surgeons on their teams have the training, tools, and resources needed to safely and effectively provide surgical care. The manual will be published in 2016.

In addition, the College maintains strong ties with The Joint Commission. As ACS Past-President and current member of The Joint Commission’s Board of Commissioners Carlos A. Pellegrini, MD, FACS, FRCSI(Hon), FRCS(Hon), FRCSEd(Hon), notes on page 47 of this issue, The Joint Commission’s Targeted Solutions Toolkit seeks to safeguard patients from preventable harm, specifically wrong site surgery, through the use of standardized practices across the perioperative phase of care.

Ongoing collaboration

It is deeply satisfying to work with other representatives of the operating team to ensure that patients receive safe, high-quality care. This type of collaboration lays the groundwork for more coordinated and collaborative care in and out of the hospital setting. Together, we truly can develop a high-reliability health care system.

Dave

If you have comments or suggestions about this or other issues, please send them to Dr. Hoyt at lookingforward@facs.org.
#ILookLikeASurgeon goes viral: How it happened

by Kathryn A. Hughes, MD, FACS
It all started with a few characters—#ILookLikeASurgeon—a hashtag, in the parlance of social media.

Hashtags take an eponymous piece of punctuation, the pound sign, followed by a word, phrase, or a string of letters and enhance a Tweet by “labeling” the text so it can be used to pull together similarly tagged posts and organize them in a way that, ideally, stimulates an exchange with other users on Twitter. Sometimes a hashtag generates interest and conversations to such a degree that they go “viral,” which is what happened with the #ILookLikeASurgeon campaign.

#ILookLikeASurgeon has generated more than 128 million impressions, nearly 40,000 individual tweets, and more than 7,900 participants, and those numbers continue to grow.¹ The hashtag has attracted the attention of medical and surgical societies and organizations, universities and resident training programs, hospital systems, surgical associations such as the American College of Surgeons (ACS) and the Royal College of Surgeons, and media outlets from around the world.

A movement is born
The movement started with a couple of tweets and a blog post on the evening of August 5. Friends Sara Scarlet, MD, and Heather Logghe, MD, both surgical residents at the University of North Carolina at Chapel Hill, were texting each other and discussing #iLookLikeAnEngineer, a movement and Twitter campaign characterized by women engineers and other marginalized groups in engineering and technology who are posting pictures with the hashtag or comment #iLookLikeAnEngineer.

₁ The numbers are as of November 1, 2015.
As Dr. Logghe, a Resident Member of the ACS, recalls, Dr. Scarlet made the comment that it was unfortunate that surgery didn’t have a hashtag along the lines of #ILookLikeASurgeon. A few tweets ensued, and on August 7, Dr. Logghe generated a blog post titled “#ILookLikeASurgeon. Tweet it. Own it: Be the Role Model You Always Wanted But Never Had,” and from there, the message spread across the Internet.

Progress for women surgeons
The time is ripe for attention to the longstanding and multiple issues facing women in surgery. Issues related to gender, racial, and ethnic diversity in surgery have garnered increased recognition, attention, and study in recent years. Open and frank discussions, presentations, and lectures, as well as changes in policy and perspectives, have resulted in some tangible and welcome change. Notably, a new book about women in surgery was recently published, titled Being a Woman Surgeon: Sixty Women Share Their Stories (edited by Preeti R. John, MB, BS, MPH, FACS), followed by a July 2015 Bulletin column by ACS Executive Director David B. Hoyt, MD, FACS, that highlighted the accomplishments of women surgeons and the challenges this group continues to face.

Both the book and the column were well received; the book received positive reviews, and both engendered positive comments across social media. These two noteworthy publications are a step in the right direction, but more must be done to address diversity and gender issues, where progress often seems to move at a glacial pace.

Social media backlash
Another social media campaign that influenced the #ILookLikeASurgeon is the “This Is What We Look Like” campaign, launched in March by two childhood friends, Margo Vallee, MD, an anesthesiologist, and Jessica Gordon-Roth, PhD, an assistant professor of philosophy, to draw attention and support for women in professions and careers traditionally dominated by or associated with men. This campaign sold plain white tee-shirts emblazoned with the catchphrase customized to the profession, and women were encouraged to post pictures of themselves on social media wearing the shirt. Soon after “This is what a surgeon looks like” shirts became available with support and encouragement from the Association of Women Surgeons (AWS), images of women surgeons wearing these tees began popping up across the Internet. Cardiothoracic surgeon and blogger from Australia, Nikki Stamp, MB, BS, FRACS, received particular attention after posting her image, and was interviewed in the local media, including a post on the site Steel Heels.

What followed next was a string of negative events, which in turn sparked reactions that flamed across the Internet, grabbing media attention. The two incidents that drew the most attention, outrage, and ire, and which led to hashtag campaigns of their own, were #DistractinglySexy and #iLookLikeAnEngineer.

#DistractinglySexy was a hashtag and photo social media campaign that was created in response to comments by biochemist and Nobel Laureate Sir Richard Timothy “Tim” Hunt, FRS, FMedSci, regarding women in science and in the research laboratory, which he made to an audience at the World Conference of Science Journalists in South Korea. Though he later claimed his comments were meant as a joke, Mr. Hunt’s references to his “trouble with girls” in the lab engendered angry comments and rebuttals from both journalists and scientists, including Pulitzer Prize-winning science journalist Deborah Blum, which led to the creation of the #DistractinglySexy hashtag response. Social media platforms were flooded with images of women scientists, often in their lab attire and protective gear or with their instruments, accompanied by brief and frequently humorous comments and the hashtag #DistractinglySexy.

The other movement that sparked a similar reaction in the public and on social media was the #iLookLikeAnEngineer campaign highlighted earlier...
in this article, which inspired the #ILookLikeASurgeon initiative. Isis Anchalee (Wenger), a platform engineer, was featured on one in a series of recruitment posters for her company, OneLogin, and her image on the posters generated a wave of social media commentary that questioned the notion that Ms. Anchalee was or could be an engineer. Disturbed by this reaction, she responded by creating the #iLookLikeAnEngineer hashtag in her August 1 blog post, and women engineers began posting to social media with images of themselves featuring the #iLookLikeAnEngineer hashtag and caption. The hashtag went viral, generating an immediate response from press outlets and social media. The followers and users of #iLookLikeAnEngineer have now evolved into a bona fide organization to promote diversity in the engineering and technology fields.

#ILookLikeASurgeon
The #ILookLikeASurgeon campaign, which was able to capitalize on the momentum of the #iLookLikeAnEngineer, received an immediate response from the surgical community. Colorectal surgeon Alison McCoubrey, MB, BCh, BAO(Hon), MRCS, MSc, FRCS, from Northern Ireland, posted the first #ILookLikeASurgeon image and soon after more pictures started to appear on social media. The photos were initially posted by individuals in the U.S., Canada, the U.K., Ireland, and Australia, and, as the hashtag began to trend, bloggers joined in, expanding the conversation beyond the 140-character limit imposed by Twitter. Several days later, the Facebook page was launched by Kathryn A. Hughes, MD, FACS, author of this article. By then, the posts had begun appearing in foreign languages, and the movement became truly global, spanning both continents and cultures.

Unlike the #iLookLikeAnEngineer hashtag campaign, #ILookLikeASurgeon was not born of hurt and anger. It was not a backlash against a tone-deaf remark or negative comments or events. With a positive and affirming mission, this campaign underscores the fact that surgeons represent a diverse array of both women and men from a variety of cultures and backgrounds. In her original blog post, Dr. Logghe states, “I like the hashtag in the first person. As women surgeons, whether we are in our first year of training or an emeritus professor, it’s most important that we ourselves believe we ‘look’ like surgeons. Because we do.”

Both the intent of and response to this campaign have been generally positive. Early on, in a move that separates it from similar campaigns, #ILookLikeASurgeon welcomed the involvement of men with the goal of including surgeons from all backgrounds, regardless of gender identity, ethnicity, culture, or physical impairment. The campaign seeks to bring a community of surgeons together to communicate and collaborate to address stereotypes in surgery that affect both men and women, and which ultimately affect all surgeons. The positive tone of the message and the spirit of inclusion have helped #ILookLikeASurgeon achieve global recognition, extending to more than 75 countries and 20 languages. Posting continues around the world, showing surgeons at work and at home; in the operating room (OR) and on vacation; with colleagues, students, residents, and mentors; with friends, family, and children—including more than a few family photos containing multiple generations of surgeons. Many have shared the opinion expressed by Terri Coutee, a breast cancer survivor and patient advocate, who noted in her post to the Allies for Health blog, “Quite simply stated, this Twitter trend has humanized a profession that, at times, is held to a standard that is difficult for even the humblest of individuals to live up to.”

It did not take long for the surgical societies to take note of this activity. The AWS supported the message early on, followed by the Royal College of Surgeons in England, and the ACS. In fact, one of the first tweets from the College was from then-ACS President Andrew L. Warshaw, MD, FACS, FRCSEd(Hon), who tweeted, “We all look alike in the OR. It’s quality, not gender, that counts.”
Surgeons, social media, and hashtags
So, what does the #ILookLikeASurgeon campaign mean for surgery? What are the implications for surgeons? The popularity of the #ILookLikeASurgeon hashtag across Twitter and social media has had two important effects beyond the idea and message itself.

First, the initiative has demonstrated that it is possible to communicate quickly and nimbly with a large, diverse group of surgeons. The communication, particularly on social media, is bidirectional and egalitarian. This campaign has effectively communicated in a horizontal fashion, with messaging and content spanning across geography, culture, academic and private practice, and urban and rural environments. The #ILookLikeASurgeon message also has been communicated with a vertical reach spanning the entire career spectrum of surgeons. With transparency and inclusion as guiding principles, this campaign has been extended to many other participants and stakeholders in the modern medical world, including patients, hospitals and health care systems, companies and industries, and the media.

Second, the #ILookLikeASurgeon campaign demonstrates that the Internet is a potent tool for building and maintaining a community. Consider this analogy—the ACS was founded in 1913 by Franklin H. Martin, MD, FACS, to bring together surgeons “…dedicated to promoting the highest standards of surgical care through the education of, and advocacy for, its Fellows and their patients, and to safeguarding standards of care in an optimal and ethical practice environment.”11 The #ILookLikeASurgeon movement extends that vision into the modern era, because, at its core, the campaign is about inclusion and supporting a profession that provides the highest quality of care by a diverse group of surgeons. It seems then that it is central to the character of surgeons and the ACS to come together and form a community centered on a common goal, a common philosophy. As an organization, and as Fellows of the ACS, we are united in our dedication to the art and science of surgery, just like the surgeons whom Dr. Martin sought to bring together more than 100 years ago. At that time, it took Dr. Martin eight years to lay the groundwork to bring a community of surgeons together in the U.S. and Canada as the ACS. With Twitter and other social media, through the use of a single hashtag, we were able to form a global community of surgeons in less than eight days. Therein lies the power and importance of social media for individual surgeons and for the surgical profession.

Future of #ILookLikeASurgeon
The mission and intent of #ILookLikeASurgeon dovetails with the mission and principles of not just the ACS, but of other surgical and medical organizations and institutions. More specifically, #ILookLikeASurgeon...
“...aims to celebrate women and diversity in surgery and show that a surgeon, in fact, can look like anyone. It is about challenging stereotypes (not solely gender-related), celebrating differences, and achieving equality in the workplace. It seeks to shine a light on gender and diversity issues in surgery and medicine, and promote dialog and collaboration between surgeons, their institutions, and their organizations, ultimately to turn celebration into action.” (Drs. Hughes and Logghe, and Marissa Boeck, MD, MPH, telephone and Skype communication, August 20, 2015.)

What began as a tweet with a hashtag evolved into a movement spawning a community—one that is now ready to become more formalized. #ILookLikeASurgeon, as a group, has dual goals. One is to provide the structure within social media to maintain the community that has developed using multiple social media platforms, and to develop a stable Internet presence with a website. With this, the group seeks to create a space where conversation, collaboration, and mentoring can occur, providing support and encouragement as needed. By virtue of being Internet-based, the organization can support efforts within the global surgery community where issues and interests align.

The group also plans to enter the realm of advocacy, to tackle the issues that this initial burst of energy and engagement on social media has brought to light. The issues include diversity in surgery, the wage gap, leadership barriers, work/life integration, burnout, surgical and workplace culture, and surgical stereotypes. These are issues that affect all surgeons, and acknowledging and addressing them, taking action and crafting solutions, will improve the lives of all surgeons and their patients.

**Conclusion**

As the #ILookLikeASurgeon campaign has demonstrated, social media, particularly Twitter, is a powerful tool for physicians and surgeons. These platforms provide unprecedented access and communication, transparency, and the ability to...
widely disseminate data and ideas. We have generally conceived of social media as a public-facing platform for interaction with patients and the public. This public face of social media is important, but physicians and surgeons increasingly use this form of communication to engage in discussion with each other in order to exchange information and foster collaboration. Social media is breaking down barriers and silos that exist between the various specialty, geographic, and practice settings.

Though it would be in vogue to claim that Twitter and other forms of social media will disrupt health care—and admittedly these tools are not without their challenges and risks—it is probably more accurate to claim that social media will have a transformative effect on the structure and practice of medicine and surgery. The potential is largely untapped; we have barely scratched the surface of what we might accomplish. The lasting impact of the #ILookLikeASurgeon campaign and the movement it created will likely extend beyond the mission and goals of promoting women and diversity in surgery. By pulling surgeons into social media, the impact may really lie in the transformation of surgery and medicine.

Acknowledgement
I would like to thank Dr. Heather Logghe for the conversations we had regarding this article, for her help reviewing the timeline of events, and for her general support in writing this feature.
Each year, the Advocacy and Issues Committee of the Resident and Associate Society of the American College of Surgeons (RAS-ACS) hosts a symposium at the Clinical Congress that features a debate on timely and controversial issues relevant to surgical training and practice. Based on input from RAS members across the nation, this year’s topic was Social Media—Threat to Professionalism and Privacy or Essential for Current Surgical Practice?

The ubiquity and importance of social media in our daily lives make it impossible to ignore these online tools and their applications in medical practice. Physicians in all practice settings may benefit from unprecedented opportunities to network with colleagues, engage patients, and participate in professional discussions and journal clubs. However, social media can also blur the boundaries between private and professional life, posing serious privacy challenges and even legal threats.

Resident members of the RAS-ACS participated in this discussion by submitting essays about the challenges and opportunities associated with social media use, and the winners of the essay competition were given the opportunity to participate in a live debate at the Clinical Congress 2015 in Chicago, IL. Following are the winning essays on this topic.

♦ Social media:

Threat to professionalism and privacy or essential for current surgical practice?

by Stefan W. Leichtle, MD
In 1440, a blacksmith in the community of Mainz, Germany, developed a revolutionary device: a movable type printing press with just 26 characters. From its inception, the printing press stood to revolutionize the dissemination of knowledge and information throughout the world. However, the printing press faced significant opposition. In many parts of Europe, a broad segment of the clergy believed the printing press would promote laziness among the monks, whose services of transcribing ancient texts would be rendered obsolete by the apparatus. As a consequence, the printing press was outlawed in the Ottoman Empire until 1729. In hindsight, these concerns seem heedless, resulting from uncertainty and myopia as opposed to forward thinking and reason. A similar negative reaction is sometimes seen today with regard to the professional use of social media in surgery. This article discusses how social media, when used appropriately, is an essential tool for the academic surgeon.

A modern, academic surgical practice encompasses three major domains: delivery of care, research, and the education of patients and colleagues alike. Social media platforms such as Facebook and Twitter, with a collective audience exceeding 1 billion users, can maximize a physician’s impact in all three areas of academic surgery. The social media audience has a broad reach, spanning all socioeconomic and demographic profiles, including Americans 65 years of age and older. Research has revealed that 41 percent of social media users would allow information featured on these platforms to affect their choice of health care provider, and 90 percent of those in the 18- to 24-year-old age group state they trust health care information...
The dissemination of current research findings is a cornerstone of academic surgery, and social media’s capacity to stimulate and deliver such information surpasses the capacity of any traditional print media to do the same.

distributed by social media networks. Notably, the broad reach and accessibility of social media is one of the reasons many leaders in academic medicine use this tool to communicate with the public and with colleagues. For example, leaders in health care, such as the Mayo Clinic, Rochester, MN, have committed to the use of social media to engage and educate patients. Similarly, training programs around the world have used social media to increase knowledge sharing and decrease the professional isolation of rural practitioners and trainees.

The medical academic community also has started to recognize the power of social media, not only to disseminate new research, but also to resurrect old publications once lost to bookshelves and archives. In addition, recognizing the influence of social media, the research analytic tool Altmetric now formally incorporates an article’s dissemination on social media into its assessment of the article’s research impact. Finally, when financial intake of the Amyotrophic Lateral Sclerosis (ALS) Association failed to meet even half of the organization’s annual needs for research, education, and community service in 2013, patients and family members used social media to raise more than $100 million dollars for research and advocacy for the disease in just a few months. The dissemination of current research findings is a cornerstone of academic surgery, and social media’s capacity to stimulate and deliver such information surpasses the capacity of any traditional print media to do the same.

Still, critics of social media in the workplace find it difficult to overlook the threats to professionalism and privacy inherent to these platforms. Common questions include the following: How should physicians address “friend requests” from patients? Should attending surgeons be Facebook “friends” with their residents? How can potentially damaging social media content be regulated?

Such concerns were elucidated in a 2014 study in the Journal of Surgical Education, which summarized the dangers of social media. In this study (n=996), 12 percent of surgical residents posted “unprofessional” content on their personal Facebook profiles, and an additional 14 percent had “potentially unprofessional” content visible. Notably, most of the surgical residents surveyed (74 percent) refrained from posting “unprofessional” content on their Facebook profiles. This study highlights not just the unprofessional decisions of a minority of residents but, more importantly, an opportunity for improved resident education on this topic. Without such education, can we fault the implicated residents of this study? As in other aspects of medical practice, social media misuse can be avoided with dedicated education and feedback. Ethical concerns similar to those regarding social media use abound in medicine and surgery, but we do not allow them to impede our social and academic progress as a community. Akin to ethics rules that provide clear guidelines on the do’s and don’ts of personal and financial relationships with patients, professional societies and hospitals can establish sensible best practice guidelines to educate providers on appropriate use of social media and ways to avoid its pitfalls.

There is no universal approach to these guidelines, although it is recommended that hospitals and professional societies create standards that are specific to the needs of their communities. Residents, ancillary staff, and attendings alike should take part in developing these guidelines to ensure that all parties are represented and that the inherent power dynamic associated with professional hierarchy is leveled. Without such regulation, residents, medical students, and even junior faculty who are accustomed to acquiescing to their superiors’ requests in the professional setting may feel compelled to share elements of their professional lives with the public.
personal lives that would otherwise be kept separate from a colleague’s eye.

Social media use comes with a level of intrinsic risk, but those hazards should not stop surgeons from progressing in a judicious and deliberate manner with this form of communication. In the 1840s, when clergymen claimed that anesthesia for a woman in labor was a direct affront to the Lord’s plan, medical professionals continued to use ether to provide painless surgery. Anesthesia’s obvious benefits outweighed the voices of its staunch opponents. Although social media may not be as overtly beneficial as ether or the printing press, the social media revolution is progressing at a rapid pace, and surgeons can choose to spend their energy resisting it or improving it.

More than 80 percent of teenagers online use at least one social media platform, and these adolescents will soon be our trainees and colleagues. Discouraging social media use from surgical practice will only deepen the stereotypical chasm that often exists between the surgeon and the patient. Social media provides one means of narrowing that gap, not just by posting content, but also by providing the means to listen, such that a better understanding of where our patients find their motivation and information—regardless of its veracity—may be gained. Social media is an essential, multifaceted tool to the academic surgeon who serves to learn from and to educate patients and colleagues alike.

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Social media is possible, in part, because the Telecommunications Act of 1996 protects website operators from legal responsibility for user-generated content. The user may face civil liability for defamatory or illegal content. This situation puts users at risk because social media collapses a wide range of audiences from varying communities, backgrounds, and interests into a single context. The audience intended or imagined by the user may be discreet in theory, but it is not necessarily bound by discretion in practice. Techniques employed in face-to-face conversation—when talking to a patient, for example—are not easily applied to social media because the user is unable to determine identifying characteristics of the audience or the specific context of communication for the audience. In effect, the era of social media has created a platform where patient, colleague, relative—in fact,
In effect, the era of social media has created a platform where patient, colleague, relative—in fact, the entire world—all become part of the same unlimited audience.

Furthermore, communications with this audience are indelible and irrevocable. This new reality must give pause to the prudent surgeon. While social media creates new opportunities, these platforms also threaten patient privacy and challenge the professionalism of surgeons.

A question of privacy
Surgeons are ethically and legally obligated to protect the privacy of their patients. Most physicians in the U.S. swear an oath, typically the Hippocratic Oath, upon graduation from medical school. Nearly all versions of these medical oaths recognize the importance of patient privacy; for example, the wording of one modern version states, “I will respect the privacy of my patients, for their problems are not disclosed to me that the world may know.” In contradistinction, the Twitter Privacy Policy reminds users, “What you say on Twitter may be viewed all around the world instantly.”

Social media has created several tempting platforms for surgeons to share their experiences, but sharing any information about the clinical care of patients may violate patient privacy and the Health Insurance Portability and Accountability Act (HIPAA). While blatant confidentiality breaches seem easy to avoid, they have occurred. Last year, a number of hospital executives in China were fired after a “surgery selfie” photo was shared on social media showing a group of surgeons posing around an unconscious patient during an operation. Fortunately, these overt violations are infrequent, but they do serve as a warning to others that severe disciplinary action and loss of employment may result from inappropriate use of social media.

Less obvious and more insidious violations of patient privacy are more commonplace. A multi-institution study of Facebook use among surgical residents at 57 residency programs revealed that 12.2 percent of users with public profiles had posted unprofessional content, including items that were in violation of HIPAA. A study at a single institution found that 14 percent of surgical residents and faculty had content publicly available on Facebook that referenced specific instances of patient care. Surgeons and trainees must remember that, even when patient names or identifiers are excluded from social media sharing, it is still possible to identify patients with minimal information. To meet the legal and ethical requirements of maintaining patient privacy, it is important to avoid specific references to patient care when using social media.

Protecting the profession’s integrity
Professionalism is the foundation of the surgeon’s relationship with patients and society. Surgeons must remember that their presence on social media reflects not only upon themselves as individuals, but also upon the entire surgical profession. The multi-institution study previously mentioned also revealed that surgical residents commonly have unprofessional content on their publicly accessible Facebook pages, including references to binge alcohol use and sexually explicit content. Another study found that 3 percent of tweets by self-identified physicians on Twitter were unprofessional, and surgeons comprised the largest subset of physicians in this study when identified by specialty. Although privacy settings are available for users to limit who may view their activity on social media, users sometimes neglect to turn on these settings or misunderstand how to use them.
However, the point of social media is to share, rather than withhold, information. One way to avoid sharing unprofessional content on social media is to avoid sharing personal content altogether.

**Accepting personal responsibility**

Khayyám’s poem, quoted at the beginning of this article, described the downfall of the Babylonian kingdom, as foretold by a disembodied hand that wrote a message on a wall. Derived from this story is the idiom often used to portend doom: “the writing on the wall.” Social media is not all doom and demise, of course, but it becomes the responsibility of the surgeon to harness this opportunity in a professional and thoughtful manner. The threats to patient privacy and professionalism require constant vigilance from surgeons. The savvy surgeon would do well to remember, as stated in Twitter’s Privacy Policy, “You are what you tweet.” Likewise, you are the writing on your Facebook wall. Although the writing may not lead to imminent demise, it is indelible, and the potential consequences are real and enduring.

**REFERENCES**

Surgeons help with recovery after earthquake in Nepal

by Micah Katz, MD; Katie Russell, MD; Dean Cardinale; Thomas White, MD, FACS; Patrick Reddish; and Courtney Scaife, MD, FACS
After the Nepal earthquake on April 25, the authors decided to join our friends in the area and lend a hand in the recovery effort. Our group included four surgeons/surgical residents from Intermountain Medical Center, Murray, UT, and the University of Utah, Salt Lake City. The physicians were joined by Dean Cardinale, founder and president of Human Outreach Project, a not-for-profit humanitarian organization, and World Wide Trekking, its sister organization, both based in Salt Lake City. This collaboration gave us the ability to be self-sufficient in terms of shelter, food, and water, as the availability of these resources in Kathmandu, Nepal’s capital, was likely to be very limited. Furthermore, the Nepalese staff members of these two organizations provided guidance and local perspective, which proved to be invaluable to our mission.

The American College of Surgeons (ACS) also supplied our team with a letter verifying that we were traveling in an official capacity under the ACS Operation Giving Back program. The College’s support was especially helpful during the registration process with the U.S. Department of State, the World Health Organization (WHO), and the International Medical Corps, allowing us to avoid any unexpected problems as we entered Nepal.

Kathmandu

Upon our arrival in Kathmandu, we registered with the WHO and the Nepalese Ministry of Health, and then departed for Manmohan Memorial Community Hospital. Ram Shrestha, MD, chief of surgery at Manmohan Memorial Teaching Hospital, greeted us at the 100-bed community hospital, which provides medical, surgical, and diagnostic services, mostly to indigent patients. We learned that all urgent trauma victims had been well managed by the hospital staff, but these health care professionals and their supplies were near exhaustion. We participated in daily rounds at three times their normal capacity, exchanging ideas and observing the excellent care provided to patients. On rounds, our team witnessed the devastation of the earthquake and heard the heart-wrenching stories of the patients.

We met scared but stoic B.K., a five-year-old boy who suffered a traumatic amputation of his left lower leg after his home had been destroyed. Fortunately,
the rest of his family was spared, and B.K. was receiving treatment for his injuries. We assisted the local physicians in debriding and cleaning his wounds in the operating room while working with nursing staff to optimize his wound care. Another patient, S.R., is a 75-year-old woman who sustained a superficial wound to her right hand in the collapse of the building that killed her husband of 55 years. Although her wounds appeared healthy and did not require our care, we were able to sit with her, hand-in-hand, listen to her story, and offer comfort.

We also had the privilege of introducing rib plating to Nepalese health care professionals. This operation was performed on S.N. and K.T., 35 and 59 years old, respectively, who were both trapped under rubble after the earthquake. They presented to the hospital with respiratory distress. Four days after the earthquake, they remained on oxygen and exhibited the need to exert significant effort to breathe, abnormal breathing mechanics due to flail segments, and considerable discomfort and pain. With donated instruments, our team assisted the local physicians and taught them how to perform rib plating for these two patients. The
cases went smoothly, and the surgeons had little difficulty learning these techniques. Both patients responded well, and the improvement in breathing mechanics for S.N. was particularly impressive. We are especially proud of this “first ascent”—a mountain climbing term referring to the first time a group or an individual has successfully completed a route—and the surgeons at Manmohan Hospital have since performed rib plating in other trauma patients with much success.

Dunche and Khumbu Valley

Our team was then dispatched to a village two hours from Kathmandu, near Navapati. We met with local military officials who reported minor injuries that they were able to manage on their own.

Our next assignment from the Ministry of Health was in Dunche, a central hub for the heavily damaged Langtang Valley. While planning our departure for this region, we encountered U.S. Special Forces who had been working in the area. They suggested that there was likely little need for medical care in the Langtang Valley, as most patients had either died, been evacuated, or had suffered only minor injuries. After chartering a helicopter, we found their assessment had, indeed, been accurate.

In Dunche, we met a well-staffed Canadian Red Cross team who were seeing only one to two patients...
per day. After returning to Kathmandu, we were told there might be need in Pokhara. Dr. Shrestha contacted the Director of Health of the district along with his colleagues at hospitals in that area. Similar to the situation in the Langtang Valley, many deaths but few injuries were reported, with no urgent need for our medical skills.

**Ongoing recovery**

A recurring theme during our time in Nepal was a lack of reliable information regarding where medical help was needed, which might be common to natural disasters in developing countries. The insights of the local team of the Human Outreach Project were invaluable, but we still made several trips where we found fewer injured patients than reported. Ultimately, we were relieved that people were not as badly injured as we had anticipated and that the local hospitals and other aid groups were able to care for the earthquake victims. The patients and providers we met along the way were extraordinarily resilient, and we admired how they had managed the crisis and had started to rebuild their lives after the earthquake.

Although the acute need was less than we expected, our trip helped in the assessment for the ongoing recovery in Nepal. While in the Khumbu, the surgeons on this trip visited the Namche Dental Clinic, which had been supported by the Human Outreach Project in the past. We toured their previous facility, which was in ruins, while Mr. Cardinale collaborated with the staff regarding their needs for rebuilding. Recognizing the public health concern regarding communicable disease with the upcoming monsoon season, the Human Outreach Project purchased and delivered hundreds of toilet tents to the areas we visited.

We are thankful to the organizations that supported our trip and provided thousands of dollars of medical supplies, including the Huntsman Cancer Institute, Mountain Star Medical, Direct Relief, and Mammoth Medical Missions. Throughout our travels we donated duffel bags of medications and bandages, along with sterile supplies to replenish the stores of inundated clinics we encountered. We are very thankful for Mr. Cardinale and the support team from the Human Outreach Project for managing our trip. We also thank Operation Giving Back for supporting our effort and for its continued interest in Nepal’s recovery.
The surgical community breathed a collective sigh of relief earlier this year when Congress passed the Medicare Access and CHIP (Children’s Health Insurance Program) Reauthorization Act (MACRA), which, among other provisions, repealed the sustainable growth rate (SGR) formula used to calculate Medicare physician payment. Because Congress no longer needs to pass annual SGR patches to prevent drastic cuts to physicians who provide care to Medicare patients, lawmakers are now free to revisit other priorities that have been on the back burner for years. In addition, various provisions in the Affordable Care Act (ACA), which was recently upheld as constitutional by the U.S. Supreme Court, continue to be implemented; as a result, health care changes are increasingly being debated. The American College of Surgeons (ACS) is monitoring legislative, judicial, and regulatory developments that continue to affect the ability of surgeons to deliver high-quality health care.

The ACS Division of Advocacy and Health Policy (DAHP) is working diligently not only to keep pace with proposed changes, but to meaningfully influence policy pertaining to surgery and surgical patients whenever possible. This article examines a few of the many federal policy areas that the ACS DAHP is tracking.

Implementation of the ACA
The U.S. Supreme Court’s June 25 King v. Burwell decision, which upholds tax credits for individuals who purchase health insurance through federally administered exchanges, was a victory for the Obama Administration and the future of the ACA. Although many candidates for office will continue to call for repeal of the legislation

HIGHLIGHTS
• Describes how ongoing implementation of the ACA is shaping the health policy agenda
• Outlines payment reforms in MACRA and how they will affect reimbursement
• Discusses proposed GME reforms
• Looks ahead to possible changes in hospital payments
• Examines the effects of EHR on surgical practice
• Suggests ways for surgeons to be involved in the legislative process
The College is vigilant in monitoring the potential impact of the mergers of large health insurance companies on surgeons.

in their political campaigns, the likelihood of the law being overturned grows smaller by the day. Nonetheless, it is possible that certain aspects of the legislation will be altered. Potential changes include increasing the number of workers who must be covered under employer-based group health insurance plans to 100 from 50; allowing consumers to use agents and brokers to purchase their insurance rather than navigate an exchange on their own; and repealing the medical device tax through passage of H.R. 160, which passed on June 18 in the House of Representatives and was awaiting Senate action at press time.

Insurance mergers and narrow networks
The College is vigilant in monitoring the potential impact of the mergers of large health insurance companies on surgeons. Studies have shown a decline in competition among health insurers, and the Aetna-Humana and Anthem-Cigna mergers proposed at press time would only exacerbate this issue. Little evidence exists to show that mergers will lower health insurance premiums or otherwise benefit consumers. Furthermore, when health care professionals and hospitals are left with fewer yet larger insurance companies, their leverage decreases and it becomes more difficult to negotiate fair reimbursement rates. The ACS is exploring the best way to address these concerns.

The narrowing of insurance networks and the tiering of health care providers based on the cost and quality of care they deliver is another specific concern among ACS Fellows. The College continues to analyze how these practices may affect access to care. One emerging problem stemming from the narrowing of insurance networks in state-run exchanges authorized in the ACA is the increased use of out-of-network providers. For example, legislation has been introduced to address out-of-network coverage in New Jersey. The New Jersey bill, S.B. 20, similar to a New York law enacted in 2014, would limit the amount of money out-of-network physician providers can charge patients. The College is actively monitoring this legislation.

The future of Medicare physician payment
Achieving passage of MACRA and repealing the SGR was an important victory for the College and for all Medicare physicians; however, passage of MACRA was only the first step in a long process of reforming Medicare physician payments. Aside from repealing the SGR, the new law will combine and streamline existing Centers for Medicare & Medicaid Services (CMS) quality programs into a new Merit-based Incentive Payment System (MIPS), which will determine the annual physician payment adjustments for fee-for-service Medicare beginning in 2019.

MACRA also encourages development and participation in alternative payment models (APMs) that tie payment to quality measures, use certified electronic health record (EHR) technology, and include an element of financial risk with the potential for monetary loss. A 5 percent lump-sum incentive payment is available for the first six years of participation to offset the risk and initial cost associated with transitioning to such a system. For more information on MACRA, see the July 2015 issue of the Bulletin.

The ACS already has begun work to ensure that the MIPS established in MACRA works for surgeons and that as many Fellows as possible have opportunities to participate in APMs. The ACS will advocate on the behalf of Fellows to ensure the final rules regulating this program are clear and fair. DAHP staff is currently participating in working groups and CMS listening sessions to help implement the new law and smooth the transition. The College also is working with outside entities to develop APMs for surgeons. For more information on APMs, see the June 2013 Bulletin.

Data collection requirements for global payment codes
In November 2014, CMS finalized a policy that would have transitioned all 10- and 90-day global codes to 0-day global codes. Independent analysis showed that this policy would have resulted in a cut in reimbursement to surgeons for most procedures. The passage
of MACRA prevented CMS from implementing this policy, due to the College’s successful advocacy efforts. Instead of eliminating 10- and 90-day codes, CMS will instead collect data on the number and levels of visits provided in the global period and use these data to improve the accuracy of the valuation of surgical services. The DAHP staff will offer its expertise to CMS as the agency develops the methodology for collecting this information. For more information on global payments, see the September 2015 Bulletin.

Rural surgery
Surgeons working in critical access hospitals (CAH) have recently started to encounter new barriers to caring for their patients, and in some cases have been forced to send patients to other hospitals far from their homes to receive care. CAHs must comply with certain conditions to receive Medicare Part A reimbursement. One condition of payment requires a physician to certify that a patient who is being admitted can be expected to be discharged or transferred from a CAH within 96 hours. Although the 96-hour rule has been in place since 1997, it was unenforced. CMS indicated in 2013, however, that it would start enforcing the rule. The ACS maintains that rural patients should be allowed to seek care in a familiar setting close to where they live. If this care can be provided safely and appropriately in a CAH, then patients, in consultation with their physicians, should be able to receive care at this type of facility. Rep. Adrian Smith (R-NE) and Sen. Pat Roberts (R-KS) have introduced the Critical Access Hospital Relief Act, H.R. 169/S. 258, which would remove the problematic 96-hour rule requirement. The College continues to meet with members of Congress to encourage legislators to cosponsor this important legislation.

The ACA authorizes a Medicare incentive payment program for major surgical procedures provided by general surgeons in health professional shortage areas (HPSAs). This initiative—called the HPSA Surgical Incentive Payment program or general surgery bonus program—is designed to increase access to surgical care in shortage areas. A 10 percent bonus is given for major operations (defined as 10-day and 90-day global procedures) provided by a surgeon who participates in Medicare with a primary specialty code of 02 (general surgeon). The operation must take place in either a primary care or mental health HPSA. Surgeons began receiving this incentive payment after January 1, 2011, but it is set to expire at the end of this year. The ACS is undertaking efforts to introduce legislation that would extend the HPSA incentive payment program.

Possible changes to hospital payments
The U.S. House Committee on Ways and Means is working on a series of hospital payment reforms that will be combined into one bill. Several of these reforms are priorities of the members of the committee. One focus is on the distribution of payments of disproportionate share hospitals (DSH). DSH allocations currently are a percentage add-on to the basic diagnostic-related group payments. The amount is based on a complex formula dependent upon the number of Medicare and Medicaid inpatients. The Strengthening DSH and Medicare Through Subsidy Recapture and Payment Reform Act of 2015, H.R. 3288, would change DSH payments from the add-on system to that of an annual $3.3 billion lump sum beginning in fiscal year (FY) 2017. DSH hospitals located in states that have not expanded Medicaid would receive money from an additional new $1 billion pool, funded annually. The authors of the bill propose the additional funds for those hospitals to level the playing field.

The Medicare Crosswalk Hospital Code Development Act of 2015, H.R. 3291, would create a new version of the Medicare Severity Diagnosis Related Groups (MS-DRGs). The new version would end reliance on the International Classification of Diseases codes, and an alternative set of codes, called the Healthcare Common Procedure Coding System (HCPCS), would be used to create the new MS-DRGs. These codes would apply to at least 10 operations that the Secretary of the U.S. Department of Health and Human Services (HHS) determines to be comparable between the inpatient
Several issues require resolution before patients and surgeons will feel the beneficial effects of digital clinical information and meaningful use of digital information becomes a reality.

and outpatient settings. The transition must be completed by January 1, 2018.

Finally, changes to indirect medical education (IME) payments are being proposed. The Medicare IME Pool Act of 2015, H.R. 3292, instructs the HHS Secretary to reimburse IME funds to teaching hospitals in a lump sum, rather than the current add-on payment they receive per inpatient discharge. This change would occur for cost-reporting periods ending during or after FY 2019 and would be paid out to teaching hospitals in the same timeframe—approximately every two weeks—as the direct graduate medical education (GME) payments. The bill would also require the Secretary to create a new IME pool, initially funded at $9.5 billion for FY 2019. The Secretary would be required to maintain the formula used today to derive IME payments.

The College is pleased that lawmakers are paying closer attention to this issue but asserts that major reforms to the way GME is funded and administered are long overdue. Changes must ensure that the physician workforce is capable of meeting the needs of our nation’s aging population. In broadest terms, the College believes solutions must be flexible, patient-centric, and, most importantly, evidence-based. To encourage the development of these types of solutions, the College has crafted a set of principles for GME reform and is actively examining options for comprehensive reform proposals. Loosely, the principles call for any reforms to move toward a more data-driven and accountable governance system, while maintaining federal support and recognizing the unique training needs of surgeons to attain the requisite technical skills.

The ACS will continue to monitor the movement of these bills and other hospital-related legislation as they move through the legislative process.

Health information technology (HIT)

Many surgeons and other physicians anticipated that EHRs would improve the flow of clinical information within their daily practices and support direct data feeds to clinical registries, thereby providing the dual benefits of better informing patients while reducing administrative burdens. However, early EHR systems have largely failed to leverage clinical information in the manner that surgeons anticipated. Surgeons’ EHR systems are difficult to use to collect, analyze, and return useful information, either at the point of care or in subsequent monthly or quarterly reviews of clinical practice.

Several issues require resolution before patients and surgeons will feel the beneficial effects of digital clinical information and meaningful use of digital information becomes a reality. Due to limited information exchange, a lack of data standards and interoperability, and virtually no real-time clinical analytics, time spent entering data into EHRs may seem like a poor use of resources. The College has worked to improve surgeons’ experiences with EHRs by providing tools to help them choose the right EHR product, offering guidance to enable a better understanding of CMS’ EHR incentive program, and empowering users to meet meaningful use requirements. In order to make improvements, we must ensure that the pertinent digital information resides in EHRs, is readily available without overly cluttered reports, and communicates the right information from these primary data sources in a way that is meaningful for surgeons and other providers.

Lawmakers have heard from constituent providers regarding the difficulties surrounding HIT. In response, congressional committee meetings have convened and comprehensive legislation has been introduced. For example, the Senate Committee on Health, Education, Labor, and Pensions has held a series of meetings regarding current impediments to successful implementation of HIT. The College submitted testimony on July 23 detailing its concerns. The testimony also described the utility of big data analytics, which makes information available to a cloud platform for real-time use in delivering better care.

The ACS has joined with other surgical societies to circulate a letter of support for H.R. 3309, the Flex-IT 2 Act, which would delay the EHR incentive program’s Meaningful Use Stage 3 rulemaking until at least 2017,
when MIPS final rules have been developed, or until at least 75 percent of physicians and hospitals are successfully meeting Stage 2 requirements. The legislation also encourages interoperability and simplifies reporting requirements for Medicare quality programs.

**Cancer resolution**

At press time, Reps. Lynn Jenkins (R-KS) and Richard Neal (D-MA) were expected to introduce a resolution recognizing the importance of voluntary accreditation by the Commission on Cancer (CoC) in ensuring access to high-quality cancer care. CoC accreditation demonstrates a cancer program’s commitment to providing comprehensive care to patients and their families. It also is useful in cancer centers’ efforts to continuously evaluate performance and make improvements where necessary. Accreditation encompasses a variety of factors and ensures that patients have access to tools and services, ranging from early distress screening to survivorship care plans. At present, the CoC accredits approximately 1,500 cancer programs across the U.S., which treat more than 70 percent of newly diagnosed cancer patients each year. The ACS will be working with the CoC to conduct a grassroots push for co-sponsorship of the resolution, as well as focus on efforts to get the legislation enacted.

**Fellows’ involvement is crucial**

Although Congress has addressed some critical health care issues during the last year, Fellows must not become complacent. The issues outlined in this article represent those receiving the most attention on Capitol Hill. However, the College is advocating on other issues as well, including pricing transparency, trauma initiatives, medical liability reform, workforce initiatives, adequate funding for research, 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. ♦

**REFERENCES**


The American College of Surgeons (ACS) Chapter Lobby Day Grant Program provides ACS chapters with support—up to $5,000 in grants for participating chapters—to engage members in grassroots advocacy initiatives. Participation has been wide-ranging, with more than 20 chapters hosting a state lobby day since the program’s inception in 2010. Lobby day events help raise the profile of ACS chapters at the state level and present an opportunity to educate lawmakers about surgeons’ legislative priorities.

Issues discussed at lobby days in 2015 include trauma funding, scope of practice, coverage for bariatric surgery, Medicaid reimbursement, and determining the legislative definition of surgery. At each of these state-house visits, ACS Fellows were able to build relationships with legislators, staff, and key health care policy decision makers. Although the advocacy approaches may vary from state to state, the end result is always the same—increased opportunities to effect change in the laws and regulations that impact surgeons and their patients at the state level. Following is a roundup of the activity at this year’s chapter lobby days.

Alabama
The Alabama Chapter of the ACS joined the Medical Association of the State of Alabama for a Day at the Legislature on April 8. The event began with a presentation on the basics of physician advocacy, followed by a discussion of grassroots lobbying opportunities. Alabama Sens. Tim Melson, MD (R), and Larry Stutts, MD (R), led a session on effective physician lobbying and provided insights into the Alabama legislature. Donald Williamson, MD, former State Health Officer, Alabama Department of Public Health, gave the keynote address on legislative budget proposals for the Alabama Medicaid program. Dr. Williamson described how proposed
cuts would affect the long-term viability of the state’s Medicaid program.

Participants then went to the capitol for meetings with their legislators and committee leadership to discuss the proposed budget cuts and how they would affect the ability of surgeons and hospitals to provide trauma care services. The day concluded with a legislative reception that provided attendees an opportunity to network with other physicians and lawmakers.

California
The three ACS chapters in California collaborated on their 2015 lobby day in conjunction with the California Medical Association’s annual legislative advocacy day on April 14. Surgeons made the trek to Sacramento, CA, to advocate on a number of issues, including increasing MediCal physician payment rates to 100 percent of Medicare rates (S.B. 243); removing some exemptions from California’s vaccination law (S.B. 277); and requiring payment for telephone/electronic patient management telehealth services (S.B. 289). Gov. Jerry Brown (D) made an unscheduled appearance at the morning issue briefing and spoke with meeting participants. Following the briefings, physicians went to the capitol for legislative visits and attended committee hearings, including one with heated testimony on the vaccine legislation. That legislation eventually passed and was signed into law by the governor.

Connecticut
The Connecticut Chapter of the ACS and the Connecticut State Medical Society (CSMS) cosponsored a lobby day in Hartford on March 11. Several Fellows participated, advocating on bills to establish a legislative definition of surgery, increase coverage for bariatric surgery, and address truth in advertising. The day opened with remarks from ACS and CSMS leadership and continued with a conversation between session attendees and State Comptroller Kevin Lembo. After the presentations, members were briefed on pending legislation and attended individual meetings with state legislators, including Senate Majority Leader Bob Duff (D).

Florida
The Florida Chapter of the ACS held its annual legislative days March 24–25. The event kicked off with a dinner and presentations from Florida Surgeon General John H. Armstrong, MD, FACS; Florida Medical Association President Alan Pillersdorf, MD, FACS; former State Rep. Jerry Paul (R); and Tara Leystra Ackerman, State Affairs Associate in the ACS Division of Advocacy and Health Policy, Washington, DC. Dr. Armstrong provided a legislative update from the perspective of the state administration; Dr. Pillersdorf gave an update on key pieces of legislation in the Florida legislature; and Mr. Paul presented on how to be a successful physician advocate, along with his perspectives on life as a political candidate and elected official.

The chapter hosted a breakfast reception the next day where legislators were able to interact more informally with Fellows to discuss current legislation. Fellows then attended a public hearing of the House Committee on Health, where they testified against a scope-of-practice bill (H.B. 547) that would have granted independent practice to advanced practice registered nurses and physician assistants. The bill did not pass.

Georgia
The Georgia Society of the American College of Surgeons (GSACS) partnered with the Medical Association of Georgia and 11 medical specialty societies for Capitol Day. Joining forces resulted in strengthened advocacy
efforts by the Georgia house of medicine. Surgeons were able to reinforce current relationships with legislators and forge new ones at the capitol and later during more intimate gatherings organized by region. Top legislative priorities were discussed, including continued support for the statewide trauma network, Medicaid funding and reimbursement issues, the introduction of the Uniform Emergency Volunteer Health Practitioners Act, and the rural hospital health care access crisis. A highlight of the event was Gov. Nathan Deal (R) having his photo taken with the physician delegation on the capitol steps.

Indiana

The Indiana Chapter of the ACS held its Lobby Day at the Capitol January 26, drawing more than 20 participants. The event included informative presentations by various Indiana stakeholders, as well as an overview of the Indiana statehouse and legislative issues by Don Selzer, MD, FACS. In addition, state Rep. Tim Brown, MD (R) provided legislative updates and a presentation on how to communicate with lawmakers. Topics presented included a discussion about physician advocacy led by Alexander Choi, MD, who recently ran for a seat in the state legislature; a review of quality programs by John Clark, MD, JD; and a presentation regarding the current environment of health care finance by Jonathan Curtwright, chief operating officer, Indiana University Health Methodist Hospital and University Hospital, Indianapolis. The leading issue surgeons discussed with lawmakers was S.B. 55, legislation that would have allowed medical liability claims of up to $187,000 to bypass the medical review panel and reach Indiana’s Patient’s Compensation Fund. This dollar amount represents a dramatic increase over the established $15,000 limit. Surgeons also focused on H.B. 1043, a bill that would have increased the medical liability cap on all liability
The Louisiana Chapter of the ACS was a first-time lobby day grant recipient in 2015, taking advantage of the program to become more engaged in state grassroots advocacy.

Kansas
The Kansas Chapter of the ACS and the Kansas Medical Society hosted a state lobby day in Topeka on January 21. The well-attended event kicked off with in-depth briefings about state and federal advocacy, the climate in the Kansas legislature, and medical liability. Several lawmakers attended the event to provide their perspectives on the issues. Following the briefings, members attended meetings with their individual legislators to advocate against scope-of-practice expansion for advanced practice registered nurses and in favor of tanning bed restrictions and an increase in the tobacco tax. After the legislative meetings, the medical societies hosted a reception that provided an opportunity for members and legislators to further interact.

Louisiana
The Louisiana Chapter of the ACS was a first-time lobby day grant recipient in 2015, taking advantage of the program to become more engaged in state grassroots advocacy. The key issue discussed at the May 13–14 event was group health plan insurance coverage for bariatric surgery. Two advocacy events sponsored by the chapter helped advance this issue—a backyard barbecue with chapter leaders and state Sen. David Heitmeier (D), resulting in his sponsorship of the legislation, S.B. 173; and a legislative dinner with invited legislators and chapter leaders to discuss the bill and other issues of interest. As a result of the grassroots activity of Louisiana ACS Fellows, S.B. 173 passed out of the Senate and went to the House Committee on Insurance. While time ran out before the bill could make it out of the committee, ACS Fellows experienced considerable success in working through the legislative process and getting the legislation to move from one chamber to the next.

New York
The New York and Brooklyn-Long Island chapters of the ACS cosponsored a lobby day with the New York Coalition of Specialty Care Physicians on May 12. The day started with presentations by physician members and government affairs staff from the associations who provided a legislative briefing, advocacy training, and an overview of issues before the legislature. The advocacy training was unique this year, incorporating role-playing exercises for meetings with legislators and their staffs. Training session participants were then critiqued and coached by government affairs staff. More than 100 physicians were in Albany, NY, advocating on legislation under consideration, including scope-of-practice expansion for certified registered nurse anesthetists, optometrists, and podiatrists, as well as health care billing transparency. Several Fellows were able to meet with their individual legislators, including Kemp Hannon (R), Chair of the Senate Public Health Committee.

Oregon
The Oregon Chapter of the ACS held its Day at the Capitol March 15–16. The event began with a chapter council meeting and dinner during which Bud Pierce, MD, PhD, former Oregon Medical Association president, discussed the state’s health care policy issues. State Rep. Knute Buehler, MD (R), also spoke with the advocates regarding his legislative priorities and provided insights into the legislature from a physician’s point of view. Participants later visited the capitol to discuss the following: an increase in virtual credit card transparency, instituting a timely grace period notification from 30 to 90 days for insurance companies to...
deny claims, and increasing the wrongful death liability cap to $1.5 million from $500,000. Attendees were also able to attend hearings held by the House and Senate Committees on Health.

Tennessee
The Tennessee Chapter of the ACS joined forces with the Tennessee Medical Association at its annual Day on the Hill in Nashville March 3. Surgeons used the opportunity to meet with lawmakers and attend legislative committee hearings. At the event, physicians opposed legislation that would authorize independent practice for nurse practitioners, S.B. 680/H.B. 456; an increased statute of limitations for health care liability, S.B. 764/H.B. 666; and repeal of the motorcycle helmet law, S.B. 925/H.B. 700. None of these bills advanced significantly in the 2015 legislative session.

In addition to addressing these issues, the Tennessee Chapter used this opportunity to educate legislators about the Tennessee Surgical Quality Collaborative, a partnership between the chapter, the Tennessee Hospital Association, and the Tennessee Health Foundation. The collaborative uses the ACS National Surgical Quality Improvement Program data to improve surgical outcomes.

Virginia
The Virginia Chapter of the ACS partnered with other surgical societies to host a lobby day January 27 in Richmond. The day began with a briefing and an advocacy presentation from the Virginia Medical Society on a wide variety of legislative and political issues. After the briefing, Fellows headed to the state capitol for meetings with their individual state legislators. These productive meetings enabled Fellows to advocate on legislation regarding prescription prior authorization reform, liquid nicotine restrictions, and injury prevention.

How to get involved
Fellows play an important grassroots advocacy role at the state level. For those chapters and states that do not sponsor a lobby day, there are other ways to make a difference. For example, all Fellows can take action by contacting their legislators on pending legislation through the Surgery State Legislative Action Center or SurgeonsVoice.

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

Whereas most state legislatures have finished their legislative business for the year, lawmakers have shifted their focus to in-district efforts and the 2016 legislative sessions. At this time, it is imperative that chapters begin to plan for the upcoming sessions by creating an advocacy strategy. The lobby day program is one of the best tools to support state grassroots activity, and the State Affairs team is available to assist with planning a lobby day or helping chapters with other grassroots advocacy initiatives. Contact the State Affairs team at state_affairs@facs.org with questions or concerns.
Health care fraud is a persistent and costly problem for both commercial and government payors. The Centers for Medicare & Medicaid Services (CMS) estimates that a significant amount of fee-for-service payments are misspent on improper payments every year, including last year when the “bulk of misspent money—$45.8 billion—went to the CMS fee-for-service program.”*

This column summarizes the major types of CMS audits that could affect physicians, as well as the entities responsible for them. It is intended to present a high-level overview of seven common audits, which include the following:

- Medicare Recovery Audit Contractors (RACs)
- Medicaid RACs
- Medicaid Integrity Contractors (MICs)
- Zone Program Integrity Contractors (ZPICs)
- State Medicaid Fraud Control Units (MFCUs)
- Comprehensive Error Rate Testing (CERT)
- Payment Error Rate Measurement (PERM)

In addition, surgeons may be subject to audits conducted by the U.S. Department of Health and Human Services (HHS) Office of the Inspector General (OIG), Medicare Administrative Contractor (MAC) prepayment reviews or audits, or the RAC Prepayment Review Demonstration Program.

What are the types of audits and what is the focus and scope of each? Who conducts these audits, and how far back can an auditor review submitted payment claims? See Table 1, page 40.

What are the processes, penalties, and appeals processes for each audit? See Table 2, page 41.

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Where can I find more information about these audits?

- MICs: [www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/MedicaidIntegrityProgram/](http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/MedicaidIntegrityProgram/)
- MFCUs: [oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/index.asp](http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/index.asp)

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### Table 1. Scope, Auditor, and Look-Back Period

<table>
<thead>
<tr>
<th>Name</th>
<th>Scope</th>
<th>Auditor</th>
<th>Look-back period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare RACs</td>
<td>Medicare RACs identify Medicare fee-for-service provider over- and underpayments, collect overpayments, and return underpayments. Medicare RACs operate nationwide and only review issues approved by CMS.</td>
<td>The four Medicare RACs, each responsible for a U.S. region, are private companies contracted by CMS. Medicare RACs are paid on a contingency fee basis, receiving a percentage of both the over- and underpayments they correct.</td>
<td>Medicare RACs perform audit and recovery activities on a postpayment basis, and claims are reviewable up to three years from the date the claim was filed.</td>
</tr>
<tr>
<td>Medicaid RACs</td>
<td>Medicaid RACs identify over- and underpayments of Medicaid providers' claims and recoup overpayments. Medicaid RACs are administered nationwide, on a state-by-state basis. States have discretion to determine which Medicaid programs to target and are not required to publicly announce audit target areas.</td>
<td>States contract with a private company that operates as a Medicaid RAC to perform audits of Medicaid claims. Individual states determine how each Medicaid RAC will be paid, usually on a contingency fee basis.</td>
<td>Medicaid RACs perform audits and recovery activities on a postpayment basis, and claims can be reviewed up to three years after the date they were filed. Review after this period requires approval from the state.</td>
</tr>
<tr>
<td>MICs</td>
<td>MICs review all Medicaid providers to identify high-risk areas, overpayments, and areas for provider education to reduce Medicaid fraud, waste, and abuse.</td>
<td>MICs are private companies contracted by CMS, which has divided the U.S. into five MIC jurisdictions, each encompassing two CMS regions. MICs are not paid on a contingency fee basis but are eligible for financial incentives based on the effectiveness of their audits.</td>
<td>MICs perform audit and recovery activities on a postpayment basis, and claims can be reviewed as far back as permitted under the laws of the states that have paid the claims (generally a five-year look-back period).</td>
</tr>
<tr>
<td>ZPICs</td>
<td>ZPICs investigate potential Medicare Parts A and B fraud, waste, and abuse and refer these cases to their associated MAC for recoupment or other federal and state agencies for other penalties.</td>
<td>ZPICs are private companies contracted by CMS, which has divided the U.S. into seven ZPIC jurisdictions, each aligned with one or two MACs. ZPICs are paid directly by CMS on a contractual basis.</td>
<td>ZPICs have no specific look-back period.</td>
</tr>
<tr>
<td>MFCUs</td>
<td>MFCUs, which are annually certified by the OIG, investigate and prosecute (or refer for prosecution) criminal and civil Medicaid fraud cases, as well as patient abuse and neglect in health care facilities.</td>
<td>MFCUs operate in each state, excluding North Dakota, and the District of Columbia and are jointly funded by the state and federal government on a matching basis.</td>
<td>MFCUs have no specific look-back period.</td>
</tr>
<tr>
<td>CERT program</td>
<td>The CERT program identifies and estimates the rate of improper Medicare payments and publishes an annual report describing national paid claims and provider compliance error rates. CERT program findings are not considered a measure of fraud, as findings are based on a random sample of Medicare claims and not an examination of billing patterns.</td>
<td>The CERT program is operated by two private CMS contractors.</td>
<td>The CERT program reviews Medicare claims on a postpayment basis. The reviewed claims are limited to the current federal fiscal year (October 1 to September 30).</td>
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Medicare RACs use proprietary software programs to conduct two types of audits: Automated audits can lead to a decision without requesting a medical record; and complex audits allow a Medicare RAC to contact providers to request medical records to make a payment decision. RACs are limited to 10 medical records per single practitioner within a 45-day period.

No penalty if the provider agrees with the Medicare RACs' overpayment determination and repays CMS. If a provider misses a deadline in the appeals process, CMS is permitted to automatically recoup alleged overpayment plus interest. RACs must wait until the second level of appeal before collecting a contingency fee.

The Medicare RAC appeals process mirrors the five-level Medicare claims appeals process. The first level of appeal must be filed by the 120th day after receiving the letter of demand.

States have flexibility to decide the structure of the appeals process for providers to appeal any adverse determination made by the Medicaid RAC.

Penalties, if any, are determined by each state. Each state individually adjudicates provider appeals.

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<table>
<thead>
<tr>
<th>Name</th>
<th>Process</th>
<th>Penalties</th>
<th>Appeals process</th>
</tr>
</thead>
<tbody>
<tr>
<td>ZPICs</td>
<td>ZPIC audits may be initiated through data analysis or directly by fraud complaints. ZPIC review of claims may occur either pre- or postpayment. There is no limit on document requests for ZPIC audits, in addition to interviews and on-site visits. ZPICs refer identified overpayments to their associated MAC for recoupment or to other state or federal agencies for other penalties.</td>
<td>ZPICs recoup overpayments and can refer findings of fraud to law enforcement for criminal, civil monetary penalty, or other administrative sanction involving the HHS OIG; ZPICs may also refer such findings to the U.S. Attorney. ZPICs also can recommend that their MAC implements prepayment or auto-denial edits, if deemed necessary.</td>
<td>A provider has the right to appeal ZPIC overpayment determination through the five-level Medicare appeals process by which fee-for-service providers appeal reimbursement decisions.</td>
</tr>
<tr>
<td>MFCUs</td>
<td>MFCUs are not restricted to a specific investigational or audit process.</td>
<td>MFCUs recoup overpayments or refer to an appropriate state agency for collection, and can refer a finding of fraud to the appropriate investigation or prosecution authority. If there is a pending Medicaid fraud investigation, MFCUs may refer providers to state Medicaid agency for payment suspension.</td>
<td>The appeal rights of providers investigated by MFCUs depend on entity to which the case is referred for overpayment, investigation, or prosecution.</td>
</tr>
<tr>
<td>CERT</td>
<td>CERT randomly selects a statistical sample of claims submitted to MACs and requests medical records from the providers who submitted the claims in the sample. The claims and associated medical records are reviewed for compliance with Medicare coverage, coding, and billing rules. Errors are assigned to claims in instances of noncompliance. CMS and CERT contractors analyze the error rate data and produce a national Medicare fee-for-service error rate after the review process is completed.</td>
<td>Claims selected for CERT review are subject to overpayment recoupment, potential postpayment denials, payment adjustments, or other administrative or legal actions depending on the result of the CERT review. If a provider fails to submit a requested record to the CERT program, the claim counts as an improper payment and may be recouped from the provider.</td>
<td>A provider has the right to appeal CERT determination through the five-level Medicare appeals process.</td>
</tr>
<tr>
<td>PERM</td>
<td>PERM is conducted over a three-year period, focusing on 17 states per year. PERM contractors draw random samples of claims from each state and request medical records associated with those claims from the providers, and the medical records are reviewed to validate compliance with Medicaid coverage, coding, and billing rules. The claims determined to have been paid incorrectly are scored as errors and payments are adjusted accordingly.</td>
<td>If a provider fails to submit a requested record to PERM, the claim counts as an improper payment and may be recouped from the provider.</td>
<td>States may pursue two levels of PERM error determination dispute: the difference resolution process and the CMS appeals process. These processes afford states the opportunity to overturn PERM error determinations.</td>
</tr>
</tbody>
</table>
Use of systemic chemotherapy before surgery has become an accepted approach in the management of breast cancer patients in the effort to improve the chance of achieving breast conservation or rendering an inoperable cancer operable. However, it took some time for many surgeons to embrace the idea of delaying surgical intervention.

Neoadjuvant chemotherapy
The National Surgical Adjuvant Breast and Bowel Protocol B-18 clinical trial compared outcomes in women receiving chemotherapy before surgery with those patients receiving adjuvant chemotherapy and demonstrated equivalent survival rates. This trial also showed a higher rate of breast preservation with neoadjuvant chemotherapy.

Since the results of these initial trials using the neoadjuvant approach were disseminated, the biologic underpinnings of breast cancer have become better understood. Previously, systemic chemotherapy decision making was largely based on tumor size and nodal status. The advent of molecular profiling has expanded and improved the definition of breast cancer to include biologic subtype in addition to the clinical stage at which the patient presents. When response to neoadjuvant chemotherapy is assessed by biologic subtype, the hormone receptor-positive tumors are less likely to achieve a pathologic complete response (pCR). Based on this finding and the responsiveness of hormone receptor positive tumors to endocrine therapy, the use of endocrine therapy in the neoadjuvant setting has evolved.

Initial neoadjuvant endocrine therapy trials
Initial studies using neoadjuvant endocrine therapy originated in Europe and the U.K. Two international randomized trials of neoadjuvant endocrine therapy demonstrated objective clinical response rates of 37 percent and 55 percent, with breast preservation rates of 44 percent to 45 percent, and showed that aromatase inhibitors were more effective than tamoxifen.

ACOSOG Z1031
In January 2006, the American College of Surgeons Oncology Group (ACOSOG) activated Z1031, a randomized phase II study designed to select the ideal agent for neoadjuvant endocrine therapy among three aromatase inhibitors (AI), with the ultimate goal of “picking the winner” to compare head-to-head in a subsequent trial with neoadjuvant chemotherapy. The trial opened in 2006 and accrual was completed in 2009. A total of 377 postmenopausal women with clinical stage II or III estrogen receptor (ER)-positive breast cancer were enrolled.

Patients were randomized to exemestane 25 mg, letrozole 2.5 mg, or anastrozole 1 mg daily for 16 to 18 weeks before surgery (cohort A). The surgical study aims included the following:

• Rate of breast-conserving surgery at first attempt without re-excision for patients classified as potential candidates for breast conservation

• Rate of breast-conserving surgery for patients classified as requiring mastectomy at baseline
Rate of successful mastectomy with primary skin closure and negative margins for patients classified as inoperable at baseline

A core needle biopsy of the tumor was performed after two to four weeks of therapy to evaluate changes in Ki67, a measure of the proliferation in the tumor. A fall in Ki67 has been shown to be predictive of better tumor response to endocrine therapy and improved long-term prognosis.5

In the second phase of Z1031 (cohort B), the needle biopsy was performed at four weeks and was used to determine therapy. If the Ki67 remained high at four weeks (greater than 10 percent, presumed endocrine resistant), the patient would discontinue endocrine therapy and switch to neoadjuvant chemotherapy or go directly to surgery. If the Ki67 was low (presumed endocrine sensitive) the patient would continue on endocrine therapy. This on-treatment biopsy result with a high Ki67 has been shown in other trials to portend resistance to endocrine therapy.

Clinical response rates with aromatase inhibitors in Z1031 were very high: 63 percent with exemestane, 69 percent with anastrozole, and 75 percent with letrozole. Disease progression was uncommon, seen in only 6 percent of patients.6 The overall breast conservation rate was 68 percent. Of the 163 patients initially deemed to require mastectomy or who were felt to be inoperable, surgical recommendations were changed in 56 percent after AI therapy. Among patients thought to require mastectomy before AI treatment, 51 percent were able to undergo breast-conserving operations. Of patients deemed marginal for breast-conserving surgery at presentation, 83 percent ultimately achieved breast preservation. Interestingly, on the final pathology of patients undergoing mastectomy, 24 percent had T1 tumors. This finding suggests that better tools are needed to assess response and measure the extent of residual disease following neoadjuvant endocrine therapy. Surgeons also may have underestimated the reduction in tumor size.

Of the 245 needle biopsies performed at the two to four-week intervals, 20 percent had Ki67 >10 percent, indicating endocrine therapy resistance.7 At the completion of neoadjuvant endocrine therapy and surgery, prognosis and endocrine sensitivity were further assessed using the preoperative endocrine prognostic index (PEPI) score, which reflects long-term outcomes and lack of benefit from adjuvant chemotherapy. The PEPI score is derived from four factors assigned a numerical score following neoadjuvant endocrine therapy, including Ki67 expression in the surgical specimen, pathologic tumor size, lymph node status, and estrogen receptor (ER) level (see Table 1, this page). In the P024 and IMPACT [Immediate Preoperative Anastrazole, Tamoxifen, or Combined with Tamoxifen] neoadjuvant endocrine therapy trials, no relapses occurred at five years among patients with a PEPI score of 0.8 In the Z1031 trial, approximately 17 percent of patients achieved a PEPI score of 0.

### TABLE 1. PREOPERATIVE ENDOCRINE PROGNOSTIC INDEX

<table>
<thead>
<tr>
<th>Pathology/biomarker status</th>
<th>Points related to relapse-free survival</th>
<th>Points related to breast cancer-specific survival</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pathologic tumor size</td>
<td></td>
<td></td>
</tr>
<tr>
<td>T1/2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>T3/4</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Node status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negative</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Positive</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Ki67 level</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0–2.7%</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>&gt;2.7%–7.3%</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>&gt;7.3%–19.7%</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>&gt;19.7%–53.1%</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>&gt;53.1%</td>
<td>3</td>
<td>3</td>
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<tr>
<td>ER status, Allred score</td>
<td></td>
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<tr>
<td>0–2</td>
<td>3</td>
<td>3</td>
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<tr>
<td>3–8</td>
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<td>0</td>
</tr>
</tbody>
</table>

Surgeons’ role
Surgeons are often the first physicians to evaluate patients with newly diagnosed breast cancer and, therefore, are critically important in presenting and explaining the option of neoadjuvant treatment to patients. Neoadjuvant endocrine therapy can reduce the extent of breast surgery and provide information that may allow patients with low-risk ER-positive tumors that achieve a favorable PEPI score to avoid chemotherapy.

Despite the dramatic responses seen with neoadjuvant endocrine therapy in Z1031, the uptake of neoadjuvant endocrine therapy in the U.S. has been slow. The Z1031 study results were presented at the American Society of Clinical Oncology annual meeting in 2010 and were published in the Journal of Clinical Oncology in 2011. In subsequent years, use of neoadjuvant endocrine therapy in patients with stage II–III ER-positive breast cancer has slowly increased. However, the overall use of neoadjuvant endocrine therapy remains low, with 2.4 percent of cT2-4c ER-positive breast cancer patients age ≥50 being treated with neoadjuvant endocrine therapy.

Historically, it has been shown that it can take 17 years for the results of a clinical trial to impact clinical practice. Allowing our patients the benefit of recent advances in oncology is important to improve the clinical care of our patients. Tailoring both surgical and systemic treatment based on the response to endocrine therapy in patients with hormone receptor-positive breast cancer allows us to take another step forward in individualizing patient care.

REFERENCES
Dr. and Mrs. Kenyon are committed to giving back

by LaMar S. McGinnis, Jr., MD, FACS, and William Sasser, MD, FACS

Editor’s note: The following is the first in a series of columns the Bulletin will be publishing on contributors to the Mayne Heritage Society (MHS)—the American College of Surgeons (ACS) Foundation’s planned giving program.

Norman Kenyon, MD, FACS, a retired general surgeon, and his wife Sue are known in the Miami, FL, area as people who give back to the community, regularly donating their time, talent, and resources to worthy causes. The College and the Florida Chapter of the ACS also have benefited from their generosity. Dr. Kenyon is a Past-President of both the Florida Chapter and the South Florida Chapter, and a Past-Governor of the ACS.

Vocal advocates
Loyal donors to the ACS Foundation for many years, Dr. and Mrs. Kenyon decided to make the College a beneficiary of their legacy plans in 2003. As a result of their intended bequest to the College, they became proud members of the MHS, the ACS Foundation’s planned giving program. Dr. Kenyon has been a vocal advocate among his peers, encouraging them to join the MHS as a way of giving back to the profession.

Dr. Kenyon believes all Fellows should support the College to the best of their ability. Estate planning has been the most efficient way to accomplish this goal for Dr. and Mrs. Kenyon, as a legacy gift allows them to maintain access to their assets while providing a future gift to support the College’s programs. “We are proud to give back to the College for all it has done and continues to do for surgeons and the profession. The ACS has always been the standard for surgical education, practice advances, and research. The College is the prominent stabilizer for the quality care of patients and education for surgeons throughout their careers,” Dr. Kenyon said.

In addition to being named the ACS Distinguished Philanthropist in 2010, other honors bestowed upon Dr. Kenyon include the Raymond H. Alexander Award from the Florida Chapter of the ACS, the James H. Corwin Distinguished Service Award from the Florida Surgical Society, the Person of the Year Award by LaMar S. McGinnis, Jr., MD, FACS, and William Sasser, MD, FACS

More about the Mayne Heritage Society
Members of the MHS support the mission of the College through a planned or legacy gift commitment. The requirements for membership are naming the ACS as a beneficiary in your will or living trust, or establishing a planned gift of any size or type, such as a charitable remainder trust, to benefit the ACS. Estate planning information is available by visiting plannedgiving.facs.org or by contacting the ACS Foundation at 312-202-5338. ♦
Last month’s column focused on the idea of surgeons using The Joint Commission’s Robust Process Improvement (RPI) toolkit—which encompasses Lean Six Sigma and other change management strategies—to bring about substantial, lasting change to health care. But how can these tools be applied in practice to achieve high-reliability for patients?

The Joint Commission Center for Transforming Healthcare has focused on a number of complex, chronic patient safety issues, which has led to the development of the Targeted Solutions Tool (TST), an online application that guides a project leader through an RPI project. The TST is available for safe surgery, hand hygiene, hand-off communications, and prevention of falls.

The project leader and team that use the TST do not need to be experts in RPI methodology and change management; RPI is a “learn while you do it” tool. The goal is to understand the key factors that contribute to a specific practice environment and to implement proven solutions to any problem factors that may inhibit the provision of optimal care.
RPI techniques can effect change in a variety of ways, such as reducing the chance of patient injury and creating a more efficient process for scheduling physicians.

**Protecting patients**
The TST application helps health care institutions safeguard patients from preventable harm, including wrong site surgery, across the continuum of surgical care. For example, the safe surgery TST provides guidelines for the project leader to evaluate the organization’s surgical care system from scheduling all the way through the completion of the operation. Through this systematic, data-driven approach, practices are standardized across the perioperative phase of care, which includes all activities aimed at optimal preparation of the patients for surgical procedures.

The Joint Commission Center for Transforming Healthcare collaborated with health care organizations, including hospital systems and other health care providers, across the U.S. to address wrong site surgery, identifying 29 main causes of these surgical errors. They ranged from scheduling and preoperative errors to operating room (OR) and organizational culture errors.

In scheduling procedures, situations that may lead to wrong site surgeries include:

- Schedulers accepting verbal requests, instead of written documents, for surgical bookings
- Unapproved abbreviations or illegible handwriting used on booking forms
- An unapproved marker identifying the surgical site or use of stickers to identify a surgical site
- Inadequate patient verification by the team

**Sources in the OR include:**

- Distractions occurring during a scheduled timeout
- Portions of the team being absent from or not participating in the timeout

**Organizational culture factors include:**

- Staff not being empowered to speak up
- Inadequate education provided to the staff regarding the changes

**RPI at work**
Applying RPI methodology in another practical scenario, Julia Berian, MD, a Clinical Scholar in Residence at the American College of Surgeons, used the RPI toolkit to improve an aspect of the vacation scheduling process (flexible time) for the general surgery residency program at the University of Chicago, IL. The previous process was not centralized, leading to a haphazard, and often strained, scheduling process with a number of last-minute time-off requests that left some residents overburdened.

Dr. Berian was able to define the key players in the process and create a system that alleviated scheduling problems by selecting a lab administrative resident who is responsible for organizing the flexible vacation time. All requests now go through this individual, eliminating part of the frustrating administrative issues that some surgeons face on a daily basis.

RPI techniques can effect change in a variety of ways, such as reducing the chance of patient injury and creating a more efficient process for scheduling physicians. In next month’s column, we will continue to highlight notable aspects of this innovative methodology.

For more information on RPI and the TSTs, go to www.centerfortransforminghealthcare.org.

**Disclaimer**
The thoughts and opinions expressed in this column are solely those of Dr. Pellegrini and do not necessarily reflect the official views of The Joint Commission or the American College of Surgeons.
The English vernacular has accumulated a collection of so-called “black” days in the past decades. Black Monday and Black Tuesday both occurred after Thursday, October 24, 1929, known as Black Thursday—the day on which the stock market crash that triggered the Great Depression began. More recently, Monday, October 19, 1987, became known as Black Monday when stock markets around the globe crashed, with the Dow Jones plummeting more than 22 percent.

Party night
Black Wednesday—one of the biggest “party nights” of the year—is a popular term among U.S. law enforcement officers, bartenders, and the media, and refers to the night before Thanksgiving Day.* With college students home for the holiday and a large percentage of the workforce off the next day, it isn’t difficult to see why Black Wednesday evening is a prime time for revelry.

The week before Thanksgiving in 2013, the National Highway Traffic and Safety Administration (NHTSA) released NHTSA 36-13, a consumer advisory reminding motorists to take safety precautions while driving over the holiday weekend.† The advisory described Thanksgiving weekend as one of the busiest travel times of the year, representing a significantly increased risk of a serious or fatal car crash. In 2012, a total of 416 fatalities occurred over the extended four-and-one-half-day holiday weekend. Some notable statistics regarding those fatalities include the percentage of victims who neglected to wear seat belts (more than 60 percent) with 42 percent of those individuals killed in a crash involving a drunk driver.

To examine the occurrence of Black Wednesday motor vehicle driver-related injuries in the National Trauma Data Bank® (NTDB®) research dataset for 2013, admissions medical records were searched for the 12-hour period using arrival date and arrival time that occurred between 7:00 pm Wednesday, November 27, 2013, and 7:00 am Thursday, November 28, 2013. Records were then searched using the International Classification of Diseases, Ninth Revision, Clinical Modification diagnoses codes. Specifically searched were records that contained the following external cause of injury codes (E-code): E810–E819 (motor vehicle crashes) with a post-decimal value of zero for driver of a car or three for driver of a motorcycle.

A total of 986 records were found for this 12-hour period; 885 records contained a discharge status, including 531 patients discharged to home, 215 to acute care/rehab, and 39 sent to skilled nursing facilities; 100 died. (See Figure 1, page 50.) Of these patients, 65.2 percent were male, on average 38.2 years of age, had a typical hospital length of stay of 7.9 days, an intensive care unit length of stay of 7.3 days, an average injury severity score of 17.3, and were on the ventilator for an average of seven days.

A total of 666 were tested for alcohol and more than half (54.4 percent) tested positive. Of the 288 tested for illicit drugs, one-third (33.3 percent) tested positive. (See Figure 2, page 50.)

**Give thanks**

For travel guidelines to stay safe during the Thanksgiving holiday, refer to the NHTSA 36-13 consumer advisory referenced earlier in this column. If one plans to go out on Black Wednesday to celebrate, be responsible in your actions so the following morning one is thankful for more than just surviving the previous evening.

Throughout the year, we will be highlighting NTDB data through brief monthly reports in the *Bulletin*. The NTDB Annual Report 2014 is available as a PDF file at [www.facs.org/quality-programs/trauma/ntdb](http://www.facs.org/quality-programs/trauma/ntdb). In addition, information is available on the website regarding how to obtain NTDB data for more detailed study. To submit your trauma center’s data, contact Melanie L. Neal, Manager, NTDB, at mneal@facs.org.

**Acknowledgement**

Statistical support for this article has been provided by Chrystal Caden-Price, Data Analyst, NTDB.
J. David Richardson, MD, FACS, professor of surgery and vice-chairman, department of surgery, University of Louisville School of Medicine, KY, was installed as President of the American College of Surgeons (ACS) at the Clinical Congress 2015 Convocation, Sunday, October 4, in Chicago, IL.

An eminent general, thoracic, and trauma surgeon and surgical educator, Dr. Richardson is a 1970 graduate of the University of Kentucky School of Medicine, Lexington. He completed a surgery internship and worked as a junior assistant resident at the University of Kentucky before moving to the School of Medicine at the University of Texas Health Science Center at San Antonio to complete a general surgery and a thoracic surgery residency. After completing his surgical training in 1976, he returned to Kentucky to teach and practice at the University of Louisville School of Medicine. He rose through the academic ranks at the institution, starting as an assistant professor of surgery and becoming associate professor of surgery in 1979.

He has served in his current position as professor of surgery since 1983 and as vice-chair of the department of surgery since 1985. He has served as chief of surgery services and director of emergency surgical services at the University of Louisville Hospital since 2005.

Dr. Richardson became an ACS Fellow in 1980. Since then, he has served the College in various leadership capacities, most recently as Chair of the Board of Regents (2011–2012). In that role, he also chaired the Regents’ Finance and Executive Committees. He was a member of the ACS Board of Regents from 2003 to 2011.

Dr. Richardson also has played a leadership role on several other ACS committees. He was the ACS Governor from Kentucky (1989–1995) and served on the Governors’ Committee on Surgical Infections (1992–1995). He was Chair of the Research and Optimal Patient Care Committee (2004–2011) and Vice-Chair of the Health Policy and Advocacy Group (2010–2011). He has been an active member of the ACS Committee on Trauma (COT), including serving as Chair of the Emergency Services-Prehospital Subcommittee (1992–1999) and as a member of the COT’s Executive Committee (1992), Membership Committee (1993), and Verification/Consultation Committee (1993).

In addition, Dr. Richardson has served on the ACS Advisory Council for General Surgery (1997–2002), the Advisory Council for Vascular Surgery as a Regent (2003–2006), and the Advisory Council for Rural Surgery as an Ex Officio member (2011–2012). He also has been a member of the ACS Committee on Video-Based Education (1991–1997). Currently, Dr. Richardson is Chair of the ACS Transition to Practice Program in General Surgery Steering Committee.

At the state level, he has served as Chair (1985–1987) and Vice-Chair (1981–1985) of the Kentucky COT, and he has been Secretary-Treasurer (1983–1986) and President (1987) of the Kentucky Chapter of the ACS. He has served on the Kentucky Committee on Applicants (1997–2002) as well.

In addition to his leadership roles within the ACS,
A Fellow of the College since 1984, Dr. Maier has played an active role on several key ACS committees, particularly the COT.

Dr. Richardson has served at the highest levels in the following organizations: American Board of Surgery (director, 1987, and chairman, 1998–1999); American Board of Emergency Medicine (director, 1994); American Association for Surgery of Trauma (president, 1999); Southeastern Surgical Congress (president, 1999); Southern Surgical Association (president, 2003); and Western Surgical Association (secretary, 1995–2000, and president, 2000–2001). He served on the Association of American Medical College’s Medical College Admissions Test content review committee (1988) and the Accreditation Council for Graduate Medical Education’s Residency Review Committee (2000–2007). He was the founding president of the Kentucky Vascular Surgical Society (1989) and president of the Kentucky Surgical Society (1987).

A prolific author, Dr. Richardson has published more than 345 articles in peer-reviewed publications, 50 book chapters, and has 10 publications in press. He currently is the editor of The American Surgeon, serves on the Editorial Board of the Journal of the American College of Surgeons, is an editorial consultant for The Journal of Trauma Injury, Infection & Critical Care, and is on the editorial board of the International Scholarly Research Network.

Vice-Presidents

Along with the President, the Vice-Presidents of the ACS were installed at Convocation. The First Vice-President is Ronald V. Maier, MD, FACS, FRCSEd(Hon), the Jane and Donald D. Trunkey Professor of Trauma Surgery, and vice-chair, department of surgery, University of Washington (UW) Medicine, Seattle. In addition, he is the director of the regional trauma center and surgeon-in-chief, Harborview Medical Center, the Level 1 trauma center in Seattle.


Dr. Maier has held numerous leadership positions in other surgical organizations, exemplified by having served as president of the Society of University Surgeons, Surgical Infection Society, Shock Society, American Association for the Surgery of Trauma, and the Halsted Society, in addition to being chair of
Dr. Pories’ major clinical interests have been in pediatric and bariatric surgery.

Dr. Pories

the Board of Directors of the American Board of Surgery.

Dr. Maier’s research interests include cell biology of inflammation, dysregulation of the immune response after severe injury, wound healing, gene expression response to injury, modulation of inflammatory mediators, acute respiratory distress syndrome, biomaterials for healing, injury prevention, trauma care outcomes, and trauma systems analyses. Dr. Maier’s research efforts have been recognized through prestigious awards, including the Scientific Achievement Award from the Shock Society, the Lifetime Achievement Award in Trauma Resuscitation from the American Heart Association, and the Fiance-Karl Award for seminal contributions in basic laboratory research with clinical surgery applications from the American Surgical Society. He received the ACS Sheen Award for Contributions to Medicine and Medical Research and delivered the Scudder Oration on Trauma in 2013.

The Second Vice-President is Walter J. Pories, MD, FACS, founding chair, department of surgery; professor of surgery, biochemistry and kinesiology; and director, bariatric surgery research group, East Carolina University, Greenville, NC.

An ACS Fellow since 1964, Dr. Pories is a former Governor (1986–1992) and was on the Governors’ Committee on Surgical Practice (1989–1993). He has played an active role on the International Relations Committee as Vice-Chair (1984–1986), and as a member/senior member (1980–1990). He served as Secretary of the Ohio Chapter of the ACS (1974–1977) while on the faculty at Case Western Reserve, Cleveland, OH, and President of the North Carolina Chapter (1985–1986).

Dr. Pories’ major clinical interests have been in pediatric and bariatric surgery. His research interests led to the discovery that zinc is an essential element and required for wound healing, the development of animal feeds, and the addition of trace elements to parenteral and alimentary formulations. He was the first surgeon to describe wound suction and the cisterna chyli/vena cava anastomosis. He also was the first surgeon to describe the full and sustained remission of type 2 diabetes following gastric bypass surgery.

He has served as the president of several surgical societies and as editor or associate editor of a number of journals. He is the recipient of numerous honors, including the Outstanding Achievement Award from the American Society for Bariatric Surgery Foundation, the Barry Goldwater Service Medal, the McLester Award in Nutrition, the John P. McGovern Compleat Physician Award, and the Max Ray Joyner Award, the highest honor given by the University of North Carolina Board of Governors.
Six outstanding surgeons conferred Honorary Fellowship in the ACS

Honorary Fellowship in the American College of Surgeons (ACS) was awarded to six prominent surgeons from Ghana, Australia, India, France, Argentina, and Barbados at the October 4 Convocation that preceded the official opening of Clinical Congress 2015 in Chicago, IL. The granting of Honorary Fellowships is one of the highlights of the Clinical Congress. This year’s recipients were as follows:

Prof. Emmanuel Quaye Archampong, MB, BS, FRCSEd, FRCSEng, has made significant contributions to the advancement of postgraduate medical education in the areas of affordable and accessible surgical practices of West Africa. He is a recipient of the National Honours of the Republics of Ghana and Senegal and has used surgery as a tool for community development efforts in rural and underserved regions of Africa. He is the former head, department of surgery, and past dean, University of Ghana Medical School, Accra.

Prof. William B. Coman, MD, MB, BS, FACS, FRCSEd, FRCSEng, FRACS, Brisbane, Australia, is director, Queensland Centre of Excellence for Head and Neck Cancer, Princess Alexandra Hospital, Brisbane; and professor, division of otolaryngology-head and neck surgery, Griffith University, Brisbane. He has an international reputation in otolaryngology, including funded research into ear diseases specific to the Aboriginal population, investigation into the molecular behavior of head and neck cancer, and elucidation of mechanisms of swallowing disorders. His achievements have been recognized with honorary membership in the Royal College of Surgeons and the Hughes Medal from the Royal Australasian College of Surgeons.

Prof. Mahesh R. Desai, MB, BS, MS, FRCSEd, FRCSEng, is managing trustee and medical director of Muljibhai Patel Urological Hospital, the first dedicated institute for kidney diseases in western India to provide treatment for patients regardless of their ability to pay. He also founded the Jayaramdas Patel Academic Centre, Nadiad, India, to train future urologists and was among the first in India to adopt the most modern techniques for treating kidney stones. He continues to be an international innovator in both kidney stone surgery and renal transplantation, bringing new techniques and treatment centers to countries worldwide.

Prof. Abraham Fingerhut, MD, FACS, FRCP(g), FRCSEng, Poissy, France, is past-chief of surgery, Centre Hospitalier Intercommunal, and has been instrumental in the inception, design, execution, data analysis, and publication of more than 100 randomized, controlled, or prospective trials in the last 21 years. He is perhaps best known for his role as founding member and secretary of the Surgical Association of Clinical Research in Europe, as well as the driving force behind the French Federation for Research in Surgery. He has served as president of the European Society of Trauma and Emergency Surgery and the European Association for Endoscopic Surgery.

Prof. Eduardo de Santibañes, MD, PhD, Buenos Aires, Argentina, is a distinguished surgeon and leader in the field of hepatobiliary surgery. He performed the first cadaveric liver transplant in Argentina and established a program that has now performed more than 1,000 hepato-pancreato-biliary (HPB) procedures. The HPB program has trained many surgeons from South America, raising the standards of HPB surgery throughout the entire continent. He is professor of general surgery, University of Buenos Aires, and chair, department of surgery, Hospital Italiano de Buenos Aires.

Prof. Errol Ricardo Walrond, MB, BS, BSc(Hon), FACS, FRCSEng, FCCS, Saint James, Barbados, exemplifies the academic general surgeon and has written extensively about...
his experiences with cancer, vascular diseases, surgery of the thyroid and pancreas, as well as ethical issues in the education and practice of physicians. He has served as a clinician, educator, administrator, and policy driver for surgical and medical education throughout the West Indies. He has chaired the National Advisory Committee on AIDS (Barbados) and the Caribbean Accreditation Authority for Education in Medicine and was the founding fellow and president of the Caribbean College of Surgeons. He is a professor of surgery, University of the West Indies, and vice-dean, faculty of medicine, University of Barbados.

Presenting on behalf of the College were Samuel Adetola Adebonojo, MD, FACS, FCCP, FWACS, Beavercreek, OH; David J. Terris, MD, FACS, Augusta, GA; Glenn M. Preminger, MD, Durham, NC; Steven D. Wexner, MD, FACS, Weston, FL; Steven M. Strasberg, MD, FACS, St. Louis, MO; and Lenworth M. Jacobs, Jr., MD, MPH, FACS, Hartford, CT.

Sir Rickman Godlee, president of the Royal College of Surgeons of England, was awarded the first Honorary Fellowship in the ACS during the College’s first Convocation in 1913. Since then, 453 internationally prominent surgeons, including the six chosen this year, have been named Honorary Fellows of the ACS. Following are the citations presented at the Convocation.
President Warshaw, it is my distinct privilege to present to you and this assembly **Prof. Emmanuel Quaye Archampong** of the University of Ghana’s College of Health Sciences, Accra, for Honorary Fellowship in the American College of Surgeons.

A Fellow of the Royal Colleges of Surgeons in England and Edinburgh, Professor Archampong is a highly regarded clinician and clinical investigator, a consummate bedside teacher, and a mentor to generations of West African surgeons.

He has, by his dedicated application and singular devotion, made significant contributions to the development of postgraduate medical education in West Africa in the areas of appropriate, affordable, and accessible surgical practices, and in the acquisition of hands-on skills in surgical manpower development.

Blessed with a charming disposition and exemplary character, Professor Archampong personifies the true breed of the West African surgical personality. His curriculum vitae attests to the qualities that have distinguished him as one of the best West African surgeons of our generation, not only by his contributions to scholarship through relevant research works and in the mentorship of undergraduate trainees in several countries in Sub-Saharan Africa, but also by his part in the development of postgraduate training through the West African College of Surgeons of which he was President from 1997 to 1999.

A recipient of the National Honours of the Republics of Ghana and Senegal, Professor Archampong also has used surgery as an anvil and a tool for community development efforts in rural and underserved regions of Africa, be they directly or indirectly through programs sponsored by the World Health Organization.

President Warshaw, Professor Archampong is a quintessential choice and I am honored to present him for the Honorary Fellowship in the American College of Surgeons.
President Warshaw, it is my distinct privilege to present to you and this assembly Prof. William B. Coman of Brisbane, Australia, a “Renaissance surgeon” who has been the principal thought leader in Australian otolaryngology for nearly 40 years, for consideration of Honorary Fellowship in the American College of Surgeons.

Professor Coman was a world-class rugby and cricket player at the University of Queensland, Brisbane, where he completed his undergraduate studies. He stayed there for medical school and then pursued postgraduate surgical training in several venues including London, U.K., and Edinburgh, Scotland. He returned to Australia and served as chairman of otolaryngology at the University of Queensland for 37 years.

In that time, Professor Coman was called upon to serve as president of the Cartesian Society, president of the Australian Society of Otolaryngology, and chairman of the Australian Board of Otolaryngology, among many other responsibilities. He is notable in having established an international reputation in all major domains of otolaryngology, including funded research into ear diseases specific to the Aboriginal population of Australia, investigation into the molecular behavior of head and neck cancer, and elucidation of mechanisms of swallowing disorders.

His achievements were recognized by honorary membership in the Royal College of Surgeons and the Hughes medal from the Royal Australasian College of Surgeons; he also is one of only 11 individuals ever to receive honorary membership in the prestigious Triological Society in the U.S.

Professor Coman has been married to Mary for more than 50 years, and they have four lovely children—and, by the way, he has transitioned from rugby and cricket to snowskiing and golf, both of which he pursues at the youthful age of 77.

Dr. Warshaw, I am proud to present to you Professor William Coman. A true “connector” who is known for forging multidisciplinary international collaborations, he personifies all of the qualities that we look for in a friend, in a colleague, and in a leader. He is unambiguously deserving of the distinction of Honorary Fellow of our organization, and I am honored to present him. ♦
President Warshaw, it is my distinct privilege to present to you and this assembly **Prof. Mahesh R. Desai**, managing trustee of the Muljibhai Patel Urological Hospital (MPUH), Nadiad, India, for Honorary Fellowship in the American College of Surgeons.

After completing his surgical training in Pune, India, and urology training in the U.K., Professor Desai returned home in 1976 and helped to establish the MPUH in Nadiad, in the state of Gujarat in northwestern India. What started in 1978 as a small, 25-bed hospital has grown into a 170-bed urology and nephrology specialty center and teaching institution. The mission of MPUH remains the same: to provide the most modern treatment for all patients, regardless of their ability to pay.

As per Professor Desai’s vision, MPUH was the first dedicated institute for kidney disease in western India, performing their first renal transplant in 1980. Surgeons there now have performed more than 2,800 laparoscopic, robotic, and single port transplants. In addition, Dr. Desai was among the first in India to adopt the most modern techniques for stone disease, performing more than 26,000 procedures including lithotripsy, ureteroscopy, and percutaneous nephrolithotomy. He was one of the first to use ultrasound in urology especially for surgical stone access and ultrasound-guided prostate biopsy. Dr. Desai continues to be an international innovator in both stone surgery and renal transplantation, bringing new techniques to centers across the globe.

To train future generations of urologists, Professor Desai established the Jayaramdas Patel Academic Center at MPUH, which has state-of-the-art facilities for teaching and training, including an interactive auditorium, dry and wet laboratories, a library, and technology for live transmission of surgeries, including 3-D projection and webcasting. The motto of this facility remains: Enter to Learn—Exit to Serve.

President Warshaw, Professor Mahesh Desai is a compassionate clinician, innovative researcher, and consummate teacher. I am honored to present him for Honorary Fellowship in the American College of Surgeons.
President Warshaw, it is my distinct privilege to present to you and to this assembly Prof. Abraham Fingerhut of Poissy, France, a world-renowned gastrointestinal tract surgeon, for Honorary Fellowship in the American College of Surgeons.

Professor Fingerhut graduated from Highland Park High School in New Jersey, received his bachelor’s degree in organic chemistry at the University of Pennsylvania, Philadelphia, and completed his medical degree and residency with honors at the University of Paris, France. After working as a research fellow in Paris, he started as an assistant surgeon at the Centre Hospitalier Intercommunal de Poissy, France. In 1987, he became chief of surgery, a position that he held until 2007. Professor Fingerhut also has appointments as associate professor of surgery at Louisiana State University, Baton Rouge, and as professor at the College of Medicine of the Hospitals of Paris and at the University of Athens in Greece. He has received honorary degrees from the University of Graz in Austria and China Medical University in Taichung, Taiwan.

He has served as president of numerous associations, including the European Society of Trauma and Emergency Surgery and the European Association for Endoscopic Surgery. Professor Fingerhut is perhaps best known for his role as a founding member and secretary of the Surgical Association of Clinical Research in Europe, as well as the driving force and secretary behind the French Federation for Research in Surgery. He has been instrumental in the inception, design, execution, data analysis, and subsequent publication of more than 100 randomized controlled or prospective trials in France during the last 21 years.

Professor Fingerhut has delivered more than 1,000 lectures around the world. He has completed his first of two terms as a Governor-at-Large representing the American College of Surgeons Fellows of France from 2012 to 2015, and in 2012 was inducted as an honorary fellow of the American Surgical Association and in 2014 as an honorary fellow of the American Society of Colon and Rectal Surgeons. In addition to all of his exceptional contributions to surgery, he is a devoted husband, father, and brother, as well as a loyal friend. He also is an avid heliskier, climber, and trekker.

President Warshaw, Professor Fingerhut embodies and has displayed the essence of academic surgery, and as such, I am honored to present him to you for Honorary Fellowship.
President Warshaw, it is my distinct privilege to present to you and this assembly Prof. Eduardo de Santibañes of Buenos Aires, Argentina, a distinguished surgeon and a leader in the field of hepatobiliary surgery, for Honorary Fellowship in the American College of Surgeons.

Dr. Santibañes was born in Argentina in 1951. He graduated at the top of his class from the University of La Plata, Buenos Aires, and obtained a doctor of medicine degree from the University of Buenos Aires. His surgical training, which he completed in 1985, took place at the historic Hospital Italiano in Buenos Aires. He then worked under Thomas Starzl, MD, FACS, in Pittsburgh, PA, for two years in the field of liver transplantation. After returning to Argentina, he became a full professor at the University of Buenos Aires in 2005 and chair of the department of surgery at the Hospital Italiano, Buenos Aires, in 2008.

It is impossible to overstate the influence that Dr. Santibañes has had in the development of hepatopancreatico-biliary (HPB) surgery in Argentina and throughout the world. He performed the first cadaveric liver transplant in Argentina and established a program that has now performed more than 1,000 of these procedures. That HPB program is the center of excellence for a wide region and has trained many surgeons from Argentina and elsewhere in Spanish-speaking South America, which undoubtedly has raised the standard of HPB surgery throughout the continent. He has published more than 170 peer-reviewed papers, many of which have influenced the practice of HPB surgery. He has attracted and trained a team of outstanding surgeons who are now international leaders in their own right. It is no surprise the president of the American Hepato-Pancreatico-Biliary Association and the president-elect of the International Hepato-Pancreatico-Biliary Association are members of his department at the University of Buenos Aires. The words one associates with Dr. Santibañes are character and credibility, authority and humility, and family. That is why he has attracted so many outstanding people to his side and built such an outstanding program.

President Warshaw, our good friend Professor Santibañes is a surgeon devoted to the improvement of surgery for the benefit of patients. I am honored to present him for Honorary Fellowship in the American College of Surgeons.
President Warshaw, it is my distinct privilege to present to you and this assembly Prof. Errol Ricardo Walrond, a surgeon and scholar from Barbados, for Honorary Fellowship in the American College of Surgeons.

Dr. Walrond attended London University, U.K., where he received his surgical education. He is the professor of surgery, the University of the West Indies (UWI), in Barbados, and vice-dean of the faculty of medicine at UWI.

Dr. Walrond is an excellent clinical general surgeon who has expertise in all aspects of general surgery. He has served as a clinician, educator, and administrator and policy driver for surgical and medical education throughout the West Indies. He has developed the faculty academic programs at the UWI and has served as chairman of the National Advisory Committee on AIDS for the government of Barbados. He has been the chairman of the Caribbean Accreditation Authority for Education in Medicine and other health professions that set standards on procedures for accreditation in medicine, dental, veterinarian, and nursing programs. He was the founding fellow and president of the Caribbean College of Surgeons and has received numerous awards and honors from surgical organizations.

By Lenworth M. Jacobs, Jr., MD, MPH, FACS

Dr. Walrond has been a surgeon’s surgeon and epitomizes the general surgeon. He has written extensively on his experiences with cancer of all body systems, vascular diseases, surgery of the thyroid, and pancreas, as well as ethical educational issues of importance in the education and practice of physicians. Dr. Walrond is respected and loved by his patients and trainees, of whom I am one.

President Warshaw, Professor Walrond epitomizes the academic general surgeon. I am honored to present him for Honorary Fellowship in the American College of Surgeons.

Dr. Walrond is an excellent clinical general surgeon who has expertise in all aspects of general surgery. He has served as a clinician, educator, administrator and policy driver for surgical and medical education throughout the West Indies.
Apply now for ACS Fellowship

Associate Fellows interested in pursuing professional excellence are encouraged to apply for American College of Surgeons (ACS) Fellowship by December 31. Many Associate Fellows are pursuing professional excellence as individual practitioners and as members of the surgical community. These attributes will serve them well as they apply for ACS Fellowship. The ACS admits to its Fellowship only those surgeons whose professional activity is devoted to surgical practice and who agree to practice by the professional and ethical standards of the College.

The ACS standards of practice are contained in the Fellowship Pledge and the Statements on Principles, which are available on the ACS website at facs.org. All Fellows of the College and applicants for Fellowship are expected to adhere to these standards.

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

The following is a brief summary of the qualifications for Fellowship and the necessary application steps. The College anticipates that all Associate Fellows will consider applying for Fellowship within the first six years of their surgical practice. To encourage this transition, Associate Fellowship is limited to surgeons with less than six years in practice.

The basic requirements for Fellowship are as follows:

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

A full list of the requirements can be found at facs.org/member-services/join/fellows.

Associate Fellows who are current with their membership dues may submit a waived-fee application online by visiting facs.org/member-services/join and clicking on the link for either Fellow or International Fellow. You will need your log-in information to access the application. If you do not have your log-in, contact the College staff at 800-293-9623 or chicks@facs.org for assistance.

The application requests basic information regarding licensure, certification, education, and current hospital affiliations. Applicants also must list the names of five Fellows of the College, preferably from their current practice location, to serve as references. Applicants do not need to request letters, but rather list the names on the application, and the College staff will contact references.

If you need assistance finding Fellows of the College
The ACS admits to its Fellowship only those surgeons whose professional activity is devoted to surgical practice and who agree to practice by the professional and ethical standards of the College.

in your area, you may view a list on the ACS website (click on the “Find a Surgeon” tab).

Applications must be submitted by December 31 to be considered for induction at the Clinical Congress 2016 in Washington, DC. When your application is processed, you will receive an e-mail notification providing more information about the application timetable along with a request for your surgical case list. The College provides several options for the submission of your surgical case list.

U.S. and Canadian Fellowship applicants are required to attend a personal interview with members of an ACS committee in their local area. Exceptions are made for military applicants and in certain rural areas. Following the interview, you will receive notification by July 15 of the action taken on your application. Approved applicants are designated as Initiates to be inducted as Fellows at the Convocation Ceremony at the Clinical Congress, usually held in October.

Contact the staff at any time throughout the application process. We look forward to you becoming a Fellow of the American College of Surgeons. ♦

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You provide the expertise, we provide the connection

surgeonjobs.facs.org

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- SEARCH our resume database of qualified candidates
- MANAGE jobs and applicant activity right on our site
- LIMIT applicants only to those who are qualified
- FILL your jobs more quickly with great talent

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- POST multiple resumes and cover letters, or choose an anonymous career profile that leads employers to you
- SEARCH and apply to hundreds of fresh jobs on the spot with robust filters
- SET UP efficient job alerts to deliver the latest jobs right to your inbox
- ASK the experts advice, resume writing, career assessment test services and more
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**Practicing Surgeons Webcast Packages**
Earn CME credit and claim self-assessment credit for each webcast. Receive a CME certificate with self-assessment credit upon successful completion of viewing the webcast and completing the posttest.

**Resident Webcast Packages**
View webcasts on demand. Individualize your education. Receive a certificate of completion.

**Choose one of the three webcast packages below:**

**2015 Complete Package**
Access all 118 webcast sessions from Clinical Congress 2015 and MP3 audio recordings of all Named Lectures and most Panel Sessions. More than 175 CME credits and 175 self-assessment credits are available for practicing surgeons.

<table>
<thead>
<tr>
<th>For Practicing Surgeons*</th>
<th>For Residents</th>
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<tr>
<td>Member $575</td>
<td>Non-Member $625</td>
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**2015 Webcast Package**
Access all 118 webcast sessions from Clinical Congress 2015.

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**Pick 25 of 2015**
Select 25 of the 118 webcast sessions from Clinical Congress 2015.

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<td>Member $325</td>
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*Practicing surgeons may earn CME credit and claim self-assessment credit.

For more information, visit [www.facs.org/education/resources/elearning/webcasts](http://www.facs.org/education/resources/elearning/webcasts) or contact Olivier Petinaux at 866-475-4696 or elearning@facs.org.
International ACS NSQIP and Surgical Education Scholarships awarded

The American College of Surgeons (ACS) International Relations Committee (IRC) cosponsored two International ACS National Surgical Quality Improvement Program (ACS NSQIP®) Scholarships and two International Surgical Education Scholars this year.

The International ACS NSQIP Scholarships enable surgeons from outside North America who are interested in surgical quality improvement to attend the annual ACS NSQIP National Conference. The scholarships are cosponsored by ACS Quality Programs. The application deadline for the 2016 International ACS NSQIP Scholarships is February 15, 2016, for attendance at the annual conference in San Diego, CA, July 16–19.

The 2015 awardees, Li Chun Hsee, MB, BChir, FACS, a general surgeon at Auckland City Hospital, New Zealand, and Okechukwu Hyginus Ekwunife, MD, BS, consultant pediatric surgeon at Nnamdi Azikiwe University Teaching Hospital, Nnewi, Nigeria, attended the ACS NSQIP conference this July in Chicago, IL, and visited several ACS NSQIP participating surgery centers tailored to their particular interests.

The two International Surgical Education Scholars attended the annual Clinical Congress this October in Chicago, a program that is cosponsored by the ACS Division of Education. Ramzi Alami, MD, FACS, a general surgeon, American University of Beirut, Lebanon, and Daniel K. Ojuka, MD, faculty, department of surgery, University of Nairobi, Kenya, attended the Surgical Education: Principles and Practices session and other programs at the Clinical Congress. They also gave brief public addresses about their work before going on to visit several ACS-approved centers for surgical education.

The application deadline for the 2016 International Surgical Education Scholarship program is May 2, 2016. The awardees will attend the 2016 Clinical Congress in Washington, DC. The program requirements will be published soon.

♦
Surgeons from the Royal Australasian College of Surgeons and the American College of Surgeons (ACS) Australia-New Zealand (ANZ) Chapter, the Japan Surgical Society and ACS Japan Chapter, and the German Surgical Society with the ACS Germany Chapter attended the 2015 Clinical Congress in October.

The International Relations Committee (IRC) of the College sponsors the three academic surgeon exchange programs that made possible the young scholars’ participation in the Clinical Congress. In all three cases, the College sends a talented young U.S. or Canadian Fellow to the annual surgical meeting of the participating country. Afterward, they tour several sites tailored to their specific research interests. In exchange, the College accepts fine young academic surgeon-scholars from the participating societies to attend the annual ACS Clinical Congress. This year’s participants in the exchange program were as follows.

The 2015 ANZ Exchange Fellow is Anita R. Skandarajah, MB, BS, FRACS, senior lecturer and consultant breast and endocrine surgeon, University of Melbourne and the Peter MacCallum Cancer Centre. Dr. Skandarajah conducts research in clinical outcomes in surgical oncology and emergency general surgery.

Her U.S. counterpart, Clifford S. Cho, MD, FACS, is a surgical oncologist and associate professor of surgery at the University of Wisconsin-Madison. He attended the Annual Scientific Congress of the Royal Australasian College of Surgeons held in Perth, Australia, in April 2015.

The College welcomed Japan Exchange Fellow Yoshito Tomimaru, MD, PhD, assistant professor of surgery, Osaka University, to this year’s Clinical Congress. Dr. Tomimaru conducts research into the activity of exosome-derived microRNA associated with hepatobiliary and pancreatic cancer.

Suresh Agarwal, MD, FACS, chief, section of trauma, acute care surgery, burn and surgical critical care, University of Wisconsin-Madison, attended the Japan Surgical Society meeting in Nagoya in April 2015.

Nikolaos Vassos, MD, PhD, an endocrine and colorectal surgeon, University Hospital Erlangen, Germany, attended the ACS Clinical Congress this year and visited several surgical sites under the guidance of his U.S. and German mentors. Dr. Vassos’ surgical research centers on sarcomas, gastrointestinal stromal tumors, and pancreatic tumors. He also consults in coloproctology.

ACS Traveling Fellow Cristina R. Ferrone, MD, FACS, assistant professor of surgery, Massachusetts General Hospital, Boston, attended the German Surgical Society’s annual meeting in Munich in May 2015.

For more information about the IRC’s Traveling Fellowships, go to www.facs.org/member-services/scholarships/traveling. ♦
Apply for Heller School Executive MBA for Physicians Program by December 1

The Heller School of Brandeis University, Waltham, MA, is now offering an Executive Master of Business Administration (MBA) for Physicians. The program will focus on improving patient care experiences, clinical outcomes, and operational results in health care institutions and organizations by training physician leaders in a blend of medicine and management.

The application deadline is December 1.

The program, designed for practicing physicians who are presently in or who aspire to serve in management or leadership positions, integrates the physician's medical expertise with new knowledge. Critical areas covered will range from health care policy and economics to operational systems management, high-performance leadership, and health care innovation.

The degree is structured as an accelerated 16-month program with four 10-day residential sessions. Students will spend off-campus time taking webinars, pursuing individual study and preparation, and engaging in online blended learning. Openings are available for up to 30 physicians, who will participate in several major projects over the period of the course (January 2016–May 2017).

American College of Surgeons members are eligible for a significant tuition discount. The description and online application information for this program are located at www.heller.brandeis.edu/physiciansemba. The application deadline for the Executive MBA for Physicians is December 1.

SCHOLARSHIPS

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<thead>
<tr>
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Calendar of events

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

**NOVEMBER**

Southwestern Pennsylvania Chapter November 4
Pittsburgh, PA
Contact: James Ireland, jireland@acms.org, www.acms.org/spec/ACS/index.html

South Korea Chapter November 5–7
Seoul, South Korea
Contact: Sun-Whe Kim, sunwkim@plaza.snu.ac.kr

Connecticut Chapter November 6
Farmington, CT
Contact: Christopher Tasik, info@ctacs.org, www.ctacs.org

Keystone Chapter November 6
Scranton, PA
Contact: Robb-Ann Cook, rcook@pamedsoc.org, www.keystonesurgeons.org

Wisconsin Surgical Society November 13–14
Kohler, WS
Contact: Terry Estness, wisurgical@att.net, www.wisurgicalsociety.com

Arizona Chapter November 14–15
Scottsdale, AZ
Contact: Ross Goldberg, ross_goldberg@dmgaz.org, www.azacs.org

**DECEMBER**

Massachusetts Chapter December 5
Boston, MA
Contact: Crystal Beatrice, cbeatrice@prri.com, www.mcas.org

New Jersey Chapter December 5
Iselin, NJ
Contact: Andrea Donelan, njsurgeons@aol.com, www.nj-acs.org

**JANUARY 2016**

Louisiana Chapter January 15–16
New Orleans, LA
Contact: Janna Pecquet, janna@laacs.org, www.laacs.org

Southern California Chapter January 15–17
Santa Barbara, CA
Contact: James Dowden, jdowden@prodigy.net, www.socalsurgeons.org

**FEBRUARY**

Montana and Wyoming Chapter & Idaho Chapters February 5–7
Sun Valley, ID
Contact: Cyan R. Sportsman, csportsman@msurgical.com

Puerto Rico Chapter February 18–20
San Juan, PR
Contact: Aixa Velez-Silva, acspuertoricochapter@gmail.com, www.acspuertoricochapter.org

North Texas Chapter February 19–20
Dallas, TX
Contact: Carrie Steffen, carrie@steffenmanagement.com www.ntexas.org

South Texas Chapter February 25–27
San Antonio, TX
Contact: Janna Pecquet, janna@southtexasacs.org, www.southtexasacs.org

**FUTURE CLINICAL CONGRESSES**

2016
October 16–20
Washington, DC

2017
October 22–26
San Diego, CA

2018
October 21–25
Boston, MA