The ethics of sharing clinical photographs
Contents

FEATURES

Graduate of the first acute care surgery fellowship program reflects on the experience 11
Daniel Wu, DO, FACS, FACOS

COVER STORY: Sharing clinical photographs: Patient rights, professional ethics, and institutional responsibilities 17
Jacquelyn M. Means, MD; Ira J. Kodner, MD, FACS; Douglas Brown, PhD; and Shuddhadeb Ray, MD, MPHS

Advocacy and grassroots: Leveraging local issues at the national level 23
Michael Carmody and Katie Oehmen

YFA Essay Contest: Introduction 28
Carlos A. Pellegrini, MD, FACS, FRCS(Hon), FRCSI(Hon), FRCSEd(Hon)

YFA Essay Contest winner: Promise of the profession: The chance to be human 29
Ellen Thomason, MD, MPH, FACS

Connect with the College.

Twitter.com/AmCollSurgeons
Twitter.com/ACSTrauma
Twitter.com/CoC.ACS
Twitter.com/NAPBC_ACS

Facebook.com/AmCollSurgeons
Facebook.com/ACSTrauma
Facebook.com/RASACS
Facebook.com/NAPBC.acs

YouTube.com/AmCollegeofSurgeons

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

### COLUMNS

<table>
<thead>
<tr>
<th>Column</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Looking forward</td>
<td>8</td>
</tr>
<tr>
<td>David B. Hoyt, MD, FACS</td>
<td></td>
</tr>
<tr>
<td>What surgeons should know about… The final rule on the Medicare Shared Savings Program</td>
<td>31</td>
</tr>
<tr>
<td>Neha Agrawal, MPH</td>
<td></td>
</tr>
<tr>
<td>Dispatches from rural surgeons: Improving access to surgical care in rural America: An interview with J. David Richardson</td>
<td>34</td>
</tr>
<tr>
<td>Mark W. Puls, MD, FACS</td>
<td></td>
</tr>
<tr>
<td>ACS Clinical Research Program: Improving resection rates in borderline resectable pancreatic cancer: Pilot study shows favorable results</td>
<td>39</td>
</tr>
<tr>
<td>Matthew H. G. Katz, MD, FACS; Syed A. Ahmad, MD, FACS; and Judy C. Boughey, MD, FACS</td>
<td></td>
</tr>
<tr>
<td>Your ACS benefits: ACS educational awards and MyCME</td>
<td>42</td>
</tr>
<tr>
<td>Kate Early, MA; Ajit K. Sachdeva, MD, FACS, FRCS; Alisa Nagler, JD, MA, EdD; and Jim Reeder, MS</td>
<td></td>
</tr>
</tbody>
</table>

### NEWS

<table>
<thead>
<tr>
<th>Article</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>A look at The Joint Commission: High reliability science and surgery: The Joint Commission’s Robust Process Improvement methodology</td>
<td>45</td>
</tr>
<tr>
<td>Carlos A. Pellegrini, MD, FACS, FRCSI(Hon), FRCS(Hon), FRCSEd(Hon)</td>
<td></td>
</tr>
<tr>
<td>NTDB data point: Fireworks</td>
<td>47</td>
</tr>
<tr>
<td>Richard J. Fantus, MD, FACS</td>
<td></td>
</tr>
<tr>
<td>ACS NSQIP conference: 10 years of putting the patient first</td>
<td>49</td>
</tr>
<tr>
<td>Jeannie Glickson</td>
<td></td>
</tr>
<tr>
<td>JACS receives highest impact factor to date</td>
<td>55</td>
</tr>
<tr>
<td>In memoriam: Dr. Norman McSwain, a pioneer in comprehensive trauma care</td>
<td>56</td>
</tr>
<tr>
<td>Will Chapleau, RN, EMT-P, and Ronald M. Stewart, MD, FACS</td>
<td></td>
</tr>
<tr>
<td>AMA HOD Annual Meeting sparks adoption of new policies</td>
<td>59</td>
</tr>
<tr>
<td>John H. Armstrong, MD, FACS, and Jon H. Sutton, MBA</td>
<td></td>
</tr>
</tbody>
</table>

### SCHOLARSHIPS

<table>
<thead>
<tr>
<th>Scholarship</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apply now for 2016 Nizar N. Oweida, MD, FACS, Scholarship</td>
<td>77</td>
</tr>
<tr>
<td>Applications now being accepted for 2016–2018 Faculty Research Fellowships honoring ACS leaders</td>
<td>78</td>
</tr>
</tbody>
</table>

### MEETINGS CALENDAR

<table>
<thead>
<tr>
<th>Calendar of events</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>80</td>
</tr>
</tbody>
</table>
The American College of Surgeons is dedicated to improving the care of the surgical patient and to safeguarding standards of care in an optimal and ethical practice environment.

EDITOR-IN-CHIEF
Diane Schneidman

DIRECTOR, DIVISION OF INTEGRATED COMMUNICATIONS
Lynn Kahn

SENIOR EDITOR
Tony Peregrin

EDITORIAL & PRODUCTION ASSISTANT
Matthew Fox

CONTRIBUTING EDITOR
Jeannie Glickson

SENIOR GRAPHIC DESIGNER/PRODUCTION MANAGER
Tina Woelke

EDITORIAL ADVISORS
Charles D. Mabry, MD, FACS
Leigh A. Neumayer, MD, FACS
Marshall Z. Schwartz, MD, FACS
Mark C. Weissler, MD, FACS

FRONT COVER DESIGN
Tina Woelke

Letters to the Editor should be sent with the writer's name, address, e-mail address, and daytime telephone number via e-mail to dschneidman@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.

Call FOR SUBMISSIONS

The American College of Surgeons Division of Education welcomes submissions to the following programs to be considered for presentation at Clinical Congress 2016, October 16–20, Washington, DC.

Scientific Forum

ORAL PRESENTATIONS*
16 Excellence in Research Awards were given in 2015

SCIENTIFIC POSTER PRESENTATIONS
Eight posters were selected for the Posters of Exceptional Merit program in 2015

Video-Based Education

VIDEO PRESENTATIONS

Submit Information

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

*Accepted authors are encouraged to submit full manuscripts to JACS.
Officers and Staff of the American College of Surgeons

Officers
Andrew L. Warshaw, MD, FACS
President
Carlos A. Pellegrini, MD, FACS
Seattle, WA
Immediate Past-President
Jay L. Grosfeld, MD, FACS
Indianapolis, IN
First Vice-President
Kenneth L. Mattox, MD, FACS
Houston, TX
Second Vice-President
Edward E. Cornwell III, MD, FACS, FCCM
Sacramento, CA

Officers-Elect
J. David Richardson, MD, FACS
Louisville, KY
President-Elect
Ronald V. Maier, MD, FACS
Washington, DC
Secretary
William G. Cioffi, Jr., MD, FACS
Providence, RI
Treasurer
David B. Hoyt, MD, FACS
Chicago, IL
Executive Director
Gay L. Vincent, CPA
Chicago, IL
Chief Financial Officer

Board of Regents
*Mark C. Weissler, MD, FACS
Chapel Hill, NC
Chair
*Valerie W. Rusch, MD, FACS
New York, NY
Vice-Chair
John L. D. Atkinson, MD, FACS
Rochester, MN
Margaret M. Dunn, MD, FACS
Dayton, OH
James K. Elsey, MD, FACS
Atlanta, GA
Henri R. Ford, MD, FACS
Los Angeles, CA
Julie A. Freischlag, MD, FACS
Sacramento, CA

Gerald M. Fried, MD, FACS, FRCS
Montreal, QC
James W. Gigantelli, MD, FACS
Omaha, NE
B. J. Hancock, MD, FACS, FRCS
Winnipeg, MB
Enrique Hernandez, MD, FACS
Philadelphia, PA
Lenworth M. Jacobs, Jr., MD, FACS
Hartford, CT
L. Scott Levin, MD, FACS
Philadelphia, PA
Mark A. Malangoni, MD, FACS
Philadelphia, PA
Raymond F. Morgan, MD, FACS
Charlottesville, VA
Leigh A. Neumayer, MD, FACS
Tucson, AZ
Marshall Z. Schwartz, MD, FACS
Philadelphia, PA
Howard M. Snyder III, MD, FACS
Philadelphia, PA
Beth H. Sutton, MD, FACS
Wichita Falls, TX
*Andrew L. Warshaw, MD, FACS
Boston, MA
Steven D. Wexner, MD, FACS
Winston, FL
*Michael J. Zinner, MD, FACS
Boston, MA

Executive Committee

Board of Governors/Executive Committee
Fabrizio Michelassi, MD, FACS
New York, NY
Chair
Karen Bray, MD, FACS
Portland, OR
Vice-Chair
James C. Dennenby III, MD, FACS
Alexandria, VA
 Secretary
Kevin E. Behrens, MD, FACS
Gainesville, FL
Diana L. Farmer, MD, FACS
Sacramento, CA
Steven C. Stain, MD, FACS
Albany, NY
Joseph J. Tepas III, MD, FACS
Jacksonville, FL

Advisory Council to the Board of Regents
(Past-Presidents)
Kathryn D. Anderson, MD, FACS
Eastvale, CA

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

Executive Staff
EXECUTIVE DIRECTOR
David B. Hoyt, MD, FACS

DIVISION OF ADVOCACY AND HEALTH POLICY
Frank G. Opelka, MD, FACS
Medical Director, Quality and Health Policy
Patrick V. Bailey, MD, FACS
Medical Director, Advocacy
Christian Shaligian

AMERICAN COLLEGE OF SURGEONS FOUNDATION
Martin H. Wojcik
Executive Director

ALLIANCE/AMERICAN COLLEGE OF SURGEONS
CLINICAL RESEARCH PROGRAM
Kelly Hunt, MD, FACS
Chair

CONVENTION AND MEETINGS
Felix Niespodziewanski
Director

DIVISION OF EDUCATION
Ajit K. Sachdeva, MD, FACS, FRCS
Director

EXECUTIVE SERVICES
Jane L. Lee-Kwon, MPS
Director, Executive Operations

MAXINE ROGERS
Director, Leadership Operations

FINANCE AND FACILITIES
Gay L. Vincent, CPA
Director

HUMAN RESOURCES AND OPERATIONS
Michelle McGovern
Director

INFORMATION TECHNOLOGY
Howard Tanzman
Director

DIVISION OF INTEGRATED COMMUNICATIONS
Lynn Kahn
Director

JOURNAL OF THE AMERICAN COLLEGE OF SURGEONS
Timothy J. Eberlein, MD, FACS
Editor-in-Chief

DIVISION OF MEMBER SERVICES
Patricia L. Turner, MD, FACS
Director

M. Margaret Knudson, MD, FACS
Medical Director, Military Health Systems Strategic Partnership

Girma Tefera, MD, FACS
Director, Operation Giving Back

PERFORMANCE IMPROVEMENT
Will Chapleau, RN, EMTP
Director

DIVISION OF RESEARCH AND OPTIMAL PATIENT CARE
Clifford Y. Ko, MD, MS, FACS
Director

Cancer:
David P. Winchester, MD, FACS
Medical Director

Trauma:
Michael F. Rotondo, MD, FACS
Medical Director
Author bios*

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

MS. AGRAWAL (a) is Regulatory Associate, American College of Surgeons (ACS) Division of Advocacy and Health Policy, Washington, DC.

DR. AHMAD (b) is professor of surgery and associate director, University of Cincinnati Cancer Institute, and director, Pancreas Disease Center, University of Cincinnati, OH. He is a member of the Gastrointestinal Committee of the Southwest Oncology Group and is surgical chair of the hepatobiliary subcommittee.

DR. ARMSTRONG (c) is Surgeon General and Secretary, Florida Department of Health, Tallahassee. He serves on the ACS Board of Governors and the ACS Health Policy and Advocacy Group.

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

DR. BROWN (e) is surgical education coordinator, department of surgery, Washington University School of Medicine, St. Louis, MO.

MR. CARMODY (f) is Government Affairs Coordinator, ACS Division of Advocacy and Health Policy.

MR. CHAPELÉAU (g) is Director, Performance Improvement, ACS Executive Services, Chicago, IL, and former Manager of the ACS Advanced Trauma Life Support® program. He is chairman, Prehospital Trauma Life Support Committee, National Association of Emergency Medical Technicians.

MS. EARLY (h) is International Liaison and Scholarships Administrator, ACS Division of Member Services, Chicago, IL.

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

continued on next page
**MS. GLICKSON** (j) is Communications Associate, ACS Division of Integrated Communications, Chicago, IL.

**DR. KATZ** (k) is associate professor, department of surgical oncology, University of Texas MD Anderson Cancer Center, Houston. He is a member of the Gastrointestinal Committee, leads the Cancer Care Standards Development Committee of the Alliance for Clinical Trials in Oncology, and is the recipient of the Alliance 2012 Clinical Scholar Award.

**DR. KODNER** (l) is emeritus professor of surgery, Washington University School of Medicine, St. Louis, MO.

**DR. MEANS** (m) is a postgraduate year (PGY)-4 obstetrics and gynecology resident, University of Texas Southwestern Medical Center, Dallas.

**DR. NAGLER** (n) is Assistant Director for Accreditation, Validation, and Credentialing, ACS Division of Education, Chicago, IL.

**MS. OEHMEN** (o) is ACSPA-SurgeonsPAC Associate, ACS Division of Advocacy and Health Policy.

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

**DR. PULS** (q) is a general surgeon in Alpena, MI, an ACS Governor, and a member of the ACS Advisory Council for Rural Surgery.

*continued on next page*
Author bios continued

DR. RAY (r) is a PGY-3 general surgery resident, Washington University School of Medicine.

MR. REEDER (s) is Senior Manager, Validation and Credentialing, ACS Division of Education.

DR. SACHDEVA (t) is Director, ACS Division of Education.

DR. STEWART (u) is professor and chair, department of surgery, University of Texas Health Science Center, San Antonio. He is Chair, ACS COT.

MR. SUTTON (v) is Manager, State Affairs, ACS Division of Advocacy and Health Policy.

DR. THOMASON (w) is a vascular surgeon and medical director of safety, Providence Regional Medical Center, Everett, WA, and Chair, ACS Young Fellows Association Communications Workgroup.

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

DR. WU (y) is associate trauma program medical director, Lancaster General Health, PA.
The practice of surgery grows ever more complex, with greater demands for health care professionals to accept accountability for patient outcomes, the development of new code sets and payment formulas, and the need to be responsive and provide quality care to an aging population. As surgeons seek to comply with new regulatory and legislative mandates and develop the skills necessary to provide coordinated, team-based patient care, the American College of Surgeons (ACS) staff and volunteers are continually working to provide our Fellows with the resources, services, and educational opportunities they need to thrive.

In fact, I would argue the need for professional societies like the ACS has never been greater. In times of uncertainty, professional societies have the intellectual property, if you will, that members need to cope with the challenges of modern-day practice. We have the authority to influence and manage change and to serve as trusted collaborators with other groups and government agencies that are committed to finding solutions to the health care-related problems facing the nation.

ACS intellectual property

Some examples of the College’s intellectual property include our advocacy, quality improvement, and educational programs.

Our team in the Division of Advocacy and Health Policy (DAHP) analyzes bills, regulations, and proposed policies to determine how they will affect surgeons and their patients. Likewise, they work with lawmakers and rule-makers to help them better understand the impact of their decisions. They provide ACS members with the tools and resources they need to influence public policy, such as the ACS Professional Association’s SurgeonsVoice program (www.surgeonsvoice.org). They also disseminate valuable information to members on how to comply with policy demands and still grow a thriving practice in an era of value-based purchasing with the following tools and resources:

- A monthly e-newsletter, The ACS Advocate
- E-mail alerts
- Regular articles and columns in the Bulletin
- Primers on medical liability, hospital employment, and practice management issues
- Coding workshops

In times of uncertainty, professional societies have the intellectual property, if you will, that members need to cope with the challenges of modern-day practice. We have the authority to influence and manage change and to serve as trusted collaborators with other groups and government agencies that are committed to finding solutions to the health care-related problems facing the nation.
Furthermore, the College collaborates with other organizations and stakeholders so that we can pool our resources and talent to improve patient care.

In addition, the DAHP works with the Division of Member Services to present the Annual Leadership & Advocacy Summit, which comprises a range of presentations on effective surgical advocacy and opportunities for surgeons to meet with members of Congress and their staffs on Capitol Hill.

The Division of Research and Optimal Patient Care offers the ACS National Surgical Quality Improvement Program to hospitals seeking to benchmark and improve outcomes. This area of the College has developed quality improvement programs that are specific to certain specialties or disciplines of surgery, including the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program, the Trauma Quality Improvement Program, pediatric quality improvement programs, cancer programs, and many more. Furthermore, this division is developing a quality manual for surgical quality officers to use in their efforts to lead departments of surgery to new levels of high reliability. Additionally, the Committee on Trauma and Commission on Cancer, which fall under the aegis of this division, run programs that verify that trauma and cancer centers are meeting the College’s standards.

Our Division of Education offers programs that allow surgeons to experience the joy of lifelong learning and comply with the surgical boards’ standards for Maintenance of Certification. The most high-profile example would be this month’s Clinical Congress. However, the College also offers programs that enable surgeons to learn about leading surgical teams, such as the Surgeons as Leaders: From Operating Room to Boardroom and the Residents as Teachers and Leaders courses. Furthermore, the Division of Education provides members with opportunities to review clinical guidelines for care through the Evidence-Based Decisions in Surgery program and to sharpen their skills and knowledge through the Surgical Education and Self-Assessment Program. Moreover, in the face of concerns that surgical trainees have expressed about their confidence in entering surgical practice after residency, the College has developed a Transition to Practice in General Surgery program. This College offering allows individuals who have completed their training to work under the supervision of experienced surgeons for a period of time before they enter practice.

Collaboration

Furthermore, the College collaborates with other organizations and stakeholders so that we can pool our resources and talent to improve patient care. For example, at last year’s Clinical Congress, Jonathan Woodson, MD, FACS, Assistant Secretary of Defense for Health Affairs, and I signed an agreement to form the Military Health System (MHS) Strategic Partnership with the American College of Surgeons. As a result, the MHS and the ACS are working together to ensure that surgeons are better prepared to provide services often learned on the battlefield, sharing educational opportunities and developing systems-based approaches to care and practice guidelines.

One project that the MHS and the College have worked on together, along with law enforcement, emergency medical services, and public health agencies and organizations, is the development of the Hartford Consensus. The Hartford Consensus statements on improving survival from active shooter and mass casualty events were generated by a joint committee convened by ACS Regent Lenworth M. Jacobs, Jr., MD, MPH, FACS. The committee’s years of work culminated in the following:
To continue to thrive in the next 100 years, the College’s leadership recognizes that we cannot rest on our laurels. To remain relevant to the next generation of surgeons we must continue to provide clarity in increasingly complex times.

- Publication of Strategies to Enhance Survival in Active Shooter and Intentional Mass Casualty Events: A Compendium, which you received with last month’s Bulletin
- The issuance of a Presidential Policy Directive on national preparedness
- On September 29, roll out of the National Security Council’s Stop the Bleed program (see inside front cover)

Another collaborative effort that should benefit many patients is being led by ACS Past-President L.D. Britt, MD, MPH, DSc(Hon), FACS, FCCM, FRCSEng(Hon), FRCSEd(Hon), FWACS(Hon), FRCSI(Hon), FCS(SA)(Hon), FRCSGlasg(Hon). Dr. Britt has worked to establish a partnership with the National Institute on Minority Health and Health Disparities (NIMHD) to improve access to surgical care for all Americans, regardless of race, ethnicity, age, socioeconomic status, and other demographic factors. Given the College’s history with quality improvement programs and the NIMHD’s considerable research and scientific resources, this partnership has the potential to expand access to surgical care for all Americans. As a first step in developing a research agenda for eliminating variations in patient care, the ACS and the NIMHD convened a highly successful meeting this past summer. The work has just begun but promises to open the door to care for many underserved Americans.

The next 100 years
The efforts described here ensure that our members have the knowledge and resources they need to ensure that their patients receive the appropriate surgical care. And whereas these programs and collaborative efforts signal the College’s commitment to advocacy, education, and quality improvement, your membership in the ACS and use of the FACS insignia demonstrate to the public that you are committed to upholding our shared values.

To continue to thrive in the next 100 years, the College’s leadership recognizes that we cannot rest on our laurels. To remain relevant to the next generation of surgeons we must continue to provide clarity in increasingly complex times. We must invest in a resilient, well-informed, talented staff and focus on the practical needs of our members. We must embrace new member communication channels and collaborate with other committed stakeholders. We must be the essential force driving quality improvement and be the trusted source of meaningful clinical solutions. We must be the organization that unites, builds consensus, and cuts through uncertainty. The ACS leadership and staff are committed to achieving these objectives and to proving that now, more than ever, membership in the College has real value.

If you have comments or suggestions about this or other issues, please send them to Dr. Hoyt at lookingforward@facs.org.
Graduate of the first acute care surgery fellowship program reflects on the experience

by Daniel Wu, DO, FACS, FACOS

HIGHLIGHTS

- Describes growing concern about the maldistribution of the general surgery workforce—particularly its effect on emergency and trauma care
- Defines acute care surgery as a new specialty encompassing trauma, critical care, and emergency care with general surgery at its core
- Explains how the first acute care surgery training program was established at the University of Nevada
- Describes the potential impact of the specialty in ensuring patients receive timely, effective emergency care
In recent decades, one of the overwhelming issues in hospital care has been overcrowding in emergency departments (ED). The general public’s increasing use of the ED, paired with inadequate staffing and resources to meet this demand, has resulted in long wait times for patients in need, ambulance diversions to other centers, and compromises in overall patient safety and care. As a result, patients are being forced to delay care and are expressing a general sense of dissatisfaction. The backlog of patients creates a barrier to the throughput in and out of the ED. This unfortunate reality has led the Institute of Medicine to suggest that emergency medicine has reached its breaking point, particularly in rural hospitals.\(^1\) Urgent care centers and retail clinics provide some relief from ED congestion by providing care to patients who are experiencing easy-to-manage illnesses and injuries. As a result, the most common reasons for presentation to the ED are major injuries and abdominal pain, which create a pressing need for general and trauma surgeons who are able to evaluate these patients in a timely way.\(^2,3\)

This article addresses how acute care surgeons can help alleviate some of these concerns, describes the development and establishment of the first acute care surgery fellowship, and outlines the important role acute care surgeons can play in the changing health care delivery system.

**General surgery workforce issues**

According to Solucient—an analytical tool providing evidence-based performance improvement suggestions for health care professionals—the recommendation for general surgery coverage is six general surgeons per 100,000 people.\(^4\) The Association of American Medical Colleges estimates that the U.S. is experiencing an overall deficit of 13,700 physicians.\(^5\) Recent projections suggest that by 2025, the physician shortage may rise to more than 90,000, including a shortage of 31,000 surgeons.\(^6\) Even if the Accreditation Council for Graduate Medical Education (ACGME) approved 10,000 additional resident positions, a large gap in the supply and demand of physicians would remain.\(^7\)

In addition to physician shortage concerns, a shift toward specialization is becoming more prevalent, with an increase in the number of specialist surgeons and a decline in the number of general surgeons, especially those exclusively performing general surgery. The nationwide trend toward use of minimally invasive techniques and the growing restrictions on duty hours limit the operative experience available to surgical residents in training. Furthermore, priorities are changing in the younger generations of physicians. Considerations collectively described as “lifestyle,” which include scheduling, workload, and family life, have risen as driving factors in determining the field of medicine that residents pursue. Moreover, increasing numbers of trainees are choosing fellowships in more specialized fields.

The discipline of surgery has become increasingly specialized for multiple reasons, including rapid expansion of medical knowledge, advances in techniques and technologies, and a rise in patient demands stemming from the proliferation of health care information on the Internet. This rapid expansion of the subspecialties has resulted in the creation of more centers of excellence and centralization of care, which has the unintended effect of further limiting patients’ access to optimal care.

Another consequence of this shift toward specialization is that specialty surgeons often are reluctant to take emergency general surgery call for the following reasons:

- It shifts the focus of their practice away from their specialty.
The discipline of surgery has become increasingly specialized for multiple reasons, including rapid expansion of medical knowledge, advances in techniques and technologies, and a rise in patient demands stemming from the proliferation of health care information on the Internet.

- They prefer to avoid getting involved with problems outside their area of expertise.
- General surgery call would increase their exposure to liability.

Finally, whereas surgeons historically took general surgery call to build their client base or to maintain hospital admitting privileges, some specialty surgeons are now shifting the focus of their practices away from the hospital setting or to institutions without an ED.

Establishing an acute care specialty
These changes in the specialists’ preferences, coupled with the overcrowding of EDs, necessitate specific remedial changes that will ensure that patients have access to 24/7 emergency care provided by surgeons who have broad-based surgical and critical care skills and training. In response to this need, the American Association for the Surgery of Trauma (AAST) set out to create the specialty of acute care surgery. Jerry Jurkovich, MD, FACS, past-president of the AAST, in a column he wrote in 2007, said that the acute care surgeon should “be responsible for managing acute general surgical problems, covering general surgical and specialty services, providing surgical critical care, and managing acute trauma.” Dr. Jurkovich went on to assert that the acute care surgeon would require training in core general surgery, “as well as in thoracic, vascular, and gastrointestinal surgery, so as to not just allow but to encourage the development of a diverse elective surgical practice.”

In 2003, the Committee to Develop the Reorganized Specialty of Trauma, Surgical Critical Care, and Emergency Surgery was formed through a joint meeting of the American College of Surgeons Committee on Trauma, the AAST, the Eastern Association for the Surgery of Trauma, and the Western Trauma Association. In 2005, the AAST created the Acute Care Surgery Committee to establish the parameters for the new specialty’s training and practice. The committee determined that this new discipline would require broad-based surgical training, including elective and emergency general surgery; it would have a strong emphasis on trauma; and it would have, at its core, a surgical critical care residency approved by the ACGME. Since its inception, the Acute Care Surgery Committee has established acute care surgery as a singular specialty, with its own curriculum, site-verified program requirements, and a certificate of completion. In that time, acute care surgery has grown as a specialty and now has a major presence at many national surgical conferences.

The UNSOM experience
A total of 19 fellowship programs have been certified by the AAST as training facilities for the specialty of acute care surgery. The first of these was at the University of Nevada School of Medicine (UNSOM) in Las Vegas. As part of the first graduating class of acute care surgery fellows at UNSOM, I had the honor of being part of the development, training, and the completion of this new specialty. In my mind, acute care surgery encompasses a combination of trauma surgery and critical care surrounding a core of elective and emergency surgery. However, there are many types of surgical emergencies: orthopaedic, neurosurgical, and those that fall under the rubric of general surgery subspecialties including vascular, thoracic, and biliary. An acute care surgeon should be familiar with each of these disciplines.

Perhaps one of the purest examples of an acute care surgeon is the general surgeon who practices in a rural environment with little specialty support. This surgeon must be a “Renaissance person” capable of taking care of anything that may come through
the hospital door. This is the surgeon that one would hope to have in the hospital when a surgical emergency enters the building. This surgeon would be able to take care of some of the most critical patients during the worst possible times.

I wanted to be the surgeon who everyone could depend on when they needed me most. I was told that UNSOM was planning to become a training facility for acute care surgeons, and I jumped at the opportunity to become a part of this process. Although I was aware that the program did not exist when I applied for fellowship, I knew my training would likely be modeled on the acute care surgery curriculum, and I anticipated that I would need a second year of fellowship training to obtain additional skills in trauma. However, three months into my fellowship, my program director at UNSOM, John Fildes, MD, FACS, told me that the curriculum for the acute care surgery fellowship had been established and that the committee was ready to review applications to approve training programs in acute care surgery. Over the course of the next month, we furiously developed goals and objectives for all of the ACGME core competencies for each rotation that the acute care surgical fellow would be expected to complete. In addition to the predetermined rotations in emergency, neurological, orthopaedic, thoracic, trauma, and vascular surgery, we created curricula for interventional radiology, burn surgery, rural surgery, and colorectal surgery, among others. Most of these curricula had never been created, but we derived the information from programs that offered complete training fellowships in these specialties, and modified them for a surgical fellow.

After submitting the application for an acute care surgery fellowship, UNSOM became the first training institution to undergo a site visit for such a program in December 2007. An esteemed panel toured each of the UNSOM facilities and probed the faculty, fellows, and residents with questions about the desire, feasibility, and impact of having an acute care surgery fellowship at UNSOM. Our specific center, the
Perhaps one of the purest examples of an acute care surgeon is the general surgeon who practices in a rural environment without much specialty support. This surgeon must be a “Renaissance person” capable of taking care of anything that may come through the hospital door.

University Medical Center of Southern Nevada, Las Vegas, was in the unique situation of having no orthopaedic or neurological surgery residency programs and no fellows in vascular, thoracic, pediatric, or colorectal surgery. Thus, the faculty, caseload, and desire were abundant for training acute care surgeons in each of these disciplines without negatively affecting the training of other fellows. In the last few hours of their inspection, the ACGME representatives spoke to my co-fellow, Scott Cinelli, DO, and me, stating, “We’ll be keeping a close eye on your careers.” At that point I knew that we had passed the inspection and were on our way to becoming the first training program for acute care surgeons.

**Personal impressions**

The new curriculum for acute care surgery was innovative and unique. The rotations I completed provided experience in many different disciplines, and not simply at the level of a medical student or intern. In most respects, Dr. Cinelli and I were trained like specialty fellows. I gained knowledge in many domains, performed diverse surgeries and procedures, and earned a level of respect among the specialists for the ultimate care of our patients.

One of the most valuable rotations that I experienced was in trauma systems. This rotation was designed to familiarize us with the requirements of caring for trauma cases beyond the walls of the hospital. We attended meetings with the Southern Nevada Health District, spent time with the coroner witnessing autopsies, rode along with emergency medical services personnel when they responded to a call, and observed incident command tactics. This gave us additional experience and insight into what it takes for a trauma system to run smoothly—from the level of government offices down to each individual within the hospital.

**Benefits to the community**

How does acute care surgery benefit the hospital and community? In the eyes of the hospital, the acute care surgeon can fill many roles: as a trauma surgeon who can meet the day-to-day requirements of managing severely injured patients, as an intensivist who manages the critically ill and injured patients, and as a general surgeon who can ameliorate the paucity of general surgeons taking emergency call. All of these roles are fully integrated into the specialty of acute care surgery. Those surgeons who enter this specialty are fully aware of the requirements and expectations of taking in-house trauma and emergency general surgery call. For hospitals in small communities or in rural environments, the acute care surgeon has the expertise to stabilize critical patients so that they can be transported to more definitive specialty care. Those surgeons will likely become indispensable to these smaller centers, which often lack many specialists.

The crucial question for larger communities is whether acute care surgery only benefits suburban and rural communities and smaller hospitals. In fact, acute care surgeons and the acute care surgery model of staffing emergency rooms can improve patient access to on-call emergency surgeons. A recent study in the *Annals of Surgery* indicates that the acute care surgeon model improves care in acute appendicitis. In a large academic center, the ED was staffed by either a model analogous to acute care surgery (staffed by trauma/emergency surgeons) or a traditional general surgery model. Between September 1999 and August 2002, a total of 294 appendectomies were performed at this
The crucial question for larger communities is whether acute care surgery only benefits suburban and rural communities and smaller hospitals. Acute care surgeons and the acute care surgery model of staffing emergency rooms can improve patient access to on-call emergency surgeons.

The effect of acute care surgeons on other general surgeons also is positive; they complement each other. As previously stated, practice models are changing, and current graduating physicians place more emphasis on workload and lifestyle. To satisfy their desire for work-life balance, an increasing number of general surgery graduates continue their training to obtain subspecialty fellowships, which creates a potential shortage of practicing general surgeons. The availability of acute care surgeons to care for many of the emergency surgery patients will encourage more trainees to enter the field of general surgery because they will be able to maintain an elective practice with more consistent office hours and surgery schedules that are not disrupted by emergency consultations and add-on operations. In return, as an acute care surgeon, I experience the satisfaction of helping patients in their time of need, dealing with the diagnostic dilemmas of the presentation to the emergency room, and performing various complex procedures—all before I go home when my shift is done. ♦

Acknowledgments
The author would like to acknowledge the guidance and mentorship of Frederick B. Rogers, MD, MS, FACS, trauma program medical director, Lancaster General Health, PA, and John Fildes, MD, FACS, foundation professor; acting chair, surgery; chief, division of acute care surgery; and program director, acute care surgery fellowship, University of Nevada School of Medicine, Las Vegas.

REFERENCES
ETHICAL HANDLING OF PATIENT PHOTOS

Sharing clinical photographs:
Patient rights, professional ethics, and institutional responsibilities

by Jacquelyn M. Means, MD;
Ira J. Kodner, MD, FACS;
Douglas Brown, PhD;
and Shuddhadeb Ray, MD, MPHs
This article addresses a common ethical dilemma in modern surgical practice: sharing clinical photographs via mobile devices. To help surgeons and surgeons in training better understand and address the ethical considerations surrounding the exchange of clinical photographs with colleagues, the authors examine the following: the level of consent physicians should seek in these scenarios, how photographs may infringe upon patient rights to privacy and confidentiality, physician responsibility to uphold patient privacy, and security issues associated with the clinical use of mobile devices.

This article describes a common scenario in which a resident is seeking the advice of an on-call surgeon to consult on a patient case and is asked to share a photograph of the patient’s injury. Possible approaches to this dilemma are described, as are the ethical issues that need to be considered in choosing one option over another.

Option 1: The resident takes several photos of the hand injury with his personal mobile device and sends the photos via text message to the PRS.

The primary issue in Option 1 is whether the resident should obtain consent to take and share the clinical photographs that the consulting surgeon has requested. In current clinical practice, the spectrum of patient consent ranges from patients being completely unaware of the care decisions their treating physician is making to participating in shared decision making. Between these alternatives are several variations. For example, the physician might make the patient aware of the plan of care, offering limited but sufficient information, and/or an opportunity to object or ask questions. No single variation on the spectrum is inherently or categorically more correct than another.

Physicians acting at any point along the spectrum may be practicing ethical medicine, but their actions must be justified by the clinical context. For example, a number of everyday tasks, such as ordering a complete blood count, often are performed without much patient discussion. These types of clinical tasks are typically low-risk, routine hospital orders. On the other hand, when several management alternatives could
be implemented, each with its own risks and benefits (for example, selecting a cancer treatment), a lengthy discussion with the patient to obtain informed consent is required.

Where should medical photography fall on the spectrum? What are the current and future roles of these images? Are patient photographs most comparable to a procedure, treatment, physical exam element, or diagnostic tool? In the case presented, if the images are intended solely to give the consulting PRS a better understanding of the degree of damage, the photographs arguably are being used both as a diagnostic tool—similar to an X-ray—and as a physical exam component.

If a health care professional accepts this analogy, then consider the type of consent typically obtained for these actions. The patient is informed of the physician's orders, is given justification, and is provided with an opportunity to object or to ask questions. If the patient consents, the physician continues with the proposed action. If clinical photographs are analogous to diagnostics and physical exams, should the physician take the same approach to patient consent?

Although clinical photography may have functional similarities to physical exams and diagnostics, it could be argued that sharing clinical photography poses a greater risk of breaching patient privacy, the deleterious consequences of which outweigh the benefit of expedited medical care. The concern is that, as technology advances and increased connectivity facilitates the exchange of digital images, the creation of such digital photos may threaten a patient's right to privacy and confidentiality. With such a risk in mind, the consent process detailed earlier in this article may seem less appropriate. The patient is informed neither of the intended use(s) of the photographs nor of the possible endangerment of his confidentiality.

But is this patient's confidentiality truly at risk? In clinical photography, personal identifiable information (PII) is defined as any physical feature that might easily distinguish a patient, such as facial features, birthmarks, and tattoos. Under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, “full face photos and any other comparable images” are considered “direct identifiers.” In the case presented, it is safe to assume that the resident plans to limit the photographs to the patient’s injured hand, which has none of these identifiers. If these particular photos are shared, is there a risk of breaching the patient’s privacy and confidentiality? To answer this question, one must determine what constitutes “other comparable images.”

This vague phrase leaves it up to the photographer who, in this case, is the treating physician, to determine if the physical attributes included in the image reveal PII.

One could argue that the definition of PII ought to be extended to include all potentially unique physical features, including limbs, digits, joints, skin color, and unique injuries. On the other hand, another physician may believe PII is strictly limited to unique markings and the face. A similar argument would be that the “full-face photos and any other comparable images” reference in the HIPAA Privacy Rule is part of a limited data set that excludes other identifiers, such as name, address, and birth date. Depending on what one concludes is PII or “other comparable photos,” clinical photographs may be considered part of the private medical record and, therefore, should be protected like any other personal health information.

Arguments that clinical photos are part of the private medical record also raise the question of who owns the photos: the hospital, physician, or patient? Typically, patients have ownership over their medical record and control third-party access to their private health information. If clinical images are considered part of the patient’s medical record, it follows that the patient should have ownership over any clinical photographs. Ownership in this discussion should be differentiated from copyright laws and instead focused on the ethical dilemma as to which party has the most at stake. The clinical photographs are valuable to all involved but are arguably most important to the patient, who has the most to lose if the photographs are released to the public. Therefore, upholding the ethical principle of justice supports the view that the
patient should have ownership of the photographs and control their distribution.

So, how should clinical images be shared with a larger audience, if at all? Clinical photographs have become a widely used educational tool and routinely appear in presentations as well as in hard copy and electronic publications. However, when clinical photographs are intended solely for educational purposes, they no longer provide a direct benefit to the patient. The benefit has now shifted to a societal impact; that is, to educate others in the hope of providing improved patient care in the future. But once the benefit shifts away from the patient, that individual is left with a risk to confidentiality. The consent issue is no longer simply whether a clinical photograph may be created but now includes permission to use the photograph.

Sharing digital images with a large audience reduces that ability to control the distribution of sensitive photos. Web-based presentations and the wide availability of electronic publications makes controlling access to patient photographs a challenge. With this concern in mind, even though a physician may be passionate about education, his or her duty to uphold the patient's right to privacy and confidentiality is still of the utmost importance; therefore, the physician must exercise great care when using sensitive photos for nonpatient care-related activities.

Option 2: The resident obtains informed consent from the patient and continues to carry out the steps outlined in Option 1.

The actions associated with Option 1 remain relevant to this option. However, two important concepts require more careful attention. In health care, informed consent is integral to shared decision making and is based on respect for patient autonomy. Informed consent provides patients with an opportunity to participate in their own medical care and aims to avoid deceit and coercion. When obtaining informed consent, a physician typically details the risks, benefits, and limitations of all available options.

Based on this understanding of informed consent, would obtaining anything less than informed consent for clinical photography infringe upon a patient's right to autonomy? If the physician sees a significant risk of breaching patient confidentiality and believes, for example, that all patient photographs should be considered personal health information, then obtaining informed consent would be the safest action, from an ethical perspective, on the consent spectrum. If the physician concludes informed consent is necessary, then a decision between verbal versus written consent must be made. In the case presented, verbal consent would certainly be quicker, easier, and less obtrusive. This approach also upholds the ethical principle of nonmaleficence by aiming to minimize patient suffering. However, from a legal standpoint, written consent may be the recommended option to protect the physician and hospital from future liability.

To help guide residents and other physicians through the process of making an ethically complex decision, as in the case presented in this article, it is recommended that health care institutions have standards and policies in place that cover this issue. Unfortunately, even when these policies exist, they rarely address the specific issue of clinical photography. Institutions need to facilitate this process by making policies available and compatible with current technology.

Option 3: The resident obtains informed consent, takes several photos with his personal mobile device, and e-mails the photos to the PRS using a secure hospital e-mail address.

The resident's decision in Option 3 highlights an understanding of mobile device security issues and the increasing need to develop secure modes of transmitting and sharing clinical photographs.

Text messaging through a mobile device should always be viewed as a vulnerable mode of transmitting sensitive data. When a text message is sent, the text is stored on a central server that is not compliant.
with HIPAA, as well as on the sending and receiving devices. Many hospital employees may be cognizant of this vulnerability and consequently avoid sending text messages containing traditional personal health information, such as patient name and date of birth. However, sending photographs via text is a newer issue, one with more associated uncertainties. When reviewing Option 3, the discussion detailed in Option 1—what constitutes PII—should be carefully considered. If a physician’s definition of PII is limited to the face, tattoos, or birthmarks in clinical photographs, the risk may be determined as minimal when sending unidentifiable clinical photographs over less secure modes of transmission. Conversely, if a physician has a broader definition of PII, they may be obligated to send clinical photos through a more secure hospital e-mail address to better protect the data.

Although a protected e-mail account does provide added security, personal mobile devices have their own inherent security issues. Personal mobile devices have become increasingly prominent in the medical workplace and are popular due to their ease of use and portability. However, their portability means they can easily be lost or stolen. An unauthorized user may then access the device’s stored data (including saved photographs and text messages). Many phones lack the technology to encrypt data, a necessary step that allows the user to securely transmit sensitive patient information. Even if a device has encryption capabilities, its secured digital memory card may be unable to encrypt the device’s stored, and potentially sensitive, data.

Modern personal mobile devices, particularly smartphones, have virtually the same capabilities as a desktop computer. Most of these mobile devices lack the security measures that are standard on all hospital computers. Personal mobile devices are protected by weak numerical passwords, do not offer firewall protection or antivirus software, and have the option to transmit data through non-secure wireless networks. In contrast, hospital desktop computers operate solely through an institution’s server and its secure network.

An institution’s information technology (IT) department makes multiple efforts to protect personal health information, including setting computer lock-out times, changing passwords, overseeing and limiting user access to certain files, detecting changes made to stored data, and monitoring secure wireless and wired networks. IT departments have far less access to and control over employees’ personal devices. The variety of brands, operating systems, and service providers for mobile devices creates an even greater challenge in developing standard security measures.

Much work still needs to be done in terms of securing and regulating mobile devices for clinical use. For the foreseeable future, the owner of the device is trusted to safeguard patients’ sensitive health information, including clinical photographs. Physicians must use these devices prudently and remain informed of the technological shortcomings.

Option 4: The resident tells the PRS that he or she is uncertain regarding the risks associated with photographing the patient and does not want to cause any unintended harm to the patient, hospital, or himself.

The resident who follows Option 4 understands the technology concerns discussed in Option 3 and decides to err on the side of caution. The physician recognizes the limitations of a personal mobile device and decides that the potential harm to the patient’s privacy and confidentiality overrides other considerations.

Option 4 leads to a possible knowledge discrepancy and a conflict between two physicians. Imagine that the consulting PRS is an older physician who is less familiar with smartphone technology than the fifth-year resident. Given this disparity, who should be responsible for protecting the patient’s privacy and confidentiality? Is it an equally shared responsibility, or is the resident more accountable because of his or her advanced acumen with smartphone technology?

To explore this issue, consider the everyday hospital practice of ordering a consult. Consults are often
requested to ensure that a more experienced, knowledgeable physician is involved in managing a patient. The consulting physician does not make the final clinical decisions but still has an ethical responsibility to provide the requesting physician with the best information and advice possible. Similarly, the resident may be obligated to provide the PRS with the technological knowledge necessary to provide the best care for the patient. Even though the PRS may have a weaker understanding of the potential risks involved, HIPAA guidelines must continue to be followed to protect personal health information, including clinical photographs.

**Conclusion**

With increasing technological capabilities and the large number of personal mobile devices used in the workplace, snapping a photo of a patient for both clinical and educational purposes can present ethical conundrums. These ethical issues—which include consent, respect for autonomy, photographic ownership, photographs as personal health information, and physician responsibility to uphold patient confidentiality—are further complicated by the security concerns associated specifically with mobile devices.

An ethical case can be made for several courses of action in the clinical scenario presented in this article. This breadth of possibilities is evidenced by the many variations and differences found in hospital policies regarding clinical photography. The issue that will most likely divide physicians is how to define PII and to recognize the validity of obtaining consent when warranted, specifically when there is a potential risk to the patient’s privacy and confidentiality. Furthermore, increased security on mobile devices is necessary and the institution must play a role in addressing these security measures.

**REFERENCES**

Advocacy and grassroots:
Leveraging local issues at the national level

by Michael Carmody and Katie Oehmen
A surgeon’s responsibility to protect his or her patients and practice extends beyond the operating room and should include taking an active role in legislative and regulatory policies that have a direct impact on surgeons and patients. Through the Division of Advocacy and Health Policy (DAHP), the American College of Surgeons (ACS) develops and advocates for health care policies that are in the best interests of surgeons and their patients.

In April, after a decade of hard work by the College and many other health care organizations, Congress finally stabilized Medicare reimbursements by repealing the sustainable growth rate (SGR) formula used to calculate Medicare physician payment. Although DAHP staff worked tirelessly to repeal this broken methodology, this achievement was due largely to our Fellows taking action and making their voices heard. This victory demonstrates that lawmakers want, and often need, to hear from you as experts on surgical care and practice and, most importantly, as constituents. When you capitalize on your position as a surgical expert and become a valuable resource to policymakers, you can effect real health policy change.

Convincing members of Congress to repeal the SGR was an important accomplishment, but many issues continue to affect surgeons’ ability to provide their patients with optimal care and therefore require our attention. Legislation pertaining to cancer, research, rural hospitals, and trauma is pending in Congress, and it is crucial that Fellows engage with their legislators and provide feedback. The DAHP has created several platforms to provide surgeons with the necessary tools to become effective surgeon advocates.

**SurgeonsVoice**

SurgeonsVoice is the American College of Surgeons Professional Association’s (ACSPA) nationwide, interactive advocacy program. This program, created by the DAHP, has been engineered to educate and motivate members of Congress and influence their decisions. It provides surgeons with tools to become effective advocates in every U.S. congressional district and to establish professional and personal relationships with decision makers, both on and off Capitol Hill, as well as at the state and regional level. While Fellows may seek assistance and coordinate efforts through the DAHP, SurgeonsVoice is designed to be a self-service tool kit, allowing Fellows to carry out advocacy activities anytime, anywhere in the nation, without setting foot in Washington, DC.

**Grassroots**

The College’s grassroots network is only as strong as its members. Working to expand the grassroots program allows surgeons to become constituents who their legislators know and trust to provide them with valuable, meaningful information regarding health care. To be considered an active member of the College’s grassroots network, Fellows should engage in the following GRASS action items:
Schedule a meeting

When seeking to influence health care policy, nothing is more important than developing personal relationships with members of Congress. Likewise, to an elected official, nothing is more valuable than receiving input and support from their constituents. Members of Congress typically return to their districts on the weekends and when Congress is on recess or adjourned. These in-district work periods allow them to spend more time with their constituents and learn about the issues that affect them.

Using these opportunities to meet with policymakers and/or their staff is extremely valuable in advancing the overall surgical advocacy agenda and provides you with an opportunity to develop relationships with legislators and their health policy advisors. You are encouraged to engage in these activities with other surgeons and surgical residents in your area. ACS staff will work with you to arrange meetings and ensure that members of Congress understand that you are

- Get involved
- Reach out to peers
- Advance the College’s health policy agenda
- Support local events
- Serve as a trusted resource to staff and contacts

Schedule a meeting

When seeking to influence health care policy, nothing is more important than developing personal relationships with members of Congress. Likewise, to an elected official, nothing is more valuable than receiving input and support from their constituents. Members of Congress typically return to their districts on the weekends and when Congress is on recess or adjourned. These in-district work periods allow them to spend more time with their constituents and learn about the issues that affect them.

Using these opportunities to meet with policymakers and/or their staff is extremely valuable in advancing the overall surgical advocacy agenda and provides you with an opportunity to develop relationships with legislators and their health policy advisors. You are encouraged to engage in these activities with other surgeons and surgical residents in your area. ACS staff will work with you to arrange meetings and ensure that members of Congress understand that you are
advocating on the College’s behalf. If you have questions or concerns after reviewing the materials on SurgeonsVoice.org, contact Michael Carmody, Congressional Affairs Coordinator, DAHP, Washington, DC.

**SurgeonsVoice resources**

Use the SurgeonsVoice advocacy handbook on SurgeonsVoice.org to guide you in scheduling legislative meetings and to engage in successful advocacy efforts at the state level. The advocacy handbook is a comprehensive resource that provides an inside look at the ACS advocacy structure, the ACSPA’s political action committee (ACSPA-SurgeonsPAC), the structure of Congress and the complex legislative process, and the state legislatures. In addition, SurgeonsVoice comes with helpful issue briefs on relevant topics such as: cancer, research, rural hospitals, trauma, the surgical workforce, and other issues of importance.

If you have any questions or concerns after reviewing the materials on SurgeonsVoice.org, contact DAHP staff at surgeonsvoice@facs.org or call 202-337-2701.

**ACSPA-SurgeonsPAC**

SurgeonsVoice works hand-in-hand with the ACSPA-SurgeonsPAC to leverage the College’s legislative agenda at the federal level. SurgeonsPAC allows the ACSPA to increase its lobbying and advocacy efforts by contributing to federal campaigns.

**What is a PAC?**

PACs raise and spend money to elect candidates. PACs typically represent common interests and seek out financial contributions from members, employees, or other eligible classes through voluntary contributions. PACs are required to register with the Federal Election Commission (FEC) within 10 days of establishment and to provide regular reports disclosing receipts (money raised) and disbursements (money contributed). With the 2016 elections looming, the following are five points every Fellow should know about PACs:

- PACs help to create a united voice at the national level to raise awareness about issues of importance to an organization.
- PACs help to educate policymakers on legislative challenges so that they can help fight for those issues of importance to members of their organizations.
- A PAC is only as strong as the individuals who support it; the more members that support a PAC, the more effective it can be in the legislative and political process on Capitol Hill.
• Building lasting relationships with members of Congress through a PAC helps representatives and senators understand the issues that matter most to a particular industry or group.

• Being proactive in the political process can be beneficial to an entire organization.

SurgeonsPAC facts
Established in 2002, the ACSPA-SurgeonsPAC is governed by an appointed Board of Directors, which seeks to support an advocacy agenda for surgeons and their patients across specialty lines.

In recent years, the ACSPA-SurgeonsPAC was ranked in the top 20 health professional PACs in Washington, DC.* Through an aggressive grassroots educational and political investment program, ACSPA-SurgeonsPAC and its members provide nonpartisan financial support to federal office holders who share surgery’s perspective on health care policy issues and are positioned to influence surgery’s legislative goals. The PAC is one of the most effective ways to promote and protect issues that can affect surgical patients and the profession.

ACSPA-SurgeonsPAC has strict criteria for contributing to candidates. It is very important to the ACSPA that the contributions are distributed to friends of the medical community and in compliance with FEC regulations.

Peer-to-peer outreach key to SurgeonsPAC’s success
SurgeonsPAC recently launched its first PAC Captain Program. More than 40 PAC Captains participated in the six week peer-to-peer campaign aimed at disseminating SurgeonsPAC’s message to a broader audience. The campaign resulted in increased awareness and support of the SurgeonsPAC. SurgeonsPAC Captain participants and winners will have their names displayed at the PAC booth during Clinical Congress and will remain key “champions” within the states working to increase the SurgeonsPAC’s membership base throughout the 2015–2016 election cycle. For more information about the SurgeonsPAC Captain Program, contact Katie Oehmen, ACSPA-SurgeonsPAC Associate, at koehmen@facs.org.

Finally, in an effort to increase visibility at the state level, SurgeonsPAC will be reaching out to Fellows across the country to begin facilitating more in-district SurgeonsPAC check deliveries. To learn more about delivering a SurgeonsPAC check at a local or state event, contact Katie Oehmen at koehmen@facs.org or Michael Carmody at mcarmody@facs.org.

SOME 2,000 YEARS AGO, HORACE WROTE, “ADVERSITY HAS THE EFFECT OF ELICITING TALENTS; WHICH IN PROSPEROUS CIRCUMSTANCES WOULD HAVE LAIN DORMANT.” THE BEAUTIFUL ESSAY THAT ELLEN THOMASON, MD, MPH, FACS, HAS WRITTEN FROM HER HEART BRINGS TO LIGHT THE MEANING OF THE WORDS OF THIS ROMAN POET. I HAD THE PRIVILEGE OF PARTICIPATING IN DR. THOMASON’S TRAINING IN THE DEPARTMENT OF SURGERY AT THE UNIVERSITY OF WASHINGTON, SEATTLE, AND LATER OF SEEING HER GROW AS A RESPECTED SURGEON—ONE WHO SERVED HER COMMUNITY WITH PASSION AND THE WASHINGTON CHAPTER OF THE AMERICAN COLLEGE OF SURGEONS WITH ENTHUSIASM, ENERGY, AND WIT. I ALWAYS THOUGHT SHE WAS AN EXAMPLE OF SUCCESS AND TOOK PRIDE IN THE FACT THAT SHE GRADUATED FROM OUR PROGRAM.

This essay shows that there is always a bright side to things, even tragedy. There is always a chance to improve, and no matter how good you are as a surgeon and a person, you can always do better for yourself and the community you serve. ♦
Before last fall, I am not sure I was always a “human” when I took care of patients. As a vascular surgeon, I had outstanding patient satisfaction scores and considered myself a compassionate physician. I listened to my patients in clinic and made sure to meet with them and start procedures at the scheduled time both in clinic and in the operating room so I wouldn’t keep them waiting. After surgery, my hand would pat their hand or leg and my words would encourage them to look at the “bright side of things.” While wearing my white coat, I would explain to each patient that as my partner in their health care, patience is the very definition of what they must bring to recovery. To heal, they must be patient.

The surgeon becomes the patient

Then life taught me a lesson. This past fall, while five months pregnant, I lost my healthy son and had to have an urgent hysterectomy. Unfortunately, there were surgical complications. One of the retractors in my pelvis left me with a crush...
My patients were the same as they had been prior to my illness; I was the one who was different. I no longer stayed by their side and offered words of wisdom. Instead, I sat down with them, I listened to them, and I cried with them. I was able to share their journey—the journey of healing.

injury to one of the nerves of my leg, and I woke up from the operation unable to move or to feel my right hip and knee. Suddenly, I transitioned from the vascular surgeon in the white coat with all of the answers to the patient in the snap-gown full of questions. As my surgeon cried, disclosing the full extent of my retractor injury, I found myself thinking, “Who cares about your shame or guilt? I am the one that cannot walk. What if I can never run or perform an operation again?”

Just after having recovered enough to go back to work, I developed a wound complication, accompanied by peritonitis, which required an emergency operation. I would be out of work for an additional number of months. Sweating and in pain from the peritonitis, in the morning prior to going to work, I called my surgeon about my wound complication. This was several weeks after the original procedure—and his response was that I must be imagining things. He advised me to go ahead and do my first case of the day, which was a carotid endarterectomy. As I operated on the carotid, I wondered why my surgeon hadn’t listened to me. Afterward, with my scrubs drenched in peritoneal fluid, I drove myself to his hospital. Later that day, I had an exploratory laparoscopy and repair for the peritonitis. Postoperatively—lying awake with only the ceiling to keep me company—I questioned whether I would have the courage to press on and get back into life. Being a patient required that I work, and so I worked hard. Being a patient meant that I had to fight to reclaim my life. Being a patient meant that I had to shed my tears and learn to laugh again. Being a patient revealed my humanity to myself, and I listened. Tears fell silently as I began to understand patience.

New perspective
As my health recovered, I began to look at my profession through a different lens. I recognized the anguish on my patient’s face as they grappled with the reality of their illness, and I stayed silent and still as they spoke, providing an ear to their concern. I noticed their pain as they lay still in bed, and I sat down and held their hand instead of standing at their side and patting it. I saw the fear in their eyes that they would never be the same again, and I witnessed their withdrawal from life as they fought to live and move forward. My patients were the same as they had been prior to my illness; I was the one who was different. I no longer stayed by their side and offered words of wisdom. Instead, I sat down with them, I listened to them, and I cried with them. I was able to share their journey—the journey of healing.

As I drove home the other day, I reflected on this story and realized that both my literal and figurative scars were fading. As my memory of these events fade, I had to ask myself if I was still “human,” or if I had returned to the focused, hard-charging, but emotionally remote surgeon that I had been before this experience. The answer is yes and no. Some days are easier to be human than others as maintaining the balance is a constant but worthwhile effort.

Yesterday in clinic, one of my patients—a man with an aortic dissection and iliac aneurysm that I repaired—came in for follow-up. His was an interesting case that was operationally challenging, and fortunately, he and I had a very satisfying outcome. While an inpatient, he always wore camouflage slippers. I asked him about them one day on rounds and he revealed his love of hunting and shooting. He bought these slippers to wear during his recovery to remind him of what he was walking toward. Hunting is a big part of his life, and he promised himself that he would recover by hunting season. I enjoyed his stories and I took the time to understand his camouflage slippers. Returning to yesterday’s clinic, he gave me a wrapped present. I was so flattered when I opened the bag and found—to my delight—a pair of camouflage slippers. I wore them tonight and they remind me that his journey is the same as my own. Being human has made all of the difference.
The final rule on the Medicare Shared Savings Program

by Neha Agrawal, MPH

The Affordable Care Act (ACA) includes a provision for the Centers for Medicare & Medicaid Services (CMS) to create the Medicare Shared Savings Program (MSSP). This program would establish a payment structure for accountable care organizations (ACOs), which would be responsible for the quality, cost, and overall care of Medicare beneficiaries. CMS issued a final rule on June 4 updating regulations that govern the MSSP, and most of the mandates went into effect in August. The final rule incorporates feedback that the American College of Surgeons (ACS) provided when CMS released a proposed rule in February. This column offers an overview of ACOs, summarizes highlights from the final rule, and provides an update on surgeons’ involvement in the MSSP.

What is an ACO?
An ACO is a group of physicians, hospitals, and/or other health care professionals and facilities that comes together voluntarily to offer coordinated, high-quality, and cost-effective care to Medicare patients. ACOs that successfully meet quality metrics and reduce health care costs can share in any Medicare program savings. As Table 1, page 32, indicates, an ACO is composed of ACO participants, which are recognized by a Medicare-enrolled billing tax identification number (TIN) used to bill Medicare.¹

To qualify for the MSSP, an ACO must agree to participate in the program for at least three years, comprise a sufficient number of primary care professionals and at least 5,000 Medicare beneficiaries, and have a formal legal structure to receive and distribute payments. As of June, the MSSP encompassed more than 400 ACOs, 170,000 Medicare-enrolled practitioners, and served approximately one in six Medicare beneficiaries.²

What are key highlights of the final rule?
The final rule eliminates exclusivity requirements for general surgery and other specialties, extends the amount of time an ACO may remain in the shared savings-only track of the program, creates an additional payment model, and makes improvements to the benchmarking methodology. Following are details on each of these topics.

Elimination of exclusivity requirements
The final rule eliminates exclusivity requirements for several physician specialties, including general surgery. This provision is significant because it means that going forward general surgeons can participate in more than one ACO and share in additional savings. In a letter to CMS before release of the rule, the College supported the exclusion of general surgeons from participating in only one ACO, citing the effect of enhancing patient access to a variety of providers and ultimately improving quality of care.

CMS assigns Medicare beneficiaries to an ACO using a two-step process focused on their previous primary care services. CMS first identifies all patients who received primary care services from an ACO health care professional in a process known as the pre-step. Within this group of patients, CMS then considers the primary care services provided by primary care physicians or nonphysician practitioners and assigns the Medicare beneficiary to those health care providers.³ The rule indicates that approximately 92 percent of beneficiaries are assigned to an ACO in this step. If beneficiaries did not receive their primary care services from either of these groups but instead from a specialist, CMS assigns the Medicare beneficiary to the specialist. ACO participants...
who are part of the assignment process cannot participate in more than one ACO. The final rule clarifies that general surgeons are excluded from the beneficiary assignment process and may thereby participate in more than one ACO.

Shared savings-only program
The final rule enables ACOs currently in the shared savings-only program, referred to as Track 1, to remain in this program for three additional years. The ACS supported this change, citing past concerns about the prospect of financial penalties after just three years in the MSSP. The College did not support CMS’ proposal to lower the maximum amount of savings ACOs can retain for those that remain in the shared savings-only model for an extra three years. Specifically, the ACS told CMS that the MSSP is relatively new and requires heavy investment; lowering the amount of savings may serve as a disincentive for providers who would otherwise participate in the program. To date, 99 percent of ACOs in the MSSP are in the shared savings-only track.4

CREATION OF A SHARED SAVINGS AND LOSSES PAYMENT MODEL
The final rule creates a shared savings and losses payment model, referred to as Track 3. This new payment model increases the shared savings and losses rates, prospectively assigns beneficiaries to an ACO, provides a waiver of the CMS rule requiring a three-day inpatient stay for coverage of a skilled nursing facility (beginning in 2017), and provides new care coordination tools.

In its comment letter to CMS, the ACS expressed support for a third payment track for ACOs who feel they are ready to take on more risk and be eligible to earn greater savings, citing the positive effect of increased flexibility for ACOs. The College further supported waiving the requirement for a prior three-day qualifying inpatient hospital stay and urged CMS to consider extending this waiver to ACO participants across all three tracks. Nonetheless, CMS finalized this waiver only for ACOs participating in Track 3.

Improvements to the benchmarking methodology
CMS refined its policies for resetting ACO benchmarks and announced its intent to propose further improvements to the benchmarking methodology. CMS establishes benchmarks by considering historical costs of Medicare patients assigned to the ACO. The benchmarks are reset at the start of each three-year agreement period, based on the previous period; they are adjusted to account for growth in national Medicare fee-for-service (FFS) spending and to adequately represent newly aligned beneficiaries.

Under current benchmarking rules, an ACO is in competition with its own previous performance and must meet increasingly stringent benchmarks every year to continue to receive savings. This system results in an increasingly high bar for ACOs that have been the most successful at controlling costs, since they are already doing well. At the same time, more inefficient ACOs have
What role has general surgery played in ACOs?

A recent analysis of the early experiences of 59 ACOs via case studies and a survey found that these ACOs devoted little attention to surgeons. These ACOs emphasized coordinating care for patients with chronic conditions and reducing unnecessary hospital readmissions and emergency department visits. The success of an ACO depends not only on the participation of qualified primary care physicians, but also on specialists, who will be crucial to the improvement of quality of care. The average American undergoes nine surgeries in his or her lifetime. Nationally, surgery represents approximately 50 percent of hospital expenditures and accounts for an estimated 30 percent of total health care costs. The ACO concept of coordinated multiple levels of care with a regionalized structure is not new to surgery. Surgical care has been organized into regional coordinated systems integrated into clinical institutions by way of trauma care networks since the 1970s. As ACOs evolve, the ACS anticipates that they will pay more attention to surgical quality, the appropriateness of surgery, and surgical outcomes.

Note

This column is not intended to serve as a comprehensive guide or framework for how surgeons can participate in an ACO or build their role in an ACO. The content is intended to provide general information on ACO policies.

REFERENCES


On October 4, J. David Richardson, MD, FACS, professor of surgery and vice-chairman, department of surgery, University of Louisville School of Medicine, KY, will be installed as the President of the American College of Surgeons (ACS). Dr. Richardson has always been concerned with the issue of access to surgical care, and he recently shared his views on the subject with me.

Rural upbringing
Dr. Richardson was born and raised in Morehead, a small rural town in eastern Kentucky. “Everybody, to some extent, is a product of their own upbringing. Being raised in a small town where we had no access to hospital or surgical care until I was 18 made me aware of the access problems in acquiring surgical care,” Dr. Richardson noted. In fact, he experienced the lack of local surgical care first-hand at an early age. “I can remember when I had a perforated appendix at age 10 and had a two-and-a-half hour ride to Lexington [KY] in a pickup truck in the pre-interstate highway days, and I can say that really did make an impression on me. I always remembered how scared I was and how uncomfortable it was,” he said.

In his second year of surgical residency at the University of Kentucky, Lexington, Dr. Richardson returned to Morehead for a three-month surgical rotation at the local hospital, St. Claire Regional Medical Center, which then had approximately 41 beds, and worked with the local general surgeons. “I did some orthopaedics, and I did a lot of gynecological surgery. I did [cesarean sections] with some of the physicians there, and just a ton of general surgery, as well as some trauma,” Dr. Richardson recalled. “It was a great experience for me.”
“I believe that the difficulty in access to rural surgical care is a crucial societal problem that has not received adequate national attention, [Dr. Richardson] added. “I have marveled for years that it has not been more of a political issue, that people in rural areas haven’t demanded better access to health care of their elected representatives.”

Although he has devoted his career to academic surgery, Dr. Richardson has maintained close ties with the Morehead area. “I have a brother who runs an insurance agency there, as well as nieces, nephews, and cousins. I have relatives in the really deep mountains of eastern Kentucky where the access to surgical care, quite honestly, is an issue,” he said.

As a result, Dr. Richardson has made many return trips to Morehead and has seen the St. Claire Regional Medical Center grow to a 159-bed regional referral center. He is well aware of the positive impact that locally available health care has had on the community. “We really have an excellent local hospital in my home town. There is outstanding surgical care. We’ve got specialty surgeons now. We’ve got four general surgeons, and they do a great job. For those [patients] within that five-county service area, the drive would be 30 minutes at the most. Over the course of my lifetime, we have gone from having no care to having high-quality emergency surgical services and can provide for a wide variety of sophisticated elective procedures. I’ve been able to see what good care can really do for a whole community and for a region. That means people don’t have to drive two-and-a-half hours to find out if they’ve got appendicitis or not,” he said.

Need for local access
“I think access to care in the rural areas is something that is extremely important. It is my understanding that one out of every six people in the [U.S.] still lives in what could be classified as a rural area,” Dr. Richardson said, adding that he strongly believes that the availability of local care is important for a patient who has abdominal pain that needs evaluation. “You
really need to be able to take care of those patients locally. Patients deserve that,” he said.

He also believes that patients with chronic illnesses and with diseases that require a long course of treatment should be able to receive care close to home. “I did a lot of breast cancer work years ago, and many of our patients simply could not drive the many miles required to do the radiation therapy for six weeks, as an example. It just wasn’t an option in their life. They had grandchildren to take care of or they didn’t have a car. The poor people who were disadvantaged and often remote and isolated really needed to have local care,” Dr. Richardson said.

“I believe that the difficulty in access to rural surgical care is a crucial societal problem that has not received adequate national attention,” he added. “I have marveled for years that it has not been more of a political issue, that people in rural areas haven’t demanded better access to health care of their elected representatives.”

“The other thing that I’ve been really impressed with through the years is the kind of work that people do at a local level,” Dr. Richardson noted. “I am tremendously impressed at the quality of surgical care that we have in many rural areas, how thoughtful and how caring surgeons are, and how good they are. In my opinion, many leaders of academic surgery really don’t understand the tremendous quality of surgery that goes on in many areas of private practice both in urban settings, and certainly rural settings as well.”

**Creating awareness among ACS leadership**

As a Regent, Dr. Richardson attended an informal breakfast meeting at the 2011 Clinical Congress with a group of approximately 12 rural surgeons. The discussion centered on rural surgical issues. Included in the group of rural surgeons were Phil Caropreso, MD, FACS, from Keokuk, IA, and ACS Governor Tyler Hughes, MD, FACS, from McPherson, KS. “I enjoyed [the meeting] very much; so the one thing I promised was that if I ever had an opportunity to advance the cause of rural surgery, I would do so,” he said. That opportunity presented itself when Dr. Richardson was elected Chair of the Board of Regents at the conclusion of the 2011 Clinical Congress. He invited Drs. Caropreso and Hughes to the first Board meeting under his chairmanship in February 2012.

“I don’t mean to sound naïve when I say this, but it was one of the most touching things I’ve ever witnessed in my life. You couldn’t have found two people to have made a case for something any better than they did, and I’m telling you that it moved people to the point of emotion. I can’t state that strongly enough, really how
“I am tremendously impressed at the quality of surgical care that we have in many rural areas, how thoughtful and how caring surgeons are, and how good they are. In my opinion, many leaders of academic surgery really don’t understand the tremendous quality of surgery that goes on in many areas of private practice both in urban settings, and certainly rural settings as well.”

—Dr. Richardson

powerful the message was. There was unanimous Regent approval to do something, and the Advisory Council for Rural Surgery [ACRS] arose out of that,” Dr. Richardson said, noting it was the first new Advisory Council of the ACS to be established in 40 years.

Since its formation, the ACRS has created greater awareness among the ACS leadership of the problems that rural surgeons face. “I don’t think there’s any question that the level of awareness of rural surgical issues has increased markedly. I do not mean to be dismissive of prior efforts by the College leadership, but the awareness of current problems is now more front and center,” Dr. Richardson said.

How the ACS can help to improve access

Now that ACS leadership is more aware of the issues in rural surgery, Dr. Richardson said, “We have some responsibility to at least educate in terms of what our workforce needs are. The College has done numerous workforce studies under the leadership of the late George F. Sheldon [MD, FACS]. Dr. Sheldon coined the term ‘surgical deserts’ for places that needed general surgeons and simply didn’t have them. What the country needs are general surgeons right now. There is very little evidence that we need more surgical specialists. Right now we have a serious disconnect between what we’re producing and what the country needs, in my opinion, and I feel that very strongly. I think that the College can help get that message out,” he said.

“It’s hard to separate the rural surgery problems from the general surgery problems. When so many people are doing fellowships and wanting to designate themselves as something other than general surgeons, then clearly you are going to have problems in rural areas. So I think until we get more general surgeons, it’s going to be really hard for rural surgery to have the workforce that it needs,” Dr. Richardson added.

With regard to general surgery training, the College “certainly has been taking the position that we can’t cut general surgery funding.” However, Dr. Richardson also feels that the ACS can help to solve rural surgical issues by helping to promote better training in general surgery. “I think part of what the College needs to do, and what I want to try to emphasize, is that we need to improve core general surgical training. If people don’t feel that they are prepared to handle the broad breadth of practice in general surgery, then the thought that they are going to go out into a small community by themselves or into a small group practice can be very daunting.” Furthermore, he added, “I think the general surgeon’s training needs to be better and I think the College needs to become more involved in the verification of that training.”

In addition, Dr. Richardson noted that the College has formed a group called “Fix the Five,” which is working to improve residency training, as well as a Transition to Practice (TTP) program. “Although the TTP program is not rural surgeon specific, we have several programs in fairly rural places,” Dr. Richardson said. “Many of those programs are really trying to produce rural surgeons and prepare them for practice in that environment.”

Dr. Richardson believes that the ACS Division of Advocacy and Health Policy has sought to address the issues facing rural surgery. He participated in the April 2015 ACS Leadership & Advocacy Summit in Washington, DC, and noted...
With regard to general surgery training, the College “certainly has been taking the position that we can’t cut general surgery funding.” However, Dr. Richardson also feels that the ACS can help to solve rural surgical issues by helping to promote better training in general surgery.

that “the big push that our group made in Kentucky was the importance of critical access hospitals, the 96-hour rule, and support for Sen. Pat Robert’s (R-KS) bill S. 258, trying to protect small hospitals. That was the major theme of that entire episode, so to me, that is one thing that the College did or has already done that’s very concrete in terms of trying to help rural surgeons,” he said. “I think that the legislative team clearly is very attuned to the things that could impact rural surgery and is trying hard to intercede on behalf of rural surgeons.”

Dr. Richardson also mentioned that Ajit K. Sachdeva, MD, FACS, FRCS, Director of the ACS Division of Education, has been very interested in enhancing the portability of medical licensure across state lines, which will ensure easier access for locum tenens coverage and coverage when rural surgeons take vacations.

To enhance the College’s efforts to improve rural access to surgical care, Dr. Richardson said he believes the nation needs a National Surgical Health Service. At present, “we have a National Health Service that provides people to do obstetrics, dentistry, and primary care. If the political awareness arose to the desperate needs of rural surgeons, then the idea of a ‘surgical health service’ might be politically palatable. This could take the form of loan forgiveness for years of service to rural communities and the like,” Dr. Richardson said. “To me, that’s a big idea that, down the road, people need to be pursuing because I don’t know that market forces alone are going to solve the problem. This is a long-term process, but initial steps should be started at a political level by those who live and work in rural communities.”

There is no question that Dr. Richardson has never lost his belief in the need for access to surgical care in rural areas. “If you want to be a leader in surgery, you really do need to look at other people’s point of view, their obstacles as well as their strengths in terms of rendering good patient care,” he said. “I’ve just tried to do that for rural surgery.”

REFERENCES


Pancreatic adenocarcinoma remains one of the deadliest cancers in the U.S.; however, margin-negative surgical resection, when feasible, may lead to cure. One of the most challenging situations for patients and surgeons is when they are faced with borderline resectable tumors that involve a portion of the adjacent mesenteric vasculature. In this situation, achieving a margin-negative resection may not be possible; resection of these tumors is also technically challenging and may be associated with significant postoperative morbidity. Use of neoadjuvant therapy with chemotherapy and radiation prior to surgery has been hypothesized to improve rates of complete surgical resection.

**Pilot study A021101**

A pilot study was designed to assess the feasibility of administering neoadjuvant chemotherapy and chemoradiation in patients with borderline resectable pancreatic cancer in a multicenter setting. Alliance A021101, Neoadjuvant FOLFIRINOX and Chemoradiation Followed by Definitive Surgery and Postoperative Gemcitabine for Patients with Pancreatic Adenocarcinoma: An Intergroup Single-Arm Pilot Study, enrolled 23 patients across 14 selected institutions from May 2013 through February 2014. Initial results from the trial were presented at the 2015 annual meeting of the American Society of Clinical Oncology in June.*

Alliance A021101 evaluated patients with borderline resectable pancreatic cancer defined by one or more of the following centrally reviewed radiographic criteria: (1) a circumferential tumor-vessel interface (TVI) with superior mesenteric/portal vein ≥ 180°; (2) TVI with superior mesenteric artery < 180°; and (3) short-segment TVI with hepatic artery of any degree. These patients received modified FOLFIRINOX (mFOLFIRINOX; oxaliplatin 85 mg/m², irinotecan 180 mg/m², leucovorin 400 mg/m² followed by 5-Fluorouracil 2400 mg/m² for four cycles) and chemoradiation (50.4 Gy in 28 fractions) with concurrent capecitabine (825mg/m², twice a day) prior to intended surgical resection and postoperative gemcitabine (1000 mg/m² on days 1, 8, and 15 for two cycles). The three specific aims of the study were to demonstrate the ability to accrue patients from multiple institutions, to demonstrate the safety and tolerability of preoperative mFOLFIRINOX and capecitabine-based chemoradiation, and to evaluate the rate of completion of all preoperative therapy and pancreatectomy.

In all, 14 selected high-volume pancreatic cancer treatment centers enrolled 23 patients.

---

Use of neoadjuvant therapy with chemotherapy and radiation prior to surgery has been hypothesized to improve rates of complete surgical resection.

in the study, which completed accrual in advance of schedule. Among 22 patients who started protocol therapy, all 22 completed mFOLFIRINOX and 21 (95 percent) completed chemoradiation. By the standards of the Response Evaluation Criteria in Solid Tumors, the best responses to preoperative therapy included complete response (two patients), partial response (four patients), stable disease (14 patients), and progressive disease (two patients).

Seven patients did not undergo planned resection due either to disease progression (six patients) or refusal (one patient). Among the 15 (68 percent) patients who underwent pancreatectomy, 14 (93 percent) operations were margin negative; 80 percent of operations required concomitant vein resection or hepatic artery resection. Five (33 percent) patients had less than 5 percent viable cells in their tumors remaining following neoadjuvant therapy.

Among all patients, 68 percent [95% confidence interval 49%–88%] underwent R0/R1 resections and two (9 percent) patients achieved pathologic complete response (CR). In all, 64 percent of patients experienced at least one grade 3 adverse event (AE) and only one patient experienced at least one grade 4 AE during preoperative therapy. One patient died within 90 days of surgery. These numbers compare favorably to historical data; for example, the rate of negative margins among patients who undergo de novo resection of similar invasive tumors in the

FIGURE 1. TREATMENT SCHEMA FOR ALLIANCE A021501
The success of Alliance A021101 was due in large part to the enthusiastic participation of surgeons with their multidisciplinary teams. The future utility of Alliance A021501 also will rely heavily upon surgical oncologist involvement in collaboration with their medical and radiation oncologists.

absence of preoperative therapy is on the order of 37 percent.†

**Trial design leads to robust outcomes**
The clinical importance of these results notwithstanding, the most significant product of Alliance A021101 is the design of the trial itself. The efficacy of preoperative chemotherapy and chemoradiation for patients with borderline resectable pancreatic cancer has historically been difficult to establish because most earlier studies have been small retrospective reports or single-institution trials of groups of patients who had a heterogeneous local tumor anatomy and who were treated with a variety of modalities in a nonstandardized way.

To address this problem, Alliance A021101 established and used standardized definitions of and procedures for the following:

- The radiographic definition of borderline resectable pancreatic cancer
- Selection criteria for a neoadjuvant strategy
- The indications for operative intervention following induction therapy
- Surgical technique
- Pathologic review of the surgical specimen that will be used in future studies

Indeed, the radiographic criteria used in the study to define tumors as “borderline resectable” have now been endorsed by the National Comprehensive Cancer Network for use in all future clinical trials of borderline resectable pancreatic cancer.‡

Alliance A021101, the first successful cooperative group study of preoperative therapy for patients with borderline resectable pancreatic cancer, has provided much-needed baseline data and a quality-controlled trial framework, which have been used to design a forthcoming Alliance trial that aims to establish a standard preoperative treatment regimen for patients with this stage of disease. This proposed trial, Alliance A021501 (see Figure 1, page 40), has been submitted to the National Cancer Institute for approval. This follow-up study will attempt to define a standard multimodality treatment regimen for patients with borderline resectable pancreatic cancer by randomizing patients to eight cycles of systemic mFOLFIRINOX or six cycles of mFOLFIRINOX followed by hypofractionated radiation therapy. The trial will evaluate the rates of 18-month overall survival comparing these two approaches.

The success of Alliance A021101 was due in large part to the enthusiastic participation of surgeons with their multidisciplinary teams. The future utility of Alliance A021501 also will rely heavily upon surgical oncologist involvement in collaboration with their medical and radiation oncologists.

For additional information, contact Matthew H. G. Katz at mhgkatz@mdanderson.org.

---


Since the 1950s, the College has offered numerous programs for domestic (U.S. and Canadian) members, all of which provide various benefits. These educational awards have been funded through contributions from Fellows, ACS chapters, and corporate sponsors, as well as from grateful patients; some of the donated funds began as memorials to beloved Fellows.

Every other month this column provides information about select benefits of membership in the American College of Surgeons (ACS). This month’s column focuses on educational opportunities and features information about ACS scholarships and fellowships, as well as the MyCME program, which allows users to track continuing medical education (CME) in one location.

ACS scholarships and fellowships
The ACS has long provided scholarships, fellowships, and research awards to its resident and young surgeon members. Since the 1950s, the College has offered numerous programs for domestic (U.S. and Canadian) members, all of which provide various benefits. These educational awards have been funded through contributions from Fellows, ACS chapters, and corporate sponsors, as well as from grateful patients; some of the donated funds began as memorials to beloved Fellows. Regardless of the source, each program has provided great benefit to the awardees and, ultimately, to surgical patients.

The College and its Scholarships Committee currently provide more than $1.5 million annually in support of these programs. Scholarships, fellowships, and awards currently offered include Resident Research Scholarships, Faculty Research Fellowships, and the George H. A. Clowes, MD, FACS, Memorial Career Development Award. Several programs, including the Health Policy Scholarships, are conducted in cooperation with surgical societies, and the Triological Society, the Society for Vascular Surgery, the American Society for Surgery of the Hand, and the National Institutes of Health supplement awards.

Other programs support specific recipient groups, such as the Nizar N. Oweida, MD, FACS, Scholarship, which assists a rural or small town surgeon who would like to attend the annual ACS Clinical Congress. Another example is the Claude H. Organ, Jr., MD, FACS, Scholarship, which assists a rural or small town surgeon who would like to attend the annual ACS Clinical Congress. Another example is the Claude H. Organ, Jr., MD, FACS, Traveling Fellowship, which supports the research of young ACS academics who are also members of the Society of Black Academic Surgeons, the Association of Women Surgeons, and the Surgical Section of the National Medical Association. In addition, the College offers several scholarships-in-residence.
MyCME provides each College member with an ongoing listing of his or her CME Credits earned through ACS educational activities. The applicable CME Certificates are available for download as needed.

positions, largely run through the ACS Quality Programs, which include the opportunity to earn a master’s degree.

Since the 1960s, the College’s International Relations Committee has offered a series of travel/research awards. Most of these programs enable surgeons from countries other than the U.S. and Canada to attend the annual Clinical Congress and tour surgery centers that offer opportunities tailored to recipients’ professional interests. International scholars can participate in the College’s quality programs via the International ACS National Surgical Quality Improvement Program Scholarships or the International Surgical Education Scholarships co-presented with the ACS Division of Education. Three traveling fellowships, offered in cooperation with the national surgical societies of Australia and New Zealand (ANZ), Germany, and Japan, also are available. Through these programs, exchange fellows are able to attend and participate in the annual meeting of their cohorts’ surgical societies. More than $200,000 is allocated to sponsoring these international programs.

For more information regarding the College’s scholarship, fellowship, and other educational award opportunities, go to www.facs.org/member-services/scholarships.

The following opportunities have application deadlines between October and the end of 2015:

- Faculty Research Fellowships: November 2
- ANZ, Germany, and Japan Traveling Fellowships: November 15
- Nizar N. Oweida, MD, FACS, Scholarship: December 15

**MyCME**

Created by the Program for Validation and Verification of Surgical Knowledge and Skills, the MyCME program is an online portal designed to provide each ACS member with an individualized Web page to document CME Credit.

**CME Credit**

MyCME provides each College member with an ongoing listing of his or her CME Credits earned through ACS educational activities. The applicable CME Certificates are available for download as needed. These certificates reflect the CME Credit claimed at ACS activities over the last six years and help document the surgeon’s fulfillment of the 90 hours of AMA PRA Category 1 Credits™ over a three-year cycle as required by the American Board of Surgery (ABS) for Maintenance of Certification (MOC).

Members also are able to enter CME Credit received from other organizations on the MyCME portal, and it offers members the option of sending their transcripts directly to the ABS as part of the board’s MOC requirement.
Self-Assessment Credit
At least 60 of the 90 hours of AMA PRA Category 1 Credits required by the ABS for fulfillment of MOC Part 2 must include a self-assessment activity—a written question-and-answer exercise that assesses the surgeon’s understanding of the material presented in the CME activity. Most of the College’s live and Web-based CME programs offer Self-Assessment. Self-Assessment Credits that ACS members earn as part of their CME participation are included on the Certificates (and transcripts) available through MyCME.

How you can participate
You can access the MyCME page using your ACS Member ID at facs.org. A record of your credits claimed from attending ACS-provided CME activities will be displayed. Members also can add attendance at programs sponsored by other organizations and institutions to their MyCME page. Documentation of all CME Credits can be stored in one location, which makes it easier to obtain credentialing or recredentialing, renew your state license, or recertify with your board.

Benefits of MyCME participation include the following:

• Members can download and print CME Certificates at any time and be assured that there is a permanent electronic record for easy access. Certificates (and transcripts) include CME Credit claimed, Self-Assessment Credit earned, and specific content that may meet other regulatory body requirements.

• Transcripts are available for download and printing. This may be helpful for members who need to provide documentation of participation in CME activities that are specific to a specialty or hospital requirement.

• The MyCME page provides an overview and links to individual state boards outlining content-specific requirements. This information, together with individual transcripts, may be used to determine what might be missing. View the calendar link from an individual MyCME page to identify future activities and address any potential gaps.

• When it is time for submission of documentation of CME to the ABS, MyCME makes it easy with automatic electronic transfer functionality.

Why should you participate?
MyCME is an online record of credits earned by members attending CME events, which allows users to document their commitment to lifelong learning and ongoing quality improvement. The ACS Division of Education is committed to helping to ease the burden associated with organizing, tracking, and submitting CME Credit. This documentation, in the form of transcripts and certificates, supports credentialing of individuals and provides requisite documentation to help in the process of privileging within medical centers and health care institutions. Take advantage of this resource to manage your CME Credit at your convenience.

For more information, go to www.facs.org/education/cme or contact MyCME staff at mycme@facs.org.
High reliability science and surgery: The Joint Commission's Robust Process Improvement methodology

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

In health care, the goal is to provide safe, high-quality care to every patient, every time. The Joint Commission President Mark R. Chassin, MD, FACP, MPP, MPH, and Jerod M. Loeb, PhD, former executive vice-president of The Joint Commission’s Division of Healthcare Quality Evaluation, wrote in the Milbank Quarterly that despite our aspiration to provide high-quality care, wrong site operations and health care-associated infections have persisted.* So, the obvious question becomes how can surgeons integrate high reliability concepts into their work?

This column is the first in a series that will investigate the answers to that question. This article provides an overview of The Joint Commission’s Robust Process Improvement (RPI) methodology. Future columns will delve into practical applications of RPI for surgeons.

What is RPI?

RPI—which uses Lean Six Sigma and other change management methodologies—can be best understood as an approach that aims to create sustainable solutions for some of health care’s most critical quality and safety issues. Think of it as the scientific method, using data-driven problem-solving techniques to determine root causes of safety issues specific to a problem area and then providing a roadmap to develop and implement solutions that lead to substantial improvements.

The Joint Commission’s Center for Transforming Healthcare has been using RPI since 2008 and has focused on 11 topics, some of which have been centered on surgery, including enhancing patient safety, decreasing the likelihood of surgical site infections, improving handoff communications, and promoting hand hygiene.

Building on DMAIC

Using the DMAIC (define, measure, analyze, improve, control) approach, members of the surgical team first define the problem from the patient’s perspective. What does the patient need? From there, the project team, project goals, a high-level process map, and a project plan are developed. If we focus on “safe surgery,” for example, the team must first be very specific in defining the problem, including where the process starts and ends. From the patient’s perspective, safe surgery begins with the initial conversation in the physician’s office and the decision to proceed with the operation. Safe surgery begins long before the timeout occurs in the operating room (OR).

The measure phase quantifies the problem through a methodical approach to defining defects, metrics, and a detailed process map. This informs the development of a robust data collection plan, which is then validated.

The analyze phase allows the team to identify sources of variation and determine root causes. For example, when a patient is ready for surgery and covered in surgical drapes, the site marking should be

The RPI toolkit is flexible and may be applied in many different ways. If a surgical team is having problems with health care-associated infections, ineffective timeouts, inconsistent handoffs, wrong site operations, or falls with injury, RPI can help the quality improvement team develop and implement solutions.

visible. Yet when the team looks into the process, it may discover that this does not always happen; there can be variation. It may find that the mark was erased during the preoperative scrub, or the mark was made with a faulty marker, which could lead to problems, especially if it is goes unnoticed during the timeout.

In the improvement phase, the team develops potential solutions to address the root causes that are critical to quality. Using the site marking issue discussed previously, one such solution may be ensuring that the suppliers to the hospital only deliver the proper markers for site marking, so that faulty ones are not available at the institution. These solutions are tested, validated, and adjusted as necessary.

Control is the sustainability phase. Standard procedures with clear accountability and monitoring are developed based on the validated solutions. Change management tools are required throughout but are especially important in the acceptance of the solutions, which, in turn, leads to greater adherence by the team and organization. When that level of buy-in has occurred, marked improvements are possible.

**The RPI toolkit**

Lean tools help to take the waste out of the processes and thereby help to show respect for frontline workers. Lean tools are used at various points in the DMAIC process, depending on the problem at hand. An example in the operating room (OR) might be entering and exiting the room to get equipment, which increases the chances of infection. Lean strategies can help address this problem by figuring out ways to ensure that ORs are equipped properly prior to surgery or by minimizing the need to leave the room. Waste is defined as anything that isn't necessary to the process or anything that is not of value to the patient.

The RPI toolkit is flexible and may be applied in many different ways. If a surgical team is having problems with health care-associated infections, ineffective timeouts, inconsistent handoffs, wrong site operations, or falls with injury, RPI can help the quality improvement team develop and implement solutions.

The RPI approach to improvement is:

- Focused on the problem(s) specific to your area
- Based on robust data
- Created and sustained by the team

RPI resources are at surgeons’ fingertips, waiting to be used to create a more reliable, safe environment for patients. And the response to process improvement initiatives, specifically RPI, can be emboldened when surgeons—respected members of their health care teams—champion the cause. It is all for the goal of moving health care toward high reliability, so that every patient can receive safe, high-quality care every time. Some of these resources can be found on the Center for Transforming Healthcare’s website at www.centerfortransforminghealthcare.org. In addition, articles and case studies about high reliability can be found on The Joint Commission’s website at www.jointcommission.org/hr_pubs.aspx.

**Disclaimer**

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

Fireworks are defined as small devices that explode to make a display of light and noise.* Entering “fireworks” into a search engine returns approximately 110 million results. The top banner will have beautiful images of aerial fireworks, followed by a definition of the word, local events with fireworks, and the top news stories relating to fireworks. This summer, several high-profile news stories pertained to firework injuries, including two National Football League players who suffered hand injuries with finger loss.

Consumer fireworks are regulated by the U.S. Consumer Product Safety Commission (CPSC) and are very safe when used in accordance with the instructions and safety warnings. They are packaged in bright colors, have safety warnings printed on the package, and display the country of origin. These typically include fountains, cones, sparklers, firecrackers, rockets, and multi-tube aerial devices. Illegal explosives, on the other hand, are often unpackaged, wrapped in brown paper, and lack safety warnings and the name of the country of origin. They go by names such as “quarter stick,” “cherry bomb,” and “M-80.” Professional-grade fireworks are only legal in the hands of licensed, trained pyrotechnicians. These materials are very powerful and are not meant for consumer use.†

Too hot to handle
According to a study conducted by the CPSC, for the 30 days surrounding July 4, 2014, an estimated 230 fireworks-related injuries sent people to hospital emergency departments each day. Furthermore, nine people died in fireworks-related incidents, and at least two of these victims were not the users. Hand and finger wounds comprised the majority of these injuries in more than one-third (36 percent) of these incidents, followed by eyes (19 percent), and head/face/ears (19 percent). In 50 percent of the cases, the injuries were burns; 20 percent were related to use of firecrackers, and 19 percent involved the use of sparklers. Only 4 percent occurred at public displays. The demographic of the injured

victim was male (74 percent) aged 25–44 (34 percent).‡

To examine the occurrence of firework-related injuries in the National Trauma Data Bank® (NTDB) research dataset for 2013, admissions medical records were searched using the International Classification of Diseases, Ninth Revision, Clinical Modification diagnoses codes. Specifically searched were records that contained the following external cause of injury codes (E-code): E923.0 (injury caused by explosive material—fireworks). A total of 2,056 records were found; 1,599 records contained a discharge status, including 1,503 patients discharged to home, 47 to acute care/rehab facilities, and 28 to skilled nursing centers; 21 died. (See figure, this page.) These patients were 86 percent male, on average 27.8 years of age, had an average hospital length of stay of 4.7 days, had an intensive care unit length of stay of 5.5 days, had an average injury severity score of 5.6, and were on the ventilator for an average of 8.2 days. A total of 790 patients were tested for alcohol, and nearly half (49 percent) tested positive.

Think before you act
Ultimately, fireworks are explosives, so a little bit of common sense and respect for their power will go a long way in avoiding mishaps. Some fireworks safety tips that surgeons may want to share with their patients include the following:

• Never allow children to play with or ignite fireworks
• Never try to relight or pick up fireworks that failed to ignite fully
• Keep a bucket of water or hose on hand to put out any unexpected fires
• Light fireworks one at a time, and then step back
• Do not hold in your hand fireworks that are intended to be placed on the ground and ignited

For a full list of consumer fireworks safety tips and safety video, visit www.fireworkssafety.org/ and www.cpsc.gov/fireworks.

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

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

Acknowledgement
Statistical support for this article has been provided by Chrystal Caden-Price, Data Analyst, NTDB.
“Never forget that the numbers we talk about are people,” said Clifford Y. Ko, MD, MS, MSHS, FACS, FASCRS, Director of the American College of Surgeons (ACS) Division of Research and Optimal Patient Care and the National Surgical Quality Improvement Program (ACS NSQIP®), in introducing the theme of the ACS NSQIP 10th National Conference: Patient-Centered Care (PCC). According to Dr. Ko, more than 1,400 participants were at the 10th Annual National Conference July 25–28 at the Hilton Chicago, IL—the highest attendance to date for an event that continues to grow annually.

“We are living in a millennial environment in which we have information at our fingertips,” Dr. Ko said. “What we lose with all this information is context,” he said. “We don’t know how the concepts work in the hospital. We lose perspective. We need to know what to do when our steps don’t work.

“Quality improvement is not that easy,” Dr. Ko added. “But at this meeting, we can tell our stories and talk about our experiences. We can talk about the infrastructure needed to achieve quality, safety, and reliability. Through quality improvement success stories, we can talk about how we got there.” Practitioners must ask the pertinent questions about PCC, he said: What are its fundamental characteristics? How are interactions measured? How do we promote it?

Dr. Ko highlighted ACS NSQIP’s major accomplishments of the last 10 years, including the fact that an increasing number of hospitals are recognizing the benefits of participation. When the program launched in 2004, 18 hospitals had agreed to participate in ACS NSQIP. Today, the program is in nearly 700 hospitals worldwide.

Moreover, “We set a bar for data rigor and accuracy,” Dr. Ko said. “We’ve expanded the clinical database and advanced knowledge about achieving quality. Using clinical data, we’ve measured outcomes and influenced legislative policy.” For example, he noted that the legislation that repealed the sustainable growth rate Medicare payment formula replaces that flawed methodology with a Merit-Based Incentive Payment System.

Perhaps most importantly, “What we have observed is that if you use accurate data and make standardization and innovation a part of your culture, you can improve health care outcomes,” Dr. Ko said. Because ACS NSQIP has had a positive effect on patient care, he noted, The Joint Commission and the National Quality Forum honored the program with the John M. Eisenberg Patient Safety and Quality Award, which recognizes the major achievements of individuals and organizations in advancing patient safety and quality of care.

Putting the patient first

“Is the patient really first in your organization?” asked Scott J. Ellner, DO, MPH, FACS, director of surgical quality, Saint Francis Hospital and Medical Center, Hartford, CT; assistant professor of surgery, University of Connecticut School of Medicine; and co-chair, ACS Connecticut Chapter Committee on Patient Safety. Following up on Dr. Ko’s remarks about PCC, Dr. Ellner, who assumed an essential role in planning and organizing this year’s conference, noted that patient safety is more than a concept—it is a discipline that must be applied in daily practice. He told conference attendees a personal anecdote of a surgical “never event”—a mistake that is never supposed to happen.
“I had talked to the patient about possible complications, but despite all our talk, she had a terrible complication, and I had to have that never event conversation with her husband. “Surgeons have to recognize that we are fallible,” Dr. Ellner added. “We will make mistakes, but what’s important is how we respond to those mistakes. Don’t get defensive. Just be very candid with family members.” The experience taught him three lessons: (1) the best patient is an empowered patient; (2) the surgeon should share decision making with the patient and family and have a frank discussion about the plan of action; and (3) the surgeon should set meaningful expectations for the patient and family.

Verifying quality
In a session on Verifying Your Quality, moderated by Dr. Ko, ACS Executive Director David B. Hoyt, MD, FACS, said that measuring quality is the future of medicine. “It’s very exciting to see the growth of interest in quality over the past five years,” he said. “The question becomes ‘How do we take all of this information and go to the next level?’” Dr. Hoyt noted that the ACS is in the process of developing a consensus-based document on surgical quality. “We decided that what we need is a companion piece for ACS NSQIP, which has written the book on quality health care.”

Dr. Hoyt acknowledged the work of the surgical clinical representatives and noted that external peer review is critical to the quality improvement process. Health care practitioners must engage in self-assessment and honestly determine whether they are living up to the standards. The goal, Dr. Hoyt said, is high-value, highly reliable care, and the question for all practitioners becomes, “How do we harness the best practices out there?”

He also urged surgeons to work with hospital administrators. “This is a tremendous opportunity for all of us to commit to a set of standards,” Dr. Hoyt said. “Surgeons need to confront errors and learn from mistakes. That is the lesson of [Ernest] Codman, [MD, FACS,] who promoted the idea of case review and attention to outcomes,” Dr. Hoyt added. “There must be personal accountability.” Changing a hospital culture is a slow, deliberate process that requires input from every member of the team. “The person who yells the loudest shouldn’t set the policy,” he said. The keys to success, according to Dr. Hoyt, are surgeon leadership, discipline in following explicitly defined processes, and evidence-based responses to the question, “Does it work?”

Change leadership
In her presentation, Quality Leadership: From Bedside to the Board, Susan D. Moffatt-Bruce, MD, PhD, FACS, chief quality and patient officer, associate dean of clinical affairs, quality and patient safety, associate professor of surgery, the Ohio State University, noted that the value of health care equals quality over cost. “The number of quality metrics imposed by the CMS [Centers for Medicare & Medicaid Services] will continue to increase, and the surgical quality officer [SQO] has to lead the transformation.” The SQO, she said, must establish a governance structure to lead surgical and safety efforts, establish mechanisms to improve surgical quality, and seek out best practice models and quality improvement techniques. What the SQO inevitably finds, she said, is resistance to change, either from the group or individuals within the group. Meet this
resistance, she urged the audience, by noting that progress is impossible without change. “Change requires proven leadership, a compelling vision, and a sense of accountability,” Dr. Moffatt-Bruce said. She distinguished between a manager and a leader. A manager, she said, focuses on the present and strives to maintain the status quo and stability. A leader focuses on the future. A manager implements policies and procedures. A leader initiates goals and strategies.

“SQOs assume a vital leadership role in value-driven health care. They are the change agents,” she said. “The SQO helps the staff and patients move from volume to value. It requires some tough conversations and some tough decisions.”

In a session on Using Stories and Personal Perspectives to Change Surgery, John Wieland, MD, FACS, director of trauma, and chair, department of surgery, Order of Saint Francis St. Joseph Medical Center, Bloomington, IL, said, “Leadership is about inspiring people and motivating them to work toward organizational goals. Problems can be viewed as opportunities, but in order for this to happen, leaders must be flexible.” Mutual respect and communication between patient and surgeon are vital, he said.

“Communicate and know the hearts and minds of your colleagues,” Dr. Wieland added, noting that the goal of the surgeon leader is to create a movement that is both optimistic and centered on the patient.

In a discussion of professionalism and surgical innovation, Peter Angelos, MD, FACS, Linda Kohler Anderson Professor of Surgery, and chief, endocrine surgery, University of Chicago Medical Center, IL, pointed out the unique ethical challenges involved with surgical innovation. “Innovation is both the key to
surgical progress and the greatest challenge to professionalism in surgery,” he said, noting the difference between innovation in surgery and in business. Surgical innovations, he said, may lead to breakthroughs, but they may add an element of risk to the patient’s life. Today’s surgical standards, he said, are the result of oversight by surgical colleagues and professional self-regulation.

The patient’s perspective
In line with the theme of PCC, the conference featured keynote speaker and best-selling author Marcus Engel, MS, author of The Other End of the Stethoscope, who captured the struggle of a patient who endured two years of rehabilitation and more than 300 hours of reconstructive facial surgery.

“I grew up in a suburb of St. Louis [MO] called Ferguson,” Mr. Engel said. “I have nothing but fond memories of growing up in a small-town environment. I lived a very normal existence.” That sense of normality, however, was turned upside-down one weekend shortly after he started college. He and a group of friends piled into a small Toyota to attend a St. Louis Blues hockey game. On the way home from the game, his life changed instantly when the car was broadsided in a busy intersection by a drunk driver going twice the posted speed limit. Only a thin piece of metal in the automobile separated him from the full impact of the oncoming vehicle. The horrific collision left him blinded.

“I went into shock,” Mr. Engel told the gathering. “Shock is a gift when the human body experiences something so bad. My face was crushed, and my left jaw was hanging out my side.” The paramedics stabilized him and transported him to Barnes Jewish Hospital, St. Louis.

“My memories of that first night in the ER are sketchy,” he said. Supported by a feeding tube and respirator, Mr. Engel recalls that someone was holding his right hand. “This voice said to me, ‘Marcus, my name is Jennifer. You were in a car accident, and you are in the hospital.’ Then she said the two most compassionate words that a human being can speak—I’m here.’”

“Jennifer,” he told the gathering, provided the “power of presence. Jennifer just knew that what a human being needed was presence.” One day, two ophthalmologists came to Mr. Engel’s bedside and gently told him that they would be unable to restore his vision. “‘There’s nothing we or you can do to save even a portion of your vision,’” they told him.

“Hurting people hurt other people, and I remember telling them that I hated them,” Mr. Engel said. “Don’t you think those two surgeons felt as bad about this as I did? I remember asking them if there was a drug I could take that would restore my vision. Finally, I remember asking, ‘Why me?’”

He recalled a nurse named Barb. “‘I get to take care of you for the next eight hours,’” she said. “She asked what I preferred to be called, Marcus or Marc. She treated me like a person, not a diagnosis. That’s what I would remind all of you: You get to carry on the legacy and care for the people behind the evidence and the surveys. The profession of medicine is sacred work, and you need to remind yourselves of that every day.”

Effective communication
In a preconference session, How to Be an Effective Communicator, Dr. Ellner offered advice on how to approach a difficult conversation with another member of the surgical team. “It’s important not to attack the
person. Reframe the conversation so that it is not a personal issue, but get to the bottom of the issue, and when you are done, there should be mutual understanding of how to move forward.”

At the same session, Marlies van Dijk, RN, MSc, provincial implementation lead, innovation/quality and health care improvement, Alberta Health Services, Calgary, offered advice on speaking in front of a group of people. It’s not what you say, she told the attendees. It’s how you say it. Be mindful of your body language, she advised. Move around. Don’t stand behind a podium. Open your chest and arms and keep your back straight. Vary your hand gestures. Pause. Breathe slowly. Be confident about your message. Think about what action you want the audience to take, she said. Begin with something that will grab their attention, such as a dramatic story or a compelling fact.

**The new surgeon champion: What now?**

In a session titled I’m a New Surgeon Champion: Now What?, Jyotirmay Sharma, MD, FACS, assistant professor of general and endocrine surgery, Emory Healthcare, Atlanta, GA, said, “The first thing that happens is that you review the semiannual report. Then you have to decide what to do with the information.”

As the surgeon champion, Dr. Sharma and his team reviewed the hospital’s patient care in totality, from preoperative visits and perioperative counseling to intraoperative issues and postoperative care, and focused first on surgical site infections (SSIs). They collected outcomes data, fed it into the ACS NSQIP database, and extracted areas in need of attention.

The hospital administrators at Emory Healthcare initiated a new protocol for wound infection prevention, which included improved compliance with antibiotic redosing, wound protectors, chlorhexidine preparation, closing pans, double gloves, and standardization of procedures. The hospital experienced considerable improvements in SSI rates. “Failure is part of the process,” Dr. Sharma said. “Quality improvement takes time, so don’t go for the biggest thing first. Start smaller, and make it a launching pad for bigger changes.” Continue to reassure the people involved that problems are driven by the system, not

**BEST PRACTICES**

Each year, ACS NSQIP issues a call for abstracts to participating hospitals to submit presentation topics on how they have used ACS NSQIP to improve patient care. Awards honored authors in three abstract areas:

- **Surgical Clinical Reviewer Abstract:** Tracey Hong, BSN, RN, How the Implementation of an Enhanced Recovery Protocol Can Improve Patient Outcomes
- **Resident Abstract Winner:** Barrett Cromeens, DO, PhD, Findings from a Quality Improvement-Directed Pediatric Surgical Morbidity and Mortality Conference One Year after Implementation
- **Clinical Abstract Winner:** Allison A. Gullick, MSPH, Readmission Risk Profiles Differ Significantly Based on Indication for Colectomy
individuals, he added. When successes occur, celebrate them.

The hospital culture is critical to the success of quality improvement, said Eric Skarsgard, MD, FACS. Dr. Skarsgard is professor and co-director, Centre for Surgical Research, department of surgery, University of British Columbia, and surgeon-in-chief, British Columbia Children’s Hospital, Vancouver.

“Engage your team and your clinical leaders and perioperative program managers,” he said. “Quality safety programs do not exist without the support of the surgical clinical representatives.”

And “be prepared for skepticism,” Dr. Skarsgard added. “It’s important to instill in surgeons the sense that [quality improvement] is a team sport, and you should focus on the performance of the division and on group improvement. The conversation will change.”

Dr. Skarsgard presented a Top 5 list for change using ACS NSQIP data. First, he said, the culture must be supportive. Second, the team must see the evidence that shows change is needed. Third, there must be mutual respect among all team members, and fourth, a sense of continuous improvement. Finally, all of the activities should be patient-focused.

Matthew M. Hutter, MD, MPH, FACS, spoke on continuous quality improvement (CQI), in a presentation titled 13 Years as a Surgeon Champion and Still Learning. “It’s a marathon, not a sprint,” Dr. Hutter said. “Know the data and how it is collected.” Expect to hear some surgeons protest that their patients are sicker than those reflected in ACS NSQIP data, he said. “You must remind them that NSQIP data is clinical, prospective, and risk-adjusted.”

Dr. Hutter offered several QI tips. “Work closely and meet regularly with the surgical clinical representatives,” he said. In addition, he suggested making sure that hospital administrators are not just aware of your position as surgeon champion but that they respect it. The surgeon champion must ensure that the necessary team and infrastructure are in place, and transparency must be a goal at every level. “The surgeon needs to be proactive and take ownership of changes,” he said. “Understand the data and monitor it continually.”

ACS: Commitment to quality

In a general session intended to provide updates on the ACS and quality improvement, Dr. Hoyt reviewed recent reforms in U.S. health care, noting that the Affordable Care Act has expanded access and significantly changed the payment model. Acknowledging the work of economist and researcher Michael Porter, PhD, Bishop William Lawrence University Professor, Harvard Business School, Boston, Dr. Hoyt noted that improvement in any field requires measuring results, that systems improve by tracking progress over time, and comparing their performance to that of peers inside and outside the organization. “If you measure performance and publish quality reports, you will drive the marketplace,” Dr. Hoyt told the gathering.

At a session titled Facilitating the Key Aspects of a Collaborative, moderated by
Karl Y. Bilimoria, MD, FACS, associate professor, surgery-surgical services and medical social sciences, department of surgery, Feinberg School of Medicine, Northwestern University, Chicago, several speakers representing health care collaboratives revealed the lessons learned by working as teams to improve surgical outcomes.

Julie K. Johnson, MSPH, PhD, professor in surgery, Center for Healthcare Studies, Institute for Public Health and Medicine, Northwestern University, spoke of the how and the why of collaborative hospital site visits. “Go to gemba,” she said, referring to the Japanese term for going to the shop floor. “We learned from our site visits what people are doing when we go to the places where they work,” she said. “That’s where people are the most comfortable talking about their work.”

Joseph B. Cofer, MD, FACS, a leader of the Tennessee Surgical Quality Collaborative (TSQC) and a Past-President of the ACS Tennessee Chapter, told attendees to consider their motivation for working with a collaborative. The TSQC, established in 2008, unites the state’s surgeons, hospitals, and insurers, to share data, compare results, and improve outcomes. “This is not about getting ahead of the competition. It is about improving surgical outcomes everywhere,” Dr. Cofer said. “It takes time, and it demands staying power.”

**Change agent**

ACS NSQIP brings a measurable, reliable path of change to an expensive, overburdened health care system. Quality improvement is slow and deliberate. It requires disciplined leaders and surgeon champions, dedicated team members, and collaboratives that work together to promote quality care and the goals of continuous quality improvement.

“Every conversation we have to improve patient care should be data driven,” said Bruce L. Hall, MD, PhD, MBA, FACS, professor of surgery, Washington University in St. Louis; vice-president of quality at Barnes Jewish Hospitals; and ACS NSQIP Consulting Director. “Accurate data are one of the strongest change agents we have.”

---

**JACS receives highest impact factor to date**

The *Journal of the American College of Surgeons (JACS)* recently learned of its 2014 Thomson Reuters impact factor for 2014—5.122. This rating represents *JACS*’ highest impact factor to date and a 15 percent increase in impact from the previous year. *JACS* now ranks eighth of 198 surgery journals on the Thomson Reuters list. Timothy J. Eberlein, MD, FACS, *JACS* Editor-in-Chief, credits the high-impact factor to the dedication and hard work of the editors, staff, and hundreds of peer reviewers.

The impact factor of an academic journal is a measure reflecting the average number of citations to recent articles published in that journal, and is often used to gauge the relevance of a particular journal in its field. Thomson Reuters ranks, evaluates, and compares journals within subject categories and publishes the results in Journal Citation Reports. The 2014 rating reflects the number of times articles published in a journal in 2012 and 2013 were cited. In other words, *JACS* papers published in 2012 and 2013 were cited an average of more than five times.

A strong impact factor can help to attract authors looking to publish their research in a journal that provides a maximum amount of exposure. *JACS* celebrates its position as one of the world’s top surgical journals and is dedicated to publishing high-quality scientific articles and providing surgeons with world-class content in timely and innovative ways.
In memoriam:

Dr. Norman McSwain, a pioneer in comprehensive trauma care

by Will Chapleau, RN, EMT-P, and Ronald M. Stewart, MD, FACS

Norman E. McSwain, Jr., MD, FACS—surgeon, teacher, mentor, collaborator, and internationally recognized visionary leader in trauma care—died July 28 in his New Orleans, LA, home, surrounded by family and friends. Dr. McSwain was 78. The dynamism, positivity, and warmth Dr. McSwain brought to all he did is greatly missed by surgeons and patients alike. He is survived by his daughter Merry Johnston McSwain; his sister Ann McSwain Kightlinger, and her husband Neal; and his niece and nephew, Janelle Eason and David Kightlinger.

Dr. McSwain was an exemplar in each professional role he undertook, which included trauma surgeon, professor, registered emergency medical technician (EMT), and leader of numerous health care organizations and initiatives. As founder and medical director of the Prehospital Trauma Life Support (PHTLS) program, he forever changed the education and training of emergency medical services (EMS) personnel and gave them the necessary tools for optimal treatment immediately following injury. He was fond of beginning his conversations with colleagues and staff with a simple but penetrating question: “What have you done for the good of mankind today?” This query represented the core of Dr. McSwain’s motivation for practicing medicine and is indicative of his humanitarian spirit.

Early years

Born in northern Alabama in 1937, Dr. McSwain earned his bachelor of science degree from Sewanee: The University of the South, TN, and in 1963 began his medical education at the University of Alabama School of Medicine, Birmingham. There he trained under Champ Lyons, MD, FACS, a prominent surgeon from the early years of the Ochsner Clinic Foundation (now the Ochsner Medical Health System), New Orleans. Dr. McSwain completed his internship at the Bowman Gray School of Medicine (now Wake Forest School of Medicine), Winston-Salem, NC. He then joined the U.S. Air Force where, under the tutelage of Major General Kermit Vandenbos, MD, FACS, he completed more than 1,000 surgical procedures before completing his residency at Grady Memorial Hospital, Emory University School of Medicine, Atlanta, GA. Dr. McSwain then became a partner in private practice with Harrison Rogers, MD, FACS, in Atlanta.

As medical director of the Road Atlanta race track, he developed an interest in emergency medicine and trauma care, and in 1973, Dr. McSwain joined the faculty of the University of Kansas School of Medicine (KUMC), Kansas City, where he developed a statewide EMS system and served as its medical director. He met this challenge with what would become familiar dedication and success, establishing a standardized EMT curriculum and training program.

In 1977, Dr. McSwain was recruited by Tulane University School of Medicine and Charity Hospital, New Orleans, where he
He was fond of beginning his conversations with colleagues and staff with a simple but penetrating question: “What have you done for the good of mankind today?” This query represented the core of Dr. McSwain’s motivation for practicing medicine and is indicative of his humanitarian spirit.

brought his tireless enthusiasm to bear in developing EMS protocols for the city. He was instrumental in developing Charity Hospital into an ACS Verified Level I Trauma Center, partnering with his colleagues at Louisiana State University. Dr. McSwain would continue to work at Tulane until the final weeks before his passing.

**COT and revolutionizing emergency trauma care**

Dr. McSwain became a Fellow of the American College of Surgeons (ACS) in 1973 and began working with the Kansas Committee on Trauma (COT) in 1975. He subsequently joined the national COT, where he led the Prehospital Care Committee and the Advanced Trauma Life Support® (ATLS®) Committee. He also worked in what is now known as the COT Verification, Review, and Consultation Program for hospitals. He would serve on the Louisiana COT for the next three decades. In time, Dr. McSwain would become the only Fellow in ACS history to receive all major trauma awards, including the Meritorious Service Award from ATLS in 1989; the National Safety Council’s Surgeons’ Award for Service to Safety in 1998; the COT Millennium Commitment Award in 2000; and the COT’s Meritorious Achievement Award. He also delivered the Scudder Oration at the ACS Clinical Congress in 2001.

Through his service on the COT, Dr. McSwain helped lead revolutionary changes in how trauma care was taught and practiced. He believed that the principles of the ATLS course—which was designed to train emergency physicians and trauma surgeons to provide standardized treatment in the so-called golden hour following an injury—could have an even more significant effect if the same techniques were taught to EMS professionals. After receiving approval from the COT to create and share a prehospital version of the course, he collaborated with the National Association of Emergency Medical Technicians to bring it to fruition. By the mid-1980s, regional faculty courses had been established and the program began to proliferate. The PHTLS course had been born with Dr. McSwain serving as medical director. Since then, the course’s impact in trauma and emergency care has been profound.

More than 1 million EMTs in more than 60 countries have participated in PHTLS—impressive numbers in and of themselves. But if this training led each of these EMS-providers to rescue even two or three trauma victims from a life-threatening hemorrhage or a blocked airway, you begin to understand that Dr. McSwain’s passion to educate and train all trauma care practitioners has likely saved millions of lives around the world. The effect becomes even more staggering if you add in the effect of training derived from PHTLS, which includes Tactical Combat Casualty Care and law enforcement, first responder, and lay-person bleeding control courses.

Dr. McSwain’s commitment to provide optimal treatment...
to trauma victims as quickly as possible never waned. Following the 2012 shooting at Sandy Hook Elementary School, Newtown, CT, Dr. McSwain collaborated with ACS Regent Lenworth H. Jacobs, Jr., MD, MPH, FACS, to form the Joint Committee to Develop a National Policy to Increase Survival from Active Shooter and Intentional Mass Casualty Events. All of the characteristics for which he had become known throughout his career—his dedication, passion, and intellect—were brought to bear in the Hartford Consensus meetings that followed. He advocated for coordinated, standardized, and improved hemorrhage control training for law enforcement and EMS professionals, and he advocated for extending this training to include the lay public responders on the scene. His goal, and the goal of his colleagues, was to empower and convert bystanders into effective and trained doers, aimed at immediate control of life-threatening bleeding. Dr. McSwain contributed to

Strategies to Enhance Survival in Active Shooter and Intentional Mass Casualty Events: A Compendium, which mailed with the September Bulletin. He died shortly before its publication, but Dr. Jacobs dedicated the publication to his friend and colleague, Dr. McSwain.

The good of mankind
As a surgical educator, Dr. McSwain was a patient, thoughtful teacher. In 2009, he received Tulane’s School of Medicine Teaching Scholar Award, in part for “McSwain’s Rules of Patient Care,” a list of 18 rules that guided his professional philosophy and that he offered to medical students and colleagues. He was an able and willing mentor, offering advice and guidance to all who sought it—surgeons, police, EMTs, even civilians—so that they would be better able to treat the trauma victim. He served as U.S. Navy Captain in the Persian Gulf as a general surgeon; volunteered as police surgeon for injured New Orleans Police Department officers for more than 35 years; served as editor or contributor to multiple surgery journals; lectured throughout the U.S. and the rest of the world; and worked in many other roles throughout his career.

“What have you done for the good of mankind today?” Looking back at a life and career dedicated to improving the lives of people around the world, we know that, for Dr. McSwain, that question has been soundly answered. ♦
The American Medical Association (AMA) House of Delegates (HOD) Annual Meeting took place June 6–10 in Chicago, IL. During the meeting, a delegation from the American College of Surgeons (ACS) advocated for policies of interest to surgeons and worked with other specialty and state medical societies to achieve consensus on recommendations from 185 resolutions and 68 reports.

The ACS Delegation is one of the largest specialty society delegations in the HOD, providing comments and leadership on surgical and health care system matters. Working collegially with other delegations is key to ensuring effective representation of surgical interests. A list of the ACS delegates appears in the sidebar on this page.

**How the HOD functions**

Twice a year, 530 delegates from national specialty and medical societies, state medical societies, and AMA sections participate in HOD meetings. The HOD operates like the U.S. Congress; each delegate is like a representative and has the opportunity to vote on policy matters and for AMA officers and council members in a way that represents the interests of his or her constituents.

**Items of business**—reports and resolutions—are introduced by medical societies and sections or by individual delegates. Each item receives a hearing by a reference committee, typically composed of seven delegates. The delegates listen to testimony on each item in an open hearing and distill comments into recommendations. These recommendations, with rationale, are then collated in a report for consideration by the entire HOD. Recommendations may be adopted, rejected, amended, or referred to the AMA Board of Trustees for study or action. If a contentious item cannot be resolved, it is generally referred to the Board of Trustees for study or action.

**AMA elections**

Elections for AMA offices are conducted at the June meeting. A number of surgeons were successful in their campaigns this year. Through the hard work and dedication of the College’s delegation and 22 endorsing organizations, Patricia Turner, MD, FACS, was re-elected to the AMA Council on Medical Education for a four-year term. In addition to serving as Director of ACS Member Services, Dr. Turner also is clinical associate professor.
One of the most significant issues discussed in [Reference Committee A] dealt with the Medicare three-day stay rule, by which a Medicare beneficiary must be an inpatient for a medically necessary stay of at least three consecutive days to qualify for post-discharge extended care services.

Reference Committee A: Health Systems
• Resolution 103, Three-Day Stay Rule: One of the most significant issues discussed in this reference committee dealt with the Medicare three-day stay rule, by which a Medicare beneficiary must be an inpatient for a medically necessary stay of at least three consecutive days to qualify for post-discharge extended care services. Three resolutions were consolidated into one, consistent with ACS policy, which can be summarized as follows: the AMA will continue to advocate before Congress and the Centers for Medicare & Medicaid Services (CMS) for the elimination of the three-day inpatient hospital stay requirement for Medicare coverage of post-hospital skilled nursing facility services. Furthermore, as long as this requirement remains, the AMA will work to include patient time in hospital observation and emergency room settings as part of the three-day hospital inpatient window before transfer to a skilled nursing facility.

Reference Committee B: Legislation
• BOT Report 6, Medical Information and Its Uses: The HOD adopted Data Transparency Principles to Promote Improvements in Quality and Care Delivery as new AMA policy. The policy comprises 14 principles that are intended to leverage health care data in a way that helps physicians improve the quality reporting of patient care data and adapt to new payment and delivery models to transform the U.S. health care system.
• Resolution 211, ICD-10 Implementation: This resolution reflected a shift in tone on this issue from stopping ICD-10 to easing the transition to ICD-10. The AMA will now advocate to Congress and CMS through a grassroots campaign seeking a two-year grace period for the ICD-10 transition, during which physicians would not be penalized for errors or system malfunctions. CMS has since agreed to a one-year grace period.
• Resolution 222, Medicare and Sequestration: Sequestration, resulting from the federal budget impasse of 2012, creates a hidden 2 percent tax on Medicare physician payments. Strong support was expressed for the AMA to take all necessary legislative and administrative steps to prevent extended or deeper sequester cuts in Medicare programs. Many delegates felt that the success of stopping Medicare cuts due to the repeal of the broken sustainable growth
rate formula used to determine Medicare physician payments should not be tarnished by cuts resulting from sequestration.

• Resolution 237, 96-Hour Rule for Critical Access Hospitals: This resolution asked the AMA and other stakeholders to support and lobby for passage of legislation to provide relief from the 96-hour rule for critical access hospitals. Under this rule, patients at these institutions who are otherwise progressing well must be transferred to a noncritical access hospital after 96 hours. The HOD agreed and adopted the resolution.

Reference Committee C: Medical Education

• Council on Medical Education Report 2, Update on Maintenance of Certification (MOC) and Osteopathic Continuous Certification: Reflecting continuing concern about the unintended financial consequences of MOC, the HOD passed this report, which directs the AMA to lobby the American Board of Medical Specialties (ABMS) to develop fiduciary standards that ensure all ABMS specialty boards provide full transparency related to the costs of preparing, administering, scoring, and reporting MOC and certifying/recertifying examinations. In addition, it directs the AMA to ensure that MOC and certifying/recertifying examinations do not result in significant financial gain to the ABMS specialty boards.

• Council on Medical Education Report 3, The Value of Graduate Medical Education (GME): This report, adopted without amendment, has the AMA engaging in policymaking and public outreach to increase awareness of the societal value of GME, advocating for expanded all-payer GME funding, pushing for congressional appropriation of the National Healthcare Workforce Commission, and promoting transparency of GME funding.

• Resolution 315, Obesity Education: The ACS cosponsored this resolution with the American Association of Bariatric Physicians, American Association of Clinical Endocrinologists, and Colorado Medical Society. The adopted resolution directs the AMA to encourage medical school accrediting bodies to study and report back on the current state of obesity education in medical schools. Furthermore, the AMA will use this report to identify organizations that currently provide educational resources about obesity education for physicians in training and, in consultation with relevant specialty organizations and stakeholders, look for gaps and make recommendations regarding obesity education in medical schools.

Reference Committee D: Public Health

• Council on Science and Public Health Report 3, Concussion and Youth Sports: The AMA now promotes the adoption of requirements that a coach, trainer, administrator, or other individual responsible for the health and well-being of school athletes and participants in other organized youth sports immediately remove from the activity any player who is suspected of having sustained a concussion. The athlete would not be allowed to return to competitive play, practice, or other sports-related activity without the written approval of a licensed physician (MD or DO) or licensed health care professional...
whose scope of practice includes proper training in the evaluation and management of concussion. When evaluating individuals for return to play, physicians and health care professionals should be mindful of the potential for other occult injuries.

- Resolution 423, Support of Mandating Protective Headgear (Helmets) in the Sport of Girls/Women’s Lacrosse: Delegates expressed considerable support for this issue and adopted a resolution requiring helmet use in girls/women’s lacrosse.

Reference Committees E: Science and Technology, and F: AMA Governance
These committees did not cover pressing surgical issues.

Reference Committee G: Medical Service
• Council on Medical Service Report 4, Price Transparency: This adopted report recommends ways to expand the availability of health care pricing information that is meaningful for patients and their physicians who want to make value-based decisions. The ACS delegation emphasized that multiple health care providers and payors beyond physicians are responsible for pricing, and a report recommendation regarding physician fee schedules was adjusted so that the AMA encourages physicians to communicate information about the cost of their professional services to individual patients, taking into consideration insurance parameters and other relevant information (hospital costs, for example).

Reference Committee on Constitution and Bylaws
• Board of Trustees Report 13, Methods to Increase U.S. Organ Donor Pool: The HOD adopted a report with strong support that offers recommendations for the AMA to support studies that evaluate the effectiveness of mandated choice and presumed consent models for increasing organ donation; urge development of effective methods for meaningful exchange of information to educate the public and support well-informed consent about donating organs; and encourage the continued study of ways to enhance the allocation of donated organs and tissues.

Surgical Caucus
More than 85 delegates attended an educational session sponsored by the Surgical Caucus. Surgical Quality at the Grass Roots: How Quality Collaboratives Improve Surgical Care featured ACS chapter leaders from the Connecticut and Tennessee quality collaboratives. Speakers described the factors that go into the development of statewide collaboratives and demonstrated how a quality collaborative can improve the delivery of surgical care.

Next meeting
The AMA House of Delegates will meet again November 14–17 in Atlanta, GA. The ACS delegation welcomes your questions and suggestions for ACS-sponsored resolutions. E-mail questions and suggestions to state_affairs@facs.org. ♦

Sequestration, resulting from the federal budget impasse of 2012, creates a hidden 2 percent tax on Medicare physician payments. Strong support was expressed for the AMA to take all necessary legislative and administrative steps to prevent extended or deeper sequester cuts in Medicare programs.
Now Available Online.

The ACS Practice Management Course for Residents and Young Surgeons, Volumes I, II, and III, is designed to educate and equip participants with basic practice management skills and the knowledge to manage a surgical practice.

Using an interactive/lecture format, the three separate courses cover a variety of topics, including:

- Pros and cons of a career in private practice
- Surgical practice organization
- Coding for surgical residents
- Surgical financial management reports
- Insurance processing
- Accumulation planning
- Goal planning and risk management
- Negotiation
- Liability equation changes

**NEW topic in each volume:**

- **Volume 1:** Interpersonal and Communication Skills—An Important Competency for Risk Management
- **Volume 2:** Professionalism—A Critical Risk Management Tool
- **Volume 3:** Postadverse Event Communication—The Key!

To access the ACS Practice Management Course today, visit [www.facs.org/education/resources/elearning](http://www.facs.org/education/resources/elearning).

For more information, contact Olivier Petinaux, Senior Manager, Distance Education and E-Learning, at elearning@facs.org or 866-475-4696.
The International Relations Committee of the American College of Surgeons (ACS) is pleased to announce a special opportunity for international ACS chapters provided by the Pon Satitpunwaycha, MD, FACS, International Fund, known as the “Dr. Pon Fund.” The Dr. Pon Fund will allow international chapters to create a local educational course that includes faculty from the ACS.

The overarching goals of this competitive grant program are to promote surgical education to the international surgical community and to encourage the active involvement of the international chapters in ACS activities.

Up to $25,000 per year will be made available to the international chapters to develop educational courses in their own countries. Subject to the quality, merit, and requirements of each proposal, grants ranging from $12,000 to $25,000 will be awarded up to two chapters. An international chapter may use the grant to present the ACS General Surgery Review Course or other surgery-focused courses (abdominal, thoracic, pediatric, vascular, plastics, trauma, oncologic, breast, head and neck, and so on) in its home country. The grant is intended to cover necessary costs, such as the travel expenses of ACS faculty who will teach the course. The grant is not expected to cover all expenses related to course material, venue rental, audiovisual equipment, and food; chapter funds should be used to support those expenses.

Application requirements and additional details

International chapters will submit an application in which they clearly indicate:

- The title of the proposed course.
- Description/purpose of activity, explaining why such a course is needed in the country; the targeted audience (surgeons, trainees, nurses, other); and learning objectives.
- Duration of the course (between one and two-and-a-half days).
- Course format (lectures, hands-on sessions, other). Submission of a preliminary program is required.
- Names of proposed faculty, both local and international. International faculty will ideally support or represent 50 percent to 60 percent of the faculty. U.S.-based ACS Fellows will ideally represent 40 percent to 50 percent of the faculty.
- A conflict of interest form must be submitted. The form is available for download at www.facs.org/international/resources/pon-fund.
- Costs broken down by category (travel, materials).
- A letter of support from the organizing institution or university.

Additional details of this program include the following:

- Preference will be given to chapters that demonstrate additional funds from other sources. Preference will also be given to proposals that can be replicated in other international chapters.
- The chapter must demonstrate ways it will encourage surgical trainees and medical students to attend and participate in their event.
- A detailed report of activities must be submitted at the conclusion of the event. In addition, a detailed
financial breakdown of grant use is required.

All proposals must be made by an officer of an international ACS chapter and should be submitted electronically to the International Liaison at kearly@facs.org. Deadline for submission of proposals is January 15, 2016. All applicants will be notified of the outcome by April 1, 2016.

For additional information, contact the ACS International Liaison at kearly@facs.org.

The overarching goals of this competitive grant program are to promote surgical education to the international surgical community and to encourage the active involvement of the international chapters in ACS activities.

Dr. Sachdeva delivers named lectures at graduation day events for surgery residents

Ajit K. Sachdeva, MD, FACS, FRCSC, Director, Division of Education, American College of Surgeons (ACS), was invited to deliver named lectures at graduation events for surgery residents completing their training at two renowned universities. Dr. Sachdeva delivered the Philip E. Donahue, MD, FACS, Keynote Address titled Training and Retraining for Lifelong Surgical Practice, at the University of Illinois, Chicago. At the University of North Dakota, Grand Forks, he delivered the Edwin C. James, MD, Lecture titled Preparation of Surgery Residents for Surgical Practice: Challenges, Opportunities, New Directions.

In these lectures, Dr. Sachdeva discussed development and maintenance of expertise and mastery in surgery, importance of lifelong learning throughout surgical careers, specific needs during the transition from residency to surgical practice, and the use of cutting-edge education and training to ensure the best outcomes.

In his ACS role, Dr. Sachdeva is responsible for the development and implementation of educational programs for surgeons, surgery residents, medical students, and members of surgical teams. He has introduced many innovations in surgical education and training, and is an internationally recognized leader in this field.
Proudly display that you’re a Fellow of the American College of Surgeons

As a Fellow, you are dedicated to improving the care of surgical patients. You have pledged to place the welfare and rights of your patients above all else, to respect each patient’s autonomy and individuality, and to advance your knowledge and skills throughout your career.

Share these commitments with your patients by displaying the Fellowship Pledge poster in your waiting room, exam room, or office.

Visit http://bit.ly/1EkGKSh to purchase or download a poster today.
The Board of Regents of the American College of Surgeons (ACS) took the following disciplinary actions at its June 5–6, 2015, meeting in Chicago, IL:

- A Fellow who is a general surgeon from Beaverton, OR, was censured. This action was taken after the Oregon Medical Board issued a corrective action agreement placing conditions on this surgeon’s license. This action was taken following an investigation related to the surgeon's preparation for a recertification exam with a specialty board.

- George D. J. Griffin III, MD, FACS, an orthopaedic surgeon from Cincinnati, OH, had his full Fellowship privileges restored following a period of probation. Dr. Griffin fulfilled the conditions for reinstatement that the ACS Board of Regents imposed on his Fellowship in September of 2012.

---

**DEFINITION OF TERMS**

Following are the disciplinary actions that may be imposed for violations of the principles of the College:

- **Admonition**: A written notification, warning, or serious rebuke.

- **Censure**: A written judgment, condemning the Fellow or Member's actions as wrong. This is a firm reprimand.

- **Probation**: A punitive action for a stated period of time, during which the Member: (a) loses the rights to hold office and to participate as a leader in College programs; (b) retains other privileges and obligations of membership; (c) will be reconsidered by the Central Judiciary Committee periodically and at the end of the stated term.

- **Suspension**: A severe punitive action for a period of time, during which the Fellow or Member, according to the membership status: (a) loses the rights to attend and vote at College meetings, to hold office, and to participate as a leader, speaker, or panelist in College programs; (b) is subject to the removal of the Member’s name from the public listing and mailing list of the College; (c) surrenders his or her Fellowship certificate to the College, and no longer explicitly or implicitly claims to be a Fellow of the American College of Surgeons; (d) pays the visitor’s registration fee when attending College programs; (e) is not subject to the payment of annual dues. When the suspension is lifted, the Fellow or Member is returned to full privileges and obligations of Fellowship.

- **Expulsion**: The certificate of Fellowship and all other indicia of Fellowship or membership previously issued by the College must be forthwith returned to the College. The surgeon thereafter shall not explicitly or implicitly claim to be a Fellow or Member of the American College of Surgeons and may not participate as a leader, speaker, or panelist in College programs.
ACS welcomes Nigeria Chapter

At its June 5–6 meeting, the Board of Regents of the American College of Surgeons (ACS) unanimously approved the establishment of the Nigeria Chapter, the 108th chapter of the College. With this addition, the College now has 67 domestic and 41 international chapters, with other proposed chapters in regions around the globe in various stages of formation.

The newly elected officers of the Nigeria Chapter are as follows: Stanley Anyanwum, MB, BS, FACS, President; Bello Bala Shehu, MB, BS, FACS, Vice-President; Samuel Adesina Ademola, MB, BCh, FACS, Secretary; Lukman Abdur-Rahman, MB, BS, FACS, Treasurer; and Adesoji Ademuyiwa, MB, BS, FACS, Councilor. Emmanuel Ameh, MB, BS, FACS, is the Governor of the Nigeria Chapter and was instrumental in its formation.

While attending the 10th Annual Scientific Conference and All Fellows Congress of the National Postgraduate Medical College of Nigeria in Abuja, officers and members of the new Nigeria Chapter met for a celebratory dinner on August 12 at the Nigerian Air Force Conference Centre. Non-member surgeons attending the Congress in Abuja were encouraged to join the festivities as guests of the Nigeria Chapter Fellows to learn more about the ACS and the benefits of membership.

North Carolina and South Carolina chapters hold annual meeting

The North Carolina and South Carolina Chapters of the ACS held their combined annual meeting at Pinehurst Resort in North Carolina. On the first day of the three-day meeting, Clifford Y. Ko, MD, MS, MSHS, FACS, FASCRS, Director, ACS Division of Research and Optimal Patient Care and the ACS National Surgical Quality Improvement Program, was the guest at a North Carolina/South Carolina Council and Quality Collaborative Lunch, where he co-moderated a discussion on building a surgical collaborative in the Carolinas. ACS President Andrew L. Warshaw, MD,
FACS, FRCSEd(Hon), delivered a keynote address, How the American College of Surgeons Is Leading in Our Profession. Dr. Warshaw presented the breadth of ACS activities, including quality measure activities from the past to the present, the growth of international membership, and the current focus on specialty membership.

Donna Tieberg, Chapter Services Manager, attended an Association of Women Surgeons (AWS) luncheon, where Nancy Gantt, MD, FACS, President of the Ohio Chapter of the ACS and the AWS, offered a keynote speech on work-life balance, suggesting to the surgeons and residents assembled that “goals are important—plus balancing the different phases of who or what needs help in your life besides your surgical practice.”

Terry Sarantou, MD, FACS, Past-President of the North Carolina Chapter, provided the Governors Report. Mark C. Weissler, MD, FACS, Chair of the ACS Board of Regents and Joseph P. Riddle Distinguished Professor and chief, division of head and neck oncology, University of North Carolina at Chapel Hill, addressed the specialty surgeons in the audience, noting, “The College pulls us all together as specialists—we have much in common with general surgeons.”

Walter J. Pories, MD, FACS, Second-Vice-President-Elect of the College, gave the Leo Waldenberg Lecture and facilitated a discussion, Curing Diabetes with Surgery… Really? According to Dr. Pories, the gastric bypass procedure often produces full and double remission of type 2 diabetes.

Representing the ACS Foundation at the meeting were Martin Wojcik, CFRE, Executive Director of the ACS Foundation, and Richard B. Reiling, MD, FACS, member of the North Carolina Chapter. Dr. Reiling noted that the Foundation helps to facilitate the Kankuben B. Gelot Scholarship Program through the funding of Raghuvir B. Gelot, MD, FACS, a North Carolina Chapter member. The Scholarship was created in honor of Dr. Gelot’s mother, Kankuben B. Gelot, and provided support for this year’s residents’ papers and poster competitions held at the North Carolina/South Carolina meeting.

The last night of the meeting featured a Carolina barbecue in the Pinehurst Resort Clubhouse, attended by chapter members and their families, staff, and other guests. After-dinner festivities included an hour of Group Surgical Jeopardy. Next year, the combined chapter annual meeting will feature a resident Surgical Jeopardy competition, including awards and teams composed of resident surgeons from local surgical training programs. The North Carolina/South Carolina Chapters received their
Resident Surgical Jeopardy Kit via the Education Committee of the Resident and Associate Society (RAS) of the ACS. The committee is pilot-testing the toolkit through the end of 2015. Your chapter may request a pilot Surgical Jeopardy toolkit at rasnews@facs.org.

Illinois Chapter Annual Meeting held with Central Illinois Surgical Week

The Illinois Chapter of the ACS held its annual meeting during the 2015 Central Illinois Surgical Week, June 16–21, at the Jump Trading Simulation & Education Center, Peoria, IL. This year’s Surgical Week comprised three different events—the second Annual Norman C. Estes Surgical Symposium, the Robotics Symposium, and the 65th Annual Scientific Meeting of the Illinois Chapter. Nearly 100 members attended the chapter meeting, the largest attendance in several years. Annual meeting Educational Program Co-Directors Steven S. Tsoraides, MD, FACS; Robin A. Alley, MD; and Allison R. Tanck, MD, created a diverse program, adding an educational segment specifically designed for mid-level health care professionals.

Keynote speakers included Theodore J. Saclarides, MD, FACS, division director, colon and rectal surgery, Loyola University, Stritch School of Medicine, Maywood, IL, who spoke on Providing Quality and State of the Art Care in Colorectal Surgery, and Richard A. Prinz, MD, FACS, endocrinologist, NorthShore University HealthSystem, Evanston, IL, and clinical professor, University of Chicago Pritzker School of Medicine. Dr. Prinz discussed Thyroid Cancer: More or Less. ACS Regent Margaret M. Dunn, MD, MBA, FACS, presented an Update on ACS Activities. Also included in the program were sessions on career planning for residents, political issues, new technology, and robotics in general surgery.

A social event for chapter members and guests took place at the Caterpillar Visitors Center in Peoria. Guests explored the museum and experimented with large equipment simulators before dinner.

In the evening, the Founder’s Resident Papers Competition award winners were announced, as follows:

• Jamie Harris, MD, Rush University Medical Center, Chicago, was the first-place award winner of the competition, receiving $500 for his paper Intra-tumoral Implantation of Vincristine-Loaded Sustained-Release Silk Sponge is Effective in Tumor Control in an Orthotopic Neuroblastoma Murine Model.

• Second place, with an award of $300, was given to Shaun D. Mendenhall, MD, Southern Illinois University School of Medicine, Springfield, for A Microbiologic Comparison of Acellular Dermal Matrices as an Aseptic Reconstructive Materia and a Scaffold for Stem Cell In-Growth.

• Third place, with an award of $200, went to V.A. Fleetwood, MD, Rush University Medical Center, for Therapeutic Influenza Infection Significantly Abrogates Development of Type I Diabetes in the NOD Mouse.
Metropolitan Philadelphia Chapter forms new Resident Subcommittee
A newly formed Resident Subcommittee of the Metropolitan Philadelphia Chapter of the ACS (MPACS) held its inaugural planning session July 9. The subcommittee strives to be the pulse of resident physicians in the Philadelphia, PA, area and to increase MPACS participation among residents. Rebecca Hoffman, MD, a general surgery resident at the University of Pennsylvania Health System, Philadelphia, chairs the new subcommittee and is the voice of residents at MPACS Council meetings. The Resident Subcommittee includes resident representatives from every Philadelphia-area surgical institution. The subcommittee will plan resident and young surgeon events in the metropolitan Philadelphia area and facilitate inter-institution networking. Currently, the Resident Subcommittee of the MPACS is planning a Fall 2015 Citywide Metro Philadelphia Surgical Jeopardy competition. For more information, go to the Metropolitan Philadelphia Chapter website at www.metrophilasurgeons.org or e-mail mpcacs@pamedsoc.org

Lebanon Chapter hosts 15th Surgical Congress in Beirut
The Lebanon Chapter of the ACS and the Lebanese Society for General Surgery hosted the 15th Surgical Congress June 11–13 at the Hilton Habtoor Grand Hotel in Beirut. Approximately 180 surgeons from Lebanon and other countries, including France, the U.S., the U.K., Jordan, the U.A.E., Saudi Arabia, Syria, Iraq, and Egypt, attended the meeting. The Congress consisted of three days of multidisciplinary educational sessions and updates, case presentations, and workshops led by recognized experts from around the world. A gala dinner took place June 12, with many local and international faculty and their guests in attendance. The 15th Surgical Congress was preceded by the much-anticipated ACS General Surgery Review Course June 5–7 in Lebanon at the American University of Beirut Medical Center.

Alberta Chapter meets in Banff, votes in new president
The Alberta Chapter of the ACS met in February in conjunction with the Alberta Association of General Surgeons. The chapter sponsored two resident research award winners to the association and chapter meeting. Pang Young, MD, was the resident research award winner from the University of Alberta for his paper Oncostatin M Plays a Critical Role in Survival following Acute Intestinal Ischemia Reperfusion Injury. Christopher Blackmore, MD, was the resident research award winner representing the University of Calgary. His presentation, Should We Still Be Performing Open Appendectomies?, compared outcomes for laparoscopic versus open appendectomy. The chapter also sponsored the annual Robert Pow Lecture, delivered by Rebecka L. Meyers, MD, a pediatric surgeon at Primary Children’s Hospital, Salt Lake City, UT. Dr. Meyers addressed specialty training and workforce planning in the U.S. The Fellows of the Alberta
Chapter also announced that they have elected Bruce C. Rothwell, MD, FACS, general surgeon, Peter Lougheed Centre, Calgary, and clinical assistant professor, Cumming School of Medicine, Calgary, as their Chapter President for 2015–2017.

Greece Chapter helps to organize Scientific Congress, participates in ATLS board meeting
The Greece Chapter of the ACS helped to organize an international meeting May 15–16 at the Athens Concert Hall, which took place in conjunction with the 21st Scientific Congress of the Scientific Society of Hellenic Medical Students. The theme of this international meeting was Cutting Edge Trauma and Emergency Surgery: Tricks, Tips, and Techniques. This unique joint academic event featured internationally renowned faculty, including Dr. Warshaw; Demetrios Demetriades, MD, PhD, FACS, professor of surgery and director, division of acute care surgery, Keck School of Medicine, University of Los Angeles County and Southern California Medical Center; Marc De Moya, MD, FACS, Massachusetts General Hospital; director, surgical clerkship for Harvard Medical School; and medical director, Trauma Nurse Practitioner Program, Boston; Jamal Hoballah, MD, FACS, ACS Governor for Lebanon; Miguel Cainzos, MD, FACS, ACS Governor for Spain; and Giuseppe Nigri, MD, PhD, FACS, FRCS, FASCRS, Treasurer, Italy Chapter.

Dr. Patrick Bailey keynote speaker at Hawaii Chapter annual meeting
The Hawaii Chapter of the ACS hosted its annual meeting August 15 at the Queen’s Medical Center in Honolulu, with
49 members and guests in attendance. Patrick V. Bailey, MD, FACS, Medical Director of Advocacy, ACS Division of Advocacy and Health Policy, was the keynote speaker. Dr. Bailey spoke on surgical outcomes as they relate to physician payment, specifically describing provisions in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) that establish a Merit-Based Incentive Payment System (MIPS). Dr. Bailey also served as a judge/evaluator at the chapter’s Resident Research Competition. Christopher H. Loo, MD, PhD, a second-year resident at the University of Hawaii, Honolulu, won the competition. Dr. Loo was awarded $300 for his paper Identification of Prostate-Specific G-Protein Coupled Receptor (PSGR) as a Tumor Associated Antigen: Using a Bio-Informatics Approach to Cancer Immunotherapy. In appreciation of Dr. Bailey’s participation, the Hawaii Chapter has contributed $1,000 to the ACS Foundation.

Portugal Chapter participates in panel session at Portuguese Society of Surgery conference
The Portugal Chapter of the ACS participated in the 35th National Congress of the Portuguese Society of Surgery (PSS) March 5–7 at the Hotel Eurostars Plaza in Figuera de Foz. Each year the Portugal Chapter invites Fellows to organize a panel discussion at this national surgical congress. The panel’s theme this year was Research and Training of Residents and Young Surgeons; Francisco Castro e Sousa, MD, PhD, FACS, professor of surgery at the University of Coimbra, served as panel chair. Panelists included Paulo Costa, MD, PhD, FACS, professor of surgery, Universidade de Lisboa, who spoke on Research and Training: Why, When, and How; Guilherme Tralhão, MD, PhD, FACS, professor of surgery, Universidade de Coimbra, who spoke on Translational Research; Jose Costa-Maia, MD, FACS, director, surgical department, University Hospital, Porto, who addressed Research during Clinical Training; and Jorge Soares, MD, PhD, professor of pathology and director, Fundação Calouste Gulbenkian, who presented on The Challenges of Research during the Training Period. Many residents and senior surgeons attended the ACS Portugal Chapter panel session. Several ACS Fellows also helped to organize and participated in presentations offered at the larger Portuguese Society of Cardiology Conference, where more than 500 Portuguese surgeons were in attendance.

Connecticut Surgical Quality Collaborative Launches ERAS Initiative
Earlier this year, the Connecticut Surgical Quality Collaborative (CtSQC), a statewide partnership of Connecticut hospitals, launched its first major quality improvement initiative—a rollout of Enhanced Recovery After Surgery (ERAS) protocols to member hospitals.  

OCT 2015 BULLETIN American College of Surgeons
The project launch began in late March when the CtSQC hosted Olle Ljungqvist, MD, PhD, professor of surgery at Örebro University Hospital, Sweden, and chairman of the ERAS Society, for an evening conversation with local surgeons and Connecticut Chapter members on the effectiveness of ERAS protocols to reduce postoperative morbidity and mortality and length of hospital stay. As a result, more than 175 surgeons, nurses, and hospital executives were able to quickly rally around the launch of an ERAS program in Connecticut.

In July of this year, the first four Connecticut hospitals began their ERAS training. Over the next four years, 16 more hospitals are expected to cover the majority of surgical cases in the state. The CtSQC is providing financial support to the hospitals that are participating in the ERAS protocols rollout to offset the cost of staff training. The ERAS Society, using a “train the trainer” methodology to facilitate the initial training, will help to reduce implementation costs.

**Tennessee Chapter hosts Resident Surgical Jeopardy program at annual meeting**

More than 100 surgeons, affiliate members, and guests attended the 2015 annual meeting of the Tennessee Chapter of the College (TNACS) at the Hilton Knoxville. Presenters included Mary C. McCarthy, MD, FACS, member, ACS Committee on Trauma, and chair, Wright State University department of surgery, Dayton, OH, who discussed The History, Impact, and Future of Women in Surgery at an American Women in Surgery (AWS)/ACS Liaison Session. Luncheon keynote speaker, Kenneth L. Mattox, MD, FACS, ACS Second Vice-President, delivered a presentation titled DaMattox Code: A Trauma Mystery. Dr. Mattox also offered an Update from ACS—Innovations within the House of Surgery. Kenneth W. Sharp, MD, FACS, ACS Foundation Board Secretary and Tennessee Chapter Member, explained how donations to the Foundation support professional education, scholarships, and other special program initiatives at the College. More than 25 residents participated in four different resident paper competitions at the meeting, and teams from each training program entertained attendees with a Resident Surgical Jeopardy Competition using the toolkit developed by the RAS Education Committee.

**Argentine Chapter organizes international course on advances in hepato surgery**

On June 11–12, the Argentina Chapter of the ACS presented its XXIV International Course.
The year’s program focused on Advances in Hepato-Biliary-Pancreatic and Esophageal-Gastric Surgery and was presented at the Auditorium of the Medical Association of Argentina in Buenos Aires. More than 70 people attended the events. The course was facilitated by Lucas McCormack, MD, FACS, director, surgery and liver transplantation, Hospital Alemán de Buenos Aires; and Adolfo Badaloni, MD, FACS, chief of surgery esophagogastric, Favaloro Foundation, University Hospital, Buenos Aires. Three international guests for the course included Michael D’Angelica, MD, FACS, Enid A. Haupt Chair in Surgery; director, hepatopancreatobiliary fellowship program; and director, surgical oncology fellowship program, Memorial Sloan Kettering Cancer Center, New York, NY; Blair A. Jobe, MD, FACS, general surgeon, Western Pennsylvania Hospital, Pittsburgh; and Nicolas Jarufe Cassisi, MD, chief, gastrointestinal surgery and associate professor, Catholic University of Chile, department of digestive surgery, University of Chile, Santiago. The chapter is organizing the 2016 International Course, which will focus on bariatric surgery. ♦
NEED TO EARN CME CREDIT?
JACS MAKES IT EASY.

Earn credit for your Maintenance of Certification
anytime, anywhere, and on any mobile device

Visit the improved JACS CME website to read articles, take a brief test, and receive your continuing medical education (CME) certification—all in one place.

- Receive 1 AMA PRA Category 1 Credit™ per article
- Access 24 months of articles
- Search for tests on topics that interest you
- Print your CME certificate as soon as you pass the test
- Connect to MyCME to easily track your CME credits

The Journal of the American College of Surgeons (JACS) is a free benefit for ACS members.

Visit www.facs.org
and click on the link for JACS CME
or visit http://jacscme.facs.org
Surgeons who serve small communities are eligible to apply for the 2016 Nizar N. Oweida, MD, FACS, Scholarship of the American College of Surgeons (ACS). Completed applications are due December 15, 2015. The $5,000 Oweida Scholarship subsidizes the attendance of a Fellow or Associate Fellow to the annual ACS Clinical Congress. This scholarship will help to defray travel expenses for the Clinical Congress, including Postgraduate Course fees, hotel costs, and per diem expenses. The scholar, who will receive preferential housing near the Clinical Congress site, will be expected to make his or her own travel arrangements.

### Basic requirements
Oweida Scholarship applicants must meet the following requirements:

- Serves a small town or rural community in the U.S. or Canada
- Is a Fellow or Associate Fellow in good standing
- Is younger than 55 years of age on the date the application is filed

### Activities
The Oweida Scholar will attend Clinical Congress 2016 in Washington, DC, October 16–20. At the annual meeting of the Scholarships Committee and the Rural Surgeons Forum, the scholar will meet with colleagues and receive the scholarship check.

The Executive Committee of the Board of Governors will select the scholar. Oweida Scholarship applicants should submit a single PDF consisting of the following items in this order:

- A one-page essay, discussing the following specific items:
  - Why the applicant wants to receive the Oweida Scholarship
  - Why the applicant believes he or she is qualified to receive the scholarship
  - Why the applicant characterizes his or her practice as serving a small community
- One copy of the applicant’s current curriculum vitae

A scholar and an alternate will be selected, and all applicants will be notified of the outcome of the selection process by February 1, 2016. The Oweida Scholar must attend the full week of the Clinical Congress in the year for which the award is designated; use of scholarship may not be postponed. The Oweida Scholar will provide a brief report on his or her experiences at the Clinical Congress for possible publication in a future issue of the Bulletin. The scholar also must submit a simple accounting for the award. These items will be due December 1, 2016.

Send applications for this scholarship to Kate Early, Scholarships Administrator, at Kearly@facs.org, or mail to: Scholarships Sections, ACS, 633 N. Saint Clair St., Chicago, IL 60611-3211.

For more information, contact Ms. Early at 312-202-5281. ♦
The American College of Surgeons (ACS) is offering two-year faculty research fellowships for surgeons entering academic careers in surgery or a surgical specialty. These 2016–2018 fellowships are supported through the generosity of Fellows, chapters, and friends of the College. The closing date for receipt of completed applications and all supporting documents is November 2, 2015.

All of the fellowships are intended to assist a surgeon in the establishment of a new and independent research program. Applicants should have demonstrated their potential to work as independent investigators. The fellowship award is $40,000 per year for each of two years, to support the research.

Five ACS Faculty Research Fellowships are now available, and three of them have been established to honor an ACS leader:

• The Franklin H. Martin, MD, FACS, Faculty Research Fellowship of the American College of Surgeons, which honors the founder of the ACS

• The C. James Carrico, MD, FACS, Faculty Research Fellowship for the Study of Trauma and Critical Care

• The Thomas R. Russell, MD, FACS, Faculty Research Fellowship, which is designated to support research aimed at improving surgical outcomes

General guidelines
General policies covering the granting of the ACS Faculty Research Fellowships include the following:

• The fellowships are open to Fellows or Associate Fellows of the College who have: (1) completed the chief residency year, or accredited fellowship training within the preceding five years, and (2) received a full-time faculty appointment in a department of surgery or a surgical specialty at a medical school accredited by the Liaison Committee on Medical Education in the U.S. or by the Committee for Accreditation of Canadian Medical Schools in Canada. Applicants who directly enter academic surgery following residency or fellowship will receive preference.

• Recipients may use the award to support their research or academic enrichment in any way deemed maximally supportive of their investigations. Each fellowship grant must support the research of the recipient and is not intended to diminish or replace the usual, expected compensation or benefits. Indirect costs are not paid to a recipient or to a recipient’s institution.

• Applications for these fellowships may be submitted even if comparable applications have been made to organizations such as the National Institutes of Health (NIH) or industry sources. If a recipient is offered a scholarship, fellowship, or research career development award from such an agency or organization, that individual is responsible for contacting the College’s Scholarships Administrator to request approval of the additional award.

• The Scholarship Committee reserves the right to review potentially overlapping awards and adjust its award accordingly.

• The College encourages each applicant to leverage the funds provided through one of these fellowships with time and monies provided by the applicant’s department. Formal statements of matching funds and time from the applicant’s department will promote favorable review by the College.

• Supporting letters from the head of the department of surgery (or the surgical specialty) and from the mentor supervising an applicant’s research effort must be submitted. This approval would involve a commitment to continuation
All of the fellowships are intended to assist a surgeon in the establishment of a new and independent research program. Applicants should have demonstrated their potential to work as independent investigators.

of the academic position and the provision of research facilities. Only in exceptional circumstances will more than one fellowship be granted in a single year to applicants from the same institution.

• Each applicant must submit a research plan and budget for the two-year period of the respective fellowship, even though renewed approval by the Scholarships Committee of the College is required for the second year.

• A minimum of 50 percent of a Fellow’s time must be spent conducting the research proposed in the application. This percentage may run concurrently with the time requirements of NIH or other accepted funding.

• Faculty Research Fellows are expected to attend the ACS Clinical Congress in 2018 to present a report at the Scientific Forum and to receive a certificate at the annual meeting of the Scholarships Committee.

Application forms may be obtained from the College’s website at facs.org, or upon request from the Scholarships Administrator at scholarships@facs.org.

Clinical Congress in 2018 to present a report at the Scientific Forum and to receive a certificate at the annual meeting of the Scholarships Committee.

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

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

Jim Henry, Inc.
435 Thirty-Seventh Avenue
St. Charles, Illinois 60174
Phone 630 584 6500
Fax 630 584 3036
www.jimhenrype.com
E-mail: kcredille@jimhenryinc.com

* Form No. 912509-10/15

SCHOLARSHIPS

OCT 2015 BULLETIN American College of Surgeons
**MEETINGS CALENDAR**

**OCTOBER**

**Arkansas Chapter**

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

**Israel Chapter**

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

**Italy Chapter**

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

**Minnesota Surgical Society**

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

**November**

**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

**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

** Depository:**  
**DECEMBER**

**Massachusetts Chapters**

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

**New Jersey Chapter**

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

**2016**

**January**

**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

**FUTURE CLINICAL CONGRESSES**

**2016**

October 16–20  
Washington, DC

**2017**

October 22–26  
San Diego, CA

**2018**

October 21–25  
Boston, MA

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