Contents

FEATURES

ACS advocates on behalf of trauma patients: An update 9
Tara Leystra Ackerman, MPH

Changes on the horizon for global services payment 14
Vinita M. Ollapally, JD

The Mayne legacy: A look back at an influential charter member of the ACS 18
Sarah B. Klein and William F. Sasser, MD, FACS

Dr. Beverley Ketel: Surgeon who brought transplant surgery to Peoria, IL, reflects on a fulfilling career 22
Karen Sisulak Binder

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COLUMNS

Looking forward 7
David B. Hoyt, MD, FACS

ACS Clinical Research Program:
Biomarker-driven adjuvant targeted
therapy for NSCLC—the ALCHEMIST
trials 25
Geoffrey R. Oxnard, MD; Colleen
Watt; Dennis Wigle, MD, FACS; and
Judy C. Boughey, MD, FACS

From the Archives: American
surgical history: Finding a home at
the Clinical Congress 28
LaMar S. McGinnis, Jr., MD, FACS,
and Norman H. Rich, MD, FACS

A look at The Joint Commission:
Safety culture is a great fit
for the OR 30
Carlos A. Pellegrini, MD, FACS,
FRCSI(Hon)

NTDB data points: Kickback 32
Richard J. Fantus, MD, FACS

NEWS

Included with this month’s
Bulletin: Compendium on
improving survivability from mass
casualty events 34

John A. Weigelt, MD, DVM, FACS,
chosen as 2015 Distinguished
Service Award recipient 35

Official notice: Annual Business
Meeting of Members, American
College of Surgeons 37

Fellows honored for volunteerism 39
Andrea L. Musolf, MBA

Bleeding control spotlighted
at new ACS Theater Sessions at
Clinical Congress 43

ACS Foundation presents two
distinguished awards at
2015 Clinical Congress 45

Renewed Excelsior Surgical Society
hosts first meeting at 2015 ACS
Clinical Congress 48

ACS CoC bestows National
Achievement Award on
21 cancer care facilities 49

James Haug, Past-Director,
ACS Socioeconomic Affairs
Department, dies 50
Diane Schneidman

Dr. Judson Graves Randolph,
pediatric surgeon, leaves
lasting legacy 52
Kurt D. Newman, MD, FACS, and
Mary Fallat, MD, FACS

Tour the cemetery where ACS
leaders are buried: Visit Archives
booth for information 54
Adam Carey

Members in the news 56
ACS in the news 58

Register for ACS TQIP Conference,
November 15–17, in
Nashville, TN 60

Report on ACSPA/ACS activities,
June 2015 62
Fabrizio Michelassi, MD, FACS

MEETINGS CALENDAR

Calendar of events 72
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.

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As I write this column, the American College of Surgeons’ (ACS) staff and volunteers are putting the finishing touches on the program for this year’s Clinical Congress, October 4–8, at McCormick Place, Chicago, IL. This year’s program, as usual, is replete with many excellent hands-on skills and didactic Postgraduate Courses, informative Panel Sessions, and opportunities to share and discuss scientific advances in surgery. In addition, we have added some member engagement activities that promise to make this Clinical Congress particularly memorable and enjoyable, and we will take some time to recap the year’s successes.

Educational programming
As always, Clinical Congress 2015 will provide the best surgical education and training opportunities for surgeons, surgery residents, medical students, and other members of the operating room team—all in one place. The theme of this year’s Clinical Congress—Achieving Your Personal Best: Improvement Based on Evidence—was selected by ACS President Andrew L. Warshaw, MD, FACS, FRCSEd(Hon).

The Program Committee, chaired by Valerie W. Rusch, MD, FACS, along with the ACS Division of Education, under the leadership of Ajit K. Sachdeva, MD, FACS, FRCSC, have developed an outstanding program. The 2015 Scientific Program has again been arranged in key thematic tracks covering both clinical and nonclinical topics and should be of interest to surgeons in every specialty. More than 120 Panel Sessions will be presented, along with 11 Named Lectures by distinguished experts in their respective fields. Didactic/Experiential and Surgical Skills Postgraduate Courses will enable attendees to develop advanced knowledge and techniques that they can apply in their practices as they strive to deliver optimal care to their patients.

This year’s Clinical Congress places increased emphasis on the science of surgery. As such, we have developed a Scientific Forum that will include surgical research presentations by residents and surgical investigators, while the Video-Based Education Sessions will showcase emerging surgical procedures. Clinical Congress attendees who are interested in learning about leading-edge issues in a less formal setting are encouraged to attend Meet-the-Expert Luncheons and Town Hall Meetings. Continuing Medical Education credits are available for most of these sessions, and Self-Assessment credit is available for participation in many Postgraduate Courses, Panel Sessions, and Video-Based Education Sessions.

Member engagement
In addition to these wonderful educational programs, this year the ACS is offering three new opportunities for attendees to meet and network in fun and innovative ways.

First, Clinical Congress attendees will have the opportunity to start their day off right with complimentary early-morning yoga and Zumba classes. Yoga will be offered 6:00–7:00 am Monday, October 5, and Zumba will be offered 5:30–6:30 am Tuesday, October 6. Both classes will take place at the headquarters hotel—the Hilton Chicago. Classes are appropriate for all ability levels, and water, yoga mats, and towels will be provided. Advance registration is required due to space limitations. (To register, go to www.facs.org/clincon2015/register.)

You’re sure to work up an appetite after a couple of days of attending yoga, Zumba, and going from meeting to meeting in the convention center. Plan to join ACS leaders and staff for ACS Taste of the City 5:00–7:00 pm Wednesday, October 7, at McCormick Place. This special event will showcase the diversity of Chicago’s dining scene and will feature music and other entertainment activities. To encourage a more relaxed environment after a full day of educational programming, we encourage you to dress casually and bring your friends and family.

Lastly, those of you who are part of the selfie craze on social media will want to participate in the ACS Selfie Scavenger Hunt and show the surgical community all that the Clinical Congress has to offer. There will be a raffle of up to three iPad Minis for...
This year’s Clinical Congress places increased emphasis on the science of surgery. As such, we have developed a Scientific Forum that will include surgical research presentations by residents and surgical investigators, while the Video-Based Education Sessions will showcase emerging surgical procedures.

those attendees who take and post the most selfies on Twitter. Selfies from the list below should be tweeted during the meeting using the Clinical Congress Twitter account at #CC15selfie:

• With a new Initiate/Fellow (include images of name badges)
• With an International Member (include images of name badges)
• With a Regent (include images of name badges)
• With an Officer (include images of name badges)
• With a Governor (include images of name badges)
• In front of McCormick Place
• In the ACS Resource Center
• In front of a poster at the Poster Session
• With a member of the ACS staff (include images of name badges)
• With a medical student (include images of name badges)
• With a resident/fellow (include images of name badges)
• With someone who went to your medical school
• With someone who trained at your program
• At the Opening Ceremony
• At the Convocation
• At the ACS Taste of the City event
• With an exhibitor in their booth (include images of name badges)

Celebrating our success
Also be sure to attend this year’s Opening Ceremony
8:00–9:00 am Monday, October 5, at McCormick Place West. During this important event, we will introduce the six new Honorary Fellows, the recipient of the Distinguished Service Award, ACS Officers, Regents, Past-Presidents, and special invited guests. In addition, we will recognize some of the College’s most significant achievements from the last year and reveal plans for the future. Examples include the following:

• The ACS National Surgical Quality Improvement Program receiving the John M. Eisenberg Patient Safety and Quality Award from The Joint Commission and the National Quality Forum
• The ongoing success of the ACS Accredited Education Institutes (AEI) and our plans to launch an AEI tour in January to educate policymakers about the value of ACS accreditation of simulation and surgical research programs
• The development of new learning management software
• The utility of the ACS Surgeon Specific Registry in complying with Centers for Medicare & Medicaid regulatory mandates
• Our role in the repeal of the sustainable growth rate formula used to calculate Medicare payment and the development of a new value-based reimbursement system, and the tools surgeons can use to ensure the sustainability of their practices under this new paradigm

See you in October
Remember, this is your meeting. The College’s staff and volunteers continue to look for ways to make the Clinical Congress more engaging and educational for surgeons of all specialties and at every stage of their career. Let us know how we can help you to make the most of your time in Chicago. We look forward to seeing you at Clinical Congress 2015.

Dave

If you have comments or suggestions about this or other issues, please send them to Dr. Hoyt at lookingforward@facs.org.
ACS advocates on behalf of trauma patients:
An update

by Tara Leystra Ackerman, MPH
State legislatures regularly address issues related to the provision of trauma care and injury prevention. The U.S. Congress has also historically played a role in trauma system development and funding, but federal lawmakers recently have experienced difficulty passing system development legislation and appropriating money for trauma, leaving it to state legislatures to identify funding sources and to design and implement their own trauma systems.

The American College of Surgeons (ACS) actively monitors state legislative activity. In 2015, for example, ACS State Affairs staff has reviewed approximately 200 pieces of trauma-related legislation. Most of these bills pertained to injury prevention efforts, but some were related to trauma system development and funding. In addition, the American Medical Association’s (AMA) House of Delegates (HOD), which includes an ACS delegation, took a close look at trauma prevention during its annual meeting in June. A number of resolutions were put forth calling for the AMA to weigh in on injury prevention policy.

This article examines the trauma-related issues considered in state legislatures and by the AMA HOD over the last year.

Injury prevention

State legislatures debated a significant amount of legislation aimed at injury prevention in 2015, including laws pertaining to distracted driving, motorcycle helmet use, gun control, and vulnerable users of roadways.

Distracted driving

The most ubiquitous type of injury prevention legislation recently considered in the state legislatures seeks to discourage distracted driving. Most states restrict the use of cell phones and other handheld devices while driving. In all, 14 states (California, Connecticut, Delaware, Hawaii, Illinois, Maryland, Nevada, New Hampshire, New Jersey, New York, Oregon, Vermont, Washington, and West Virginia), and the District of Columbia and Puerto Rico, have prohibited drivers from using handheld devices; however, most states have specifically banned texting while driving with either a primary or secondary enforcement mechanism. A primary enforcement mechanism means that an officer can ticket the driver for the offense without any other traffic violation taking place, whereas a secondary enforcement mechanism means an officer can only issue a ticket if a driver has been pulled over for another violation, such as driving erratically. Only two states, Montana and Arizona, allow texting while driving. This year, the lawmakers at the state level considered legislation that would update current distracted driving statutes to address advances in technology. Utah is one of the few states that attempted to weaken its law by altering its ban on texting while driving to allow one-button dialing on cell phones with voice commands and similar one-button commands for music or other apps. However, that legislation failed to advance.

Motorcycle helmet mandates

In a number of states, legislators attempted but ultimately failed to change current laws related to mandatory helmet use. In Iowa, H.F. 267 would have mandated that motorcycle operators and passengers wear a safety helmet. In New Mexico, two bills were introduced that would have placed new requirements on motorcycle operators. One bill, S.B. 327, would have implemented a universal helmet requirement. The other bill, S.B. 308, would have instituted a helmet requirement, although under the proposed law operators would have been permitted to ride helmetless if they were older than 18 years of age and if they had purchased a validating sticker for $692. The fees collected...
would have gone to the Trauma System Fund, the Brain Injury Services Fund, and the Fatal-Injury Diagnosis and Reporting Fund. Similar legislation, S.B. 356, was introduced in West Virginia. This bill would have provided an exemption from wearing helmets for operators who meet certain safety requirements and have at least $10,000 in medical coverage, including coverage for motorcycle accidents.

In Tennessee, separate pieces of legislation were considered that would loosen helmet restrictions. S.B. 925/H.B. 700 would have exempted motorcycle drivers and passengers older than 21 years of age from the helmet requirement if those individuals were covered by health or medical insurance other than the state-funded TennCare program. This legislation advanced through the committee process but ultimately failed to pass. It will, however, carry over to next year’s legislative session. Another bill of a much more limited scope, S.B. 469, was signed into law in Tennessee. This new law allows for a helmet wearing exemption for persons riding in a funeral procession, memorial ride under a police escort, or body escort.

Nebraska bill L.B. 31 would have repealed the state’s mandatory helmet law completely, and in Washington, S.B. 5198 would have removed the mandatory helmet requirement for individuals older than age 18. Both bills received public hearings, but neither advanced further.

Gun control
Gun control continues to be a hot topic in the state legislatures. Dozens of bills were considered on issues ranging from private sale background checks to permit-less concealed carry of guns. Kansas, Maine, and Mississippi all passed bills allowing for concealed guns to be carried in public without a permit. Nevada passed a bill (S.B. 175) that expands the state’s stand-your-ground statute, which protects individuals who decide not to retreat when defending a motor vehicle and recognizes out-of-state conceal and carry permits. H.B. 2014 was signed into law in Oklahoma, which allows a school district to permit school personnel to carry loaded firearms on the grounds of public elementary and secondary schools if they obtain reserve officer certification, and in Georgia, school districts are now prohibited from regulating gun possession on school grounds as mandated by H.B. 492. Texas will now allow concealed carry permit holders to carry loaded firearms openly in public as well as allowing permit holders to carry firearms on college and university campuses with some regulation permitted by local school officials.

Oregon enacted S.B. 941, which requires background checks on unlicensed gun purchasers in the state. In Nevada, S.B. 240 was signed into law, prohibiting mentally ill convicted of owning a gun. The law also removes Nevada’s $35 fee for background checks for private gun sales, criminalizes the practice of buying a gun for another person, and strengthens reporting requirements on criminal history and mental illness. Also in Nevada, S.B. 175, mentioned previously, prohibits individuals convicted of a domestic violence misdemeanors from owning or possessing a firearm. Alabama, Delaware, Louisiana, Oregon, South Carolina, and Washington State all passed legislation making it more difficult for individuals charged with domestic violence to possess firearms.

Safe travels for vulnerable users
An emerging issue in the state legislatures in recent years has focused on improving safety for so-called vulnerable users on roadways. Vulnerable users are typically defined as pedestrians or individuals using bicycles, skateboards, roller skates, inline skates, and other nonmotorized modes of transportation. These bills differ by state but usually require increased penalties when a vulnerable user is injured or killed by a motor vehicle. These penalties include increased fines, license suspension, community service, or mandatory traffic courses. A total of 12 states (Colorado, Delaware, Hawaii, Illinois, Louisiana, Maryland, Mississippi, Nevada, New York, Oregon, Tennessee, and Washington) have already adopted some sort of vulnerable user protections. An additional eight states (Arizona, Delaware, Florida, Maine, Massachusetts, New Hampshire, Utah, and Vermont) considered bills this year, but only Utah enacted legislation.
Minimal activity in the state legislatures pertained to trauma system development and funding, as most state budgets are still recovering from the recession and some are still facing budget deficits. In addition, many states have trauma systems in place with at least some available funding. Nonetheless, a few state legislatures did consider changes to their trauma systems or are trying to identify new funding sources. State lawmakers took unique approaches to reforming these systems, especially with respect to establishing funding.

In Texas, legislation to repeal the Driver Responsibility Program, which provides funding for the state trauma system, did not pass this session. S.B. 93 received unexpected support in the legislature and was passed by the Senate, but the House did not act before the session ended. The Driver Responsibility Program imposes surcharges on drivers who receive citations for traffic violations. As originally written, S.B. 93 would have repealed the Driver Responsibility Program entirely, but the amended bill left the program intact. The amended legislation, however, also removed a provision that would suspend the driver’s licenses of those individuals who fail to pay the fine. License suspension is the main enforcement mechanism for the program; if eliminated, it would have led to a significant decrease in funding for trauma care in the state. The ACS actively opposed the bill and will continue to counter efforts to cut trauma funding when the Texas legislature reconvenes in 2017.

Legislation was introduced in Nevada that would have required the Department of Health and Human Services to develop a standardized system for the collection of information for the state trauma registry. The bill, S.B. 189, also would have created the Fund for the State Trauma Registry, which would have required automobile and home insurers to charge an annual $1 fee to fund the development of this system. The bill did not make it out of committee.

In Ohio, H.B. 261 was introduced to create a new Ohio Trauma Board and to make other changes to its trauma system. The Ohio Trauma Board, which would be administered within the Ohio Department of Health, would comprise 19 members appointed by the Governor, the Speaker of the House, and the President of the Senate. The board would be responsible for operating the state trauma registry, seeking and distributing grants, and developing a statewide system for improving the quality of trauma and rehabilitative care. At least three of the Ohio Trauma Board members would be trauma surgeons. The Ohio Chapter of the ACS would be required to submit nominations for two of the positions.

In addition, H.B. 261 also would add new designation standards, such as participation in statewide and regional injury prevention activities and submission of more timely data to the registry. Furthermore, the bill would require the Department of Health to hire an executive director and chief medical director. The ACS would still verify trauma centers, but additional standards would be added for centers to gain verification. Currently, the trauma system in Ohio is funded solely through fees assessed on trauma hospitals, and this legislation does not address that issue. One suggested means of addressing the funding situation would require hospitals to contribute at least some of the revenue needed to make the proposed changes in the legislation. Ohio’s original trauma law was passed in 2000.

A bill introduced this year in Indiana would have provided some funding for the statewide trauma system. Although funds have been authorized for the trauma system through the Spinal Cord and Brain Injury Fund that became effective through legislation passed eight years ago, no actual funding is provided for trauma system development and infrastructure support. The bill introduced this year, H.B. 1404, would have used speed cameras to identify drivers speeding through construction or school zones or illegally passing a school bus and would have imposed a fine with a ticket sent through the mail. Half of the funds received from these fines would have been directed to the Spinal Cord and Brain Injury Fund, specifically for use in developing a statewide trauma hospital network. The bill failed in the Committee on Roads and Transportation.

In 2015, ACS State Affairs staff has reviewed approximately 200 pieces of trauma-related legislation. Most of these bills were related to injury prevention efforts, but some were related to trauma system development and funding.
In addition, significant behind-the-scenes work is occurring in some states to gain support for trauma system development. As a result, increased legislative activity is expected to occur next year.

AMA HOD activities
In the course of its annual meetings, the AMA HOD typically considers a number of resolutions pertaining to trauma care. This year’s meeting was no exception. Reference Committee D, which considers resolutions focused on public health, reviewed a number of resolutions centered on injury prevention.

One of the more hotly debated resolutions centered on mandatory protective headgear/helmets for female lacrosse players in order to prevent concussions. U.S. Lacrosse, the national governing body of the sport, currently opposes mandatory helmet use for female players but is debating whether to change policy. Some delegates argued that the AMA should wait until U.S. Lacrosse has ruled before getting involved. After hearing significant testimony in favor of the resolution, the AMA adopted the new policy and will advocate for protective headgear for female lacrosse players.

In another effort to prevent youth concussions, the AMA adopted a policy to promote requirements for youth sports participants who are suspected of having a concussion. Specifically, these requirements mandate the suspension of these athletes from all forms of the activity until written approval is provided by a physician or designated member of the care team.

The AMA also regularly considers resolutions dealing with gun safety. At this year’s meeting, the House of Delegates adopted a resolution directing the AMA to encourage toy gun manufacturers to take additional steps to further differentiate toy guns from real guns. Currently, makers of toy guns add an orange tip to their products to distinguish them from actual weapons. The resolution that was adopted was amended from its original version, which would have required the AMA to support legislation strengthening current laws on the manufacturing of toy guns.

Another resolution that garnered some attention dealt with the use of restraint systems for children on commercial airline flights. There was mixed testimony on the resolution, which recognized the need to keep children safe on flights but acknowledged the logistical challenges. The delegates adopted a policy, which calls on the AMA to support the use of restraint systems for children on flights and for public education about the use of the devices. The resolution also recommends that the AMA work with relevant federal and international agencies to establish criteria for appropriate child restraint systems.

The AMA also considered and adopted an amendment to its current policy on distracted driving. The amendment added in language about the dangers of using headphones/earbuds while driving and while partaking in outdoor activities such as biking, jogging, rollerblading, walking, and skateboarding. The amendment directs the AMA to support education about these dangers, as well as the addition of warning labels indicating the dangers of using handheld devices with headphones/earbuds. The ACS supported the resolutions on increasing toy gun safety, concussion and youth sports, and mandating support of protective headgear in lacrosse.

Learn more
ACS staff members work closely with the Committee on Trauma to review trauma-related policies and to take a position on them as appropriate. The College also builds relationships with individual members and State Chairs of the Committee on Trauma to ensure proper coordination of state legislative advocacy.

If you have questions or would like more information about the ACS state legislative activities, contact Tara Leystra Ackerman or Justin Rosen, State Affairs Associates, at state_affairs@facs.org. If you have any questions or would like more information regarding the work of the ACS delegation to the AMA HOD, contact Jon Sutton, Manager, State Affairs, at jsutton@facs.org or 202-672-1526. ♦
Although an immediate overhaul of the global services reimbursement mechanism has been averted, significant modifications that will affect all surgeons are on the horizon for the coming years.

Global codes include necessary services normally provided by a surgeon before, during, and after a surgical procedure. Global codes are classified as 0-day, 10-day, or 90-day based on the number of postoperative days that will be covered for specific procedures. Approximately 4,200 of the more than 9,900 Current Procedural Terminology (CPT) codes are categorized as either 10- or 90-day global codes.*

This article describes policies by which the Centers for Medicare & Medicaid Services (CMS) would have transitioned all 10- and 90-day global codes to 0-day; the congressional action that prohibited the agency from implementing those policies; the

*All specific references to CPT (Current Procedural Terminology) codes and descriptions are © 2014 American Medical Association. All rights reserved. CPT and CodeManager are registered trademarks of the American Medical Association.
Although initially it appeared that this proposal could benefit surgeons given that they would be able to bill separately for each follow-up visit, analysis by the ACS GSCRC showed that this policy would result in a decrease in payments to surgeons.

CMS’ proposal
In July 2014, CMS proposed to transition all 10- and 90-day global codes to 0-day global codes in 2017 and 2018, respectively. Under this proposal, medically reasonable and necessary visits would have been billed separately during the preoperative and postoperative periods outside the day of the surgical procedure. CMS’ rationale behind this policy was concern that the current valuation methodology for global codes is problematic, in that it is based on assumptions about the resources used in furnishing a typical case for each individual service rather than actual data on the cost of furnishing services. CMS also questioned whether the values included in the postoperative global codes reflect the care actually furnished during that period. CMS’ proposal did not include a methodology for making this transition, nor did it provide an analysis of its impact on surgical patients or the surgeons who care for them.

Although initially it appeared that this proposal could benefit surgeons, given that they would be able to bill separately for each follow-up visit, an analysis by the ACS General Surgery Coding and Reimbursement Committee (GSCRC) showed that this policy
would result in a decrease in payments to surgeons. This reimbursement reduction is attributable to separately reportable evaluation and management (E/M) codes being reimbursed at a lower rate than the E/M codes included in the value of global codes. Furthermore, the separately reportable E/M services would not cover the practice expenses and liability costs associated with postoperative visits. In addition, some postoperative work now included in 10- and 90-day global surgical packages is unreportable through E/M codes; thus, depending on the methodology that CMS would have used, surgeons might not have been paid for some follow-up care.

Based on these findings, in September 2014 the ACS submitted a detailed comment letter to CMS describing these and other reasons why the agency should refrain from implementing the policy. In the letter, the College stated that CMS first should complete a comprehensive analysis of the effect the policy would have on surgical patients and on access to surgical care, and develop a methodology for making the transition to 0-day global codes. Without a transparent methodology, it would be impossible for stakeholders to provide cogent feedback to CMS on the validity and viability of its proposed policy. Despite these and other efforts by the ACS regulatory staff to counter the policy, in November 2014, CMS finalized the policy to transition 10- and 90-day global codes to 0-day.

Before finalization of this policy, the ACS GSCRC also embarked on an extensive data analysis and modeling project to estimate the impact of a transition to 0-day global codes. The findings from this project were used to support recommendations to CMS on how to develop a fair and accurate methodology for transitioning to 0-day global codes if the agency intended to move forward. GSCRC and ACS staff presented these recommendations to CMS in meetings with senior CMS officials in February and April 2015.

**Congress intervenes**

In parallel with its regulatory efforts, the College’s legislative and political team spent several months working to bring about a legislative solution to the problems associated with CMS’ proposal to eliminate 10- and 90-day global codes. During Congress’ lame-duck session following the November 2014 election, a coalition of surgical groups led by the College provided legislative language to lawmakers for inclusion in the catchall omnibus spending bill. The language would have precluded CMS from moving forward with its plan to transition 10- and 90-day global codes to 0-day global codes. However, despite strong support from a group of physicians in the House of Representatives known as the congressional Doctors Caucus and other representatives, the language was omitted from the final legislation.

When Congress reconvened in January, the College redoubled its efforts to ensure this policy was not permitted to take effect. Reps. Larry Bucshon, MD, FACS (R-IN), and Ami Bera, MD (D-CA), drafted a letter to House Speaker John Boehner (R-OH) and Minority Leader Nancy Pelosi (D-CA), urging them to take action to nullify CMS’ plan. Dr. Bucshon, a cardiothoracic surgeon, and Dr. Bera, a family physician, worked to encourage other House members to sign on to the letter, making sure the issue rose to a priority level in Congress (see sidebar, page 15). The letter ultimately garnered strong support. Due to the hard work and determination of surgical champions in Congress, this issue remained on the table throughout negotiations on the bipartisan Medicare reform legislation, and was included in the final package that was passed by overwhelming margins in the House and Senate. This significant legislative victory was made possible through the continuous efforts of Drs. Bucshon and Bera and other members of the Doctors Caucus, including Reps. Tom Price, MD, FACS (R-GA); Dan Benishek, MD, FACS (R-MI); and Charles Boustany,
The hard-fought victory for both the repeal of the SGR and blocking the implementation of the global services transition policy was achieved through the advocacy efforts of the ACS and other medical associations, Fellows’ participation in meetings with lawmakers, and thousands of letters and calls to Capitol Hill.

MD, FACS (R-LA); as well as Phil Roe, MD (R-TN), chairman. The ACS’ advocacy efforts were ultimately successful when President Barack Obama signed the Medicare Access and Children’s Health Insurance Program Reauthorization Act of 2015 (MACRA) into law on April 16. This law not only repealed the sustainable growth rate (SGR) formula used to calculate Medicare physician payments, but it also prevented CMS from implementing the policy to transition 10- and 90-day global codes to 0-day.

With MACRA in place, beginning on or before January 1, 2017, CMS is required to collect the data needed to value surgical services from a representative sample of physicians. These data must include information on the number and level of medical visits furnished during the global period and on other appropriate items and services related to surgery furnished during the global period. MACRA also allows 5 percent of the surgical payments to be withheld until these data are reported at the end of the global period and grants authority to discontinue the reporting requirement if sufficient information can be derived from Qualified Clinical Data Registries, surgical logs, electronic health records, or other sources. Beginning in 2019, CMS must use these and possibly other data that the agency might identify to improve the accuracy of the valuation of surgical services.

The hard-fought victory for both the repeal of the SGR and blocking the implementation of the global services transition policy was achieved through the advocacy efforts of the ACS and other medical associations, Fellows’ participation in meetings with lawmakers, and thousands of letters and calls to Capitol Hill.

The future for global surgical services
As the law currently states, CMS is prohibited from implementing its policy to transition 10- and 90-day global codes to 0-day global codes, but the agency is required to collect data on global services starting no later than January 1, 2017, and use those data to revise global services starting in 2019.

The ACS will continue working to influence the implementation of this new global payments policy. Efforts will include developing recommendations for CMS on the methodology for collecting data, as the methodology used by CMS is directly relevant to the type of data that will be gathered. The ACS will then put forth recommendations on how these data should be used to revalue global surgical services in 2019. The ACS GSCRC will continue to collaborate and build on its relationship with CMS to ensure that the agency implements the MACRA-mandated revisions to global services in a fair and accurate manner.

More information about CMS’ sidelined proposal to transition global payments and the revisions mandated under MACRA is available on the ACS website at [www.facs.org/advocacy/regulatory/medicare-a-b/global-codes](http://www.facs.org/advocacy/regulatory/medicare-a-b/global-codes). ♦
The Mayne legacy:

A look back at an influential charter member of the ACS

by Sarah B. Klein
and William F. Sasser, MD, FACS
Engineer, surgeon, health care advocate, entrepreneur—Earl Hugh Mayne, MD, FACS, could only dream of earning these titles as a young boy growing up on a small farm near Mason City, IA. He eventually attained these professional goals through hard work, education, and business acumen. But one of Dr. Mayne’s most striking achievements was in philanthropy—he established the Mayne Educational Fund in 1944, thus becoming the first Fellow to provide a legacy gift for the educational mission of the American College of Surgeons (ACS).

Iowa roots
Born on October 19, 1866, Dr. Mayne was the youngest of eight children. According to the Mayne Educational Fund archives, it was “in a sturdy home atmosphere of a large family and an efficiently run farm that Dr. Mayne learned the value of industry, self-reliance, and self-respect.” He also had the good fortune in his formative high school years to come under the influence of Carrie Lane, the young principal of the Mason City High School, who encouraged Dr. Mayne to continue his academic pursuits beyond high school. Ms. Lane, better known as Carrie Chapman Catt, eventually became a familiar leader in the American women’s suffrage movement.

With money he earned by raising cattle and with a county scholarship, Dr. Mayne completed civil engineering courses at the University of Iowa, Iowa City. As an undergraduate student, he waited tables and cut cordwood for professors to pay the wages of a hired man who took his place on the family farm. Although his primary studies were in engineering, Dr. Mayne began adding elective classes in medicine and observing operations. A few fainting spells in his early viewings of surgery did not diminish his newfound passion to become a surgeon.

Surgical career
Using his training in civil engineering, Dr. Mayne worked as a bridge builder along the Ohio River to save enough money to attend medical school, intent on becoming a practicing surgeon. Along the way, he met the vivacious Isabella “Maud” Rittenhouse of Cairo, IL, whose lively journals kept from her girlhood through marriage were published in 1939 and became a bestselling book, Maud. They later married and had three daughters. Mrs. Mayne was an accomplished artist, graduating from the St. Louis School of Fine Art, Washington University, MO, in 1887.

Dr. Mayne earned enough money to study at the Bellevue Hospital Medical College, New York, NY, where he completed his course work in the spring of 1893. After a trip abroad to Italy and other parts of Europe, Dr. Mayne hung his physician’s shingle in Bath Beach, a suburb of Brooklyn, NY, and had his first patient call in April 1894. In a letter to Maud later that year, he wrote that his practice income had grown to $484 per month and that he was “making as many as 26 patient visits per day, barely sleeping.”* His practice soon expanded, and he went from making his rounds on a bicycle to a steam-powered Locomobile that he purchased in 1902.

In 1915, Dr. Mayne was admitted to the ACS as a charter member and was later elected to serve on its Board of Governors. Throughout his career, Dr. Mayne campaigned for health care advances, often ignoring prejudices against modern medicine. For example, he was a pioneer in the use of diphtheria antitoxin during a time that the disease had a 40 percent mortality rate.

Dr. and Mrs. Mayne also gave back to the community in their adopted home state of New York. He was a founder of the Bay Ridge Hospital and for many years was the president of the institution’s board of directors, as well as president of the Bay Ridge Medical Society. He had many interests in real estate and was a director of the Atlantic Gulf and

### MAYNE HERITAGE SOCIETY MEMBERS

**(AS OF JUNE 2015)**

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<td>†Dr. William W. Allen</td>
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<td>Dr. and Mrs. H. Randolph Bailey</td>
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<td>Charles and Carol Balch</td>
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<td>†Dr. Wilfred Guerra</td>
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<td>Dr. Robert T. J. Holl-Allen</td>
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<td>Mary and John Iacuzzo, MD, FACS</td>
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<td>Dr. and Mrs. Paul H. Jordan, Jr.</td>
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<td>†Dr. Hector and Mrs. Ruth Marin</td>
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<td>LaMar and Julia McGinnis</td>
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<td>†Dr. Arie D. Verhagen</td>
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<td>†Dr. A. Stark Wolkoff</td>
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<td>Dr.† and Mrs. Scott W. Woods</td>
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†Deceased
Pacific Company. Mrs. Mayne volunteered and was active in the women’s suffrage movement.

**Philanthropic leadership**

Dr. Mayne is perhaps best remembered among members of the ACS and in the philanthropy community for the contributions that he has made, including gifts that extended well beyond his lifetime. In honorable recognition for the role that education had on his professional success, he established the Mayne Educational Fund in 1944 to help deserving young men and women have access to educational opportunities. He directed that this charitable trust be dissolved 50 years later, at which time the corpus and all other accumulated income would be paid to the ACS. With an initial contribution of $64,000 in the Mayne Educational Fund trust, the College ultimately received a sum of more than $1 million in 1994. Dr. Mayne also bequeathed an outright sum of $5,000 to the College upon his death in 1949, the equivalent of nearly $50,000 today.

The first distribution of the Mayne Educational Fund, in conjunction with the Robert Wood Johnson Foundation, supported the work of Clinical Scholars within the ACS Division of Research and Optimal Patient Care. Future distributions from the fund will soon be used to advance other educational opportunities for ACS Fellows and Affiliate Members. Per Dr. Mayne’s directive in his will, the determined usage will be at the behest of the College’s Board of Regents. Dr. Mayne’s extraordinary generosity and foresight to create a legacy gift are remarkable and have led to the development of resources that will enable the College to meaningfully support the educational and lifelong learning pursuits of Fellows.

**The Mayne Heritage Society**

In 1994, the Board of Regents honored Dr. Mayne by naming the ACS Foundation’s planned giving program the Mayne Heritage Society to recognize his leadership in philanthropy. Members of the society are those who have followed Dr. Mayne’s example and have generously included the College in their future philanthropic plans. No single gift is the same, as donation amounts and gift formats vary. However, all of these philanthropic efforts share a common goal of supporting the College’s educational mission for future generations through forward-thinking donors who have the opportunity to give to the area of their choice (see the list of Mayne Heritage Society members, page 20).

If you are interested in learning more about Mayne Heritage Society membership, contact the ACS Foundation at 312-202-5338, or visit plannedgiving.facs.org.
One of the first events Beverley L. Ketel, MD, FACS, attended following her retirement this spring was the dedication of a new memorial at Rutherford Park near the OSF (Order of Saint Francis) Saint Francis Medical Center, Peoria, IL. This space is filled with flowers, shrubs, and other carefully curated flora, planted in recognition of all the tissue and organ donors that have helped the Level I trauma and tertiary care center become the top donor hospital in Illinois.

Tucked between all the tributes was another thank you, this one honoring Dr. Ketel for her work as a transplantation surgeon, 1984–1990 and 2002–2015, with the medical center and the Gift of Hope Organ & Tissue Donor Network. The inscribed paver stone was placed in the garden and reads: “Dr. Beverley Ketel—33 years of dedication to donation & transplantation.” During the 12-year gap in her service at Saint Francis, she served as chief of transplantation at the University of Arkansas-Little Rock and remained there until her children had grown and moved out of the house.

Making dreams come true

“She actually had a better feel for what was needed more than the typical transplantation surgeon,” said Jerry Anderson, chief executive officer of the Gift of Hope from 1987 to 2013. “When I first met Beverley, she was running her own organ donation organization. That certainly speaks to her as an advocate for patients.”

Hospital archives note the tandem successes shared by the hospital and Dr. Ketel since she joined the staff in 1984, particularly in
July of that year, when she started the hospital’s kidney transplant program. With this act, she made “a medical dream a reality,” as noted by an article published in the hospital’s history retrospective publication.

The next milestone for Dr. Ketel and the medical center occurred on July 14, 1985, when she performed the first kidney transplant in the Peoria area. This 5.5-hour operation was the first in what would become an estimated 3,700 procedures completed at the Peoria facility by 2014. Dr. Ketel would again make history at the medical center by performing the first pancreas and kidney-pancreas transplant surgeries in September 2002. She assisted in another landmark procedure in 2011 by performing the center’s 1,000th transplant.

Overcoming obstacles
Many health care professionals would consider these benchmarks to be extraordinary achievements for a regional hospital in a rural setting, let alone to occur largely under the leadership of a woman surgeon in the 1980s. Currently boasting 850 physicians and 6,500 employees, OSF Saint Francis also is a member of the Gift of Hope Organ & Tissue Donor Network (originally the Regional Organ Bank of Illinois). It was in central Illinois that Dr. Ketel found the ideal setting for a young woman surgeon launching her career.

U.S. medical culture in the 1980s could be intimidating, “especially for a petite woman in a world most certainly dominated by men,” Dr. Ketel said. “That just meant that I had to work harder, and that’s exactly what I did.”

Dr. Ketel was raised in Eugene, OR, before attending the University of Chicago Medical School, IL. When she applied at the institution, university administrators were actively recruiting medical students specifically from small and rural towns. “I was one of a dozen admitted in a grassroots talent search,” she recalled. “There was a fear that we would not be able to compete with the other students. We all did well.”

In her second year of medical school at the University of Chicago (U of C), she met her husband, Richard, an infectious disease specialist. The couple speculated on whether it was possible to match at the same hospital for their residency training. They did—both at U of C—and then started thinking about taking their relationship to the next level.

“I thought at one point we should keep our marriage secret,” she said. “There were questions whether a wife could devote herself to her husband, a family, and medicine. It was unproven ground. I felt a little under the microscope during my five-year residency.”

She asked a physician mentor if he thought it would be all right to marry. He endorsed the union, and her first two of three children were born during her transplant fellowship.

“That I started to apply for jobs. It felt like no one wanted to hire me because I was a woman with a young family,” she said. Her husband’s family was from the Kansas City, MO, area, so she settled for a general surgery position that did not include transplantation at the University of Missouri School of Medicine, Kansas City. But eventually she would receive an opportune phone call.

Administrators at OSF Saint Francis wanted the facility to be one of the nation’s first regional hospitals with a transplant program, and they reached out to Dr. Ketel to see if she would lead the program. She accepted eagerly but with some concerns.

“I was excited, but it was also a little frightening as a young surgeon,” she said. “Once I came back to Peoria, I never sensed a problem with me being a woman. The culture changed very quickly in the mid- to late 1980s. It was strictly professional.”

Transplantation history
From a technical standpoint, Dr. Ketel said, kidney transplantation has changed little over the last few decades, but transplantation drugs have certainly evolved. The transplantation success rate was 50 percent in 1984; today, it is 91 percent to 92 percent. This drastic improvement can be attributed to the advent of medicines that help control the immune
From a technical standpoint, Dr. Ketel said, kidney transplantation has changed little over the last few decades, but transplantation drugs have certainly evolved. The transplantation success rate was 50 percent in 1984; today, it is 91 percent to 92 percent.
Biomarker-driven adjuvant targeted therapy for NSCLC—the ALCHEMIST trials

by Geoffrey R. Oxnard, MD; Colleen Watt; Dennis Wigle, MD, FACS; and Judy C. Boughey, MD, FACS

It has become clear that one way to achieve durable disease control for advanced NSCLC, with minimal toxicity, is to identify a gene target and to treat it with a potent targeted agent.

Tumor genotyping has had an enormous impact on the management of advanced non-small cell lung cancer (NSCLC). Today, tumor genotyping for epidermal growth factor receptor (EGFR) mutations and anaplastic lymphoma kinase (ALK) gene rearrangements is widely accepted as a standard of care for advanced non-squamous NSCLC in order to identify patients for treatment with EGFR tyrosine kinase inhibitors (TKIs), such as erlotinib, or ALK TKIs, such as crizotinib. Furthermore, genotyping to identify other rare but targetable genotypes (such as ROS1 rearrangements, BRAF V600E mutations, and so on) is increasingly performed. It has become clear that one way to achieve durable disease control for advanced NSCLC, with minimal toxicity, is to identify a gene target and to treat it with a potent targeted agent.

Previous studies
Though widely used and extremely effective, these potent targeted agents are not part of our curative management of NSCLC. Several randomized studies have investigated the role of EGFR TKIs in resected NSCLC, but none have studied these agents specifically in the group known to gain the most benefit—cancers harboring EGFR mutations. The BR.19 trial randomized 503 patients with resected NSCLC to gefitinib versus placebo; however, only 15 of those patients were identified as having EGFR mutations.* The Randomized Double-blind Trial in Adjuvant NSCLC with Tarceva (RADIANT) trial randomized 973 patients with resected NSCLC positive for EGFR by immunohistochemistry or fluorescence in situ hybridization to erlotinib versus placebo, and 161 of those had EGFR mutations—disease-free survival (DFS) was more favorable in the erlotinib arm (HR 0.6), but no difference in overall survival

was evident. One single-arm study, the SELECT trial, studied adjuvant erlotinib in resected EGFR-mutant NSCLC and found it to be a feasible therapy, with 40 percent of patients requiring a dose reduction and 69 percent of patients completing more than 22 months of treatment (of the 24 months intended). The two-year DFS rate was 89 percent, which was better than expected for resected NSCLC.

Given that adjuvant TKI in genotype-defined NSCLC populations is feasible and may improve outcomes, the National Clinical Trials Network and National Cancer Institute (NCI) joined together to design a clinical trial platform that would facilitate definitive studies of adjuvant targeted therapies in biomarker-selected NSCLC patients. This platform was named ALCHEMIST—Adjuvant Lung Cancer Enrichment Marker Identification and Sequencing Trials. The ALCHEMIST program comprises three studies at present: one overall screening study (A151216) to perform tumor genotyping and collect tissue and data for correlative studies, and two treatment trials that randomize EGFR-mutant NSCLC (A081105) or ALK-rearranged NSCLC (E4512) to two years of adjuvant TKI (erlotinib for EGFR, crizotinib for ALK) versus placebo (see Figure 1, this page). The effort balances an important clinical aim and an important translational research goal: (1) to study whether adjuvant targeted therapies can improve overall survival in resected NSCLC, and (2) to perform advanced genomics on a large cohort of resected NSCLCs and to correlate these findings with detailed clinical annotation.

How to get involved with ALCHEMIST
Surgical involvement is critical to the success of the ALCHEMIST screening study. This study has two aims: (1) to perform EGFR and ALK genotyping, which may lead to enrollment in the ALCHEMIST-EGFR and ALCHEMIST-ALK studies; and (2) to collect high-quality formalin-fixed, paraffin-embedded tissue to allow advanced genomics at the NCI. Patients may provide consent for the screening trial at any time in their care (before or after operation, or during adjuvant chemotherapy or radiation), so long as the patients remain in-window for treatment on
the two treatment trials (see Table 1, this page). Ideally, patients should be enrolled before resection so that an extra tumor block can be collected for the study, ensuring adequate tissue for clinical genotyping and advanced genomics. The eligible patient population for ALCHEMIST screening is patients with resectable or resected NSCLC, node-positive (IIA-III A) or high-risk node-negative disease (IB with size ≥ 4cm), non-squamous histology, who did not receive neoadjuvant therapy.

For patients enrolled postoperatively, sites may either submit a tumor block or a combination of standard slides and thick-cut “scrolls” for analysis. All patients also must have a tube of blood collected and complete an epidemiological questionnaire. Those patients who are ineligible for the EGFR or ALK treatment trials are followed on the ALCHEMIST screening study every six months for five years. If a biopsy is performed at the time of recurrence, a portion of this sample should be submitted to the NCI for further genomics. Importantly, the EGFR and ALK genotyping results are returned directly to the site within 14 business days; however, the advanced genomics at the NCI is considered investigational. Thus, while these data will be shared publicly when analysis is completed, they will not be provided to sites for clinical use.

Surgeons and medical oncologists both will enroll patients in the screening study, and medical oncologists will enroll eligible EGFR- or ALK-positive patients in the two treatment trials. Both trials will accept patients who have completed standard adjuvant therapy. Adjuvant chemotherapy and/or radiation therapy is permissible but not required prior to enrollment in the treatment trial. Both treatment studies are placebo-controlled trials that study two years of adjuvant TKI versus two years of placebo. Because U.S. medical oncologists are experienced with the two targeted therapies being studied (erlotinib for EGFR, crizotinib for ALK), it is expected that toxicity and compliance will not be major issues. The primary endpoint of both studies is an improvement in overall survival; patients are allowed to receive any therapy at time of recurrence, including crossing over from placebo to TKI.

Future directions

The ALCHEMIST platform is intended to allow room for growth in the number of adjuvant treatment trials supported by the screening protocol. At present, an additional treatment trial is in development to study adjuvant therapy with a PD1 inhibitor, which also will involve expanding the ALCHEMIST screening study to include squamous NSCLC. The surgeons involved in the study anticipate that the effort will continue to grow in the future to accommodate emerging agents. In this way, the ALCHEMIST trial offers an infrastructure that can answer a range of scientific questions over the coming years, all with the aim of improving the overall treatment of resected and potentially curable NSCLC.

For more information about ALCHEMIST, contact Colleen Watt from the Alliance for Clinical Trials in Oncology at cboyle@uchicago.edu.

### Table 1. Eligibility Windows for ALCHEMIST Trials

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American surgical history: Finding a home at the Clinical Congress

by LaMar S. McGinnis, Jr., MD, FACS, and Norman H. Rich, MD, FACS

In 2014, a newly formed group at the American College of Surgeons (ACS) began to find its place. Driven by a consensus that our rich surgical heritage was not only reflective of our past but could also serve as a guide to our future, the members of this group felt it was imperative that the College begin to collect, collate, reflect upon, and highlight how surgeons and surgery have evolved, believing that awareness of this history adds richness to our daily lives.

One of the ACS Surgical History Group’s (ACSSHG) initial goals was to make surgical history an integral part of the Clinical Congress. We were pleased that the 2014 Clinical Congress Program Committee accepted our proposal for a Panel Session titled Factors Shaping Surgery during the 20th Century—the Inaugural Session of the ACSSHG, and we are equally grateful that the Program Committee has agreed to present a second panel discussion on this subject at the upcoming Clinical Congress in Chicago, IL.

Overview of 2014 program
Recognizing the enormity of the forces at play over the last century, we thought this inaugural venture should focus on four principal topics: The Training of a Surgeon, presented by ACS Past-President John Cameron, MD, FACS; Professional Organizations and Their Impact on American Surgery, presented by ACS Distinguished Service Award recipient David Nahrwold, MD, FACS; What Surgeons Learn from Wars, presented by Basil Pruitt, MD, FACS; and A Fruitful Partnership: Surgeons and Technology, presented by Mark Talamini, MD, FACS. These distinguished experts impressed the large audience assembled on the afternoon of October 28, 2014, in San Francisco, CA. A video of the session is available at the Archives & History/Films section of the ACS website at www.facs.org/about-acs/archives/collections/films.

The evolution of training
Dr. Cameron opened the session by explaining that surgical education and training have evolved to create generations of highly skilled surgeons who are able to care for evermore complex patient cases. He provided an overview of Civil War surgery, focusing on John Shaw Billings, MD (essentially untrained as a surgeon), and the enormity of his exploits as an innovator in surgery. He then used the famous Thomas Eakins paintings of the Gross Clinic and of the Agnew Clinic to exemplify and to contrast progress in the training of surgeons.

Dr. Cameron moved on to the evolution of the surgical training program developed by William Halsted, MD, FACS, at The Johns Hopkins School of Medicine, Baltimore, MD, as the model that profoundly changed and improved surgical training over the 20th century. Dr. Cameron then pointed to modifications of the model that were implemented at other institutions, such as the move from a pyramidal to a rectangular program led by Edward Churchill, MD, FACS, at Massachusetts General Hospital, Boston.

In addition, Dr. Cameron commented on the 21st century use of fellowships following residency training, describing them as representative of a transition to a more disease-oriented approach to surgical training. He closed by noting that the progression of responsibility in surgical training and an ever-increasing focus on science are perhaps the greatest influences on American surgery in the 20th century.

Profound impact of professional organizations
Dr. Nahrwold spoke of the impact that professional organizations have had over this last century of surgical progress, particularly on ethical and moral standards and on professionalism. The
[W]e now look forward to the 2015 Clinical Congress and another ACSSHG Panel Session, Factors Shaping Surgery over the 20th Century II, which builds on last year’s theme....

formation of the American Medical Association in 1847, the founding of the American Surgical Association in 1880 and the ACS in 1913, the first surgical examining board (the American Board of Ophthalmology) in 1913, and the American Board of Surgery in 1937, along with many others, represented a remarkable change in the climate of surgical practice. Dr. Nahrwold further remarked on the major influence of the organized medical staff at hospitals, beginning in 1917 with the first standards for hospitals promulgated by the ACS. The evolution of the Clinical Congress, along with other professional association meetings and their publications—all with a primary focus on education—have been of inestimable benefit to the field. Therefore, professional organizations have not only benefitted surgeons, but also their patients and society as a whole. Standard setting and professional education were and remain the primary strengths of our organizations, serving to bind us together as surgical professionals.

**Advances in technology**

We all benefit daily from the marvels of technology. Dr. Talamini addressed the subject in his presentation on A Fruitful Partnership: Surgeons and Technology, depicting the often tenuous relationship between technology and hesitant surgeons that ultimately results in benefits for our patients. Dr. Talamini provided an overview of some of the major technological changes that have occurred over time, including better visualization of the operative field, dramatically improved instrumentation, heightened ability to control hemorrhage, enhanced ability to join tissues, and so on. He discussed the important relationship between industry and the surgeon and used the experience of George Berci, MD, FACS, who collaborated personally with Karl Storz, to illustrate his point. According to Dr. Talamini, Dr. Berci believes that in a physician/industry partnership, there needs to be complete trust on both sides, creative freedom, the ability to respectfully disagree and debate details, and an understanding that the goal of the alliance is the creation of a better instrument or service—not making money. Dr. Talamini then guided us from the first Bovie to the Argon beam and gave us an appreciation for the ups and downs that have occurred along the way.

**More to come this year**

With the remarkable success of the inaugural panel in 2014, we now look forward to the 2015 Clinical Congress and another ACSSHG Panel Session, Factors Shaping Surgery over the 20th Century II, which builds on last year’s theme and will include the following presentations: Imaging: A Radiology and Surgery Synergism (Barry Katzen, MD); Infection Control to Purge the Scourge of Sepsis (Hiram Polk, Jr., MD, FACS); Cardiovascular Surgery: The Heart of the Matter (Alden Harken, MD, FACS); and Transplantation: Surgical Use of Used Parts (Nancy Asher, MD).

The ACSSHG welcomes your presence and participation at this event on Wednesday, October 7, 2015, at the Clinical Congress meeting in Chicago.

SEPT 2015 BULLETIN American College of Surgeons
Imagine a scenario in which someone on the operating room (OR) team is about to make a mistake while performing a surgical procedure, and no one speaks up. This is an undesirable situation that often results from the hierarchical OR structure that has developed over the years. Under those conditions, individuals are unlikely to raise concerns for fear of disturbing or even offending the most senior member of the team. Safety experts in other areas have recognized that hierarchy trumps safety and that improvements of safety require elimination of this intimidating structure, as well as encouragement of all members of the team “to speak up.”

Creating a culture of safety

According to an article by Mark R. Chassin, MD, MPP, MPH, FACP, president and chief executive officer of The Joint Commission, and Jerod M. Loeb, PhD, titled “High-reliability health care: Getting there from here,” one of the methods that health care institutions can use to attain levels of quality and safety similar to other industries that strive to achieve zero harm includes establishing a safety culture.*

The authors write that “a culture of safety that fully supports high reliability has three central attributes: trust, report, and improve.”

Furthermore, “maintaining trust also requires the organization to hold employees accountable for adhering to safety protocols and procedures.”

In the article, Dr. Chassin and Dr. Loeb also state that accountability for adhering to safe practices should be instilled in all employees “and is spurred by implementing standards for invoking disciplinary procedures that apply to all staff, regardless of seniority or professional credentials…. Becoming much safer requires caregivers’ willingness and ability to recognize and report close calls and unsafe conditions, combined with an organizational capacity to act effectively on this report to eliminate the risks they embody.”

Flattening the hierarchy and communicating

I believe surgeons should champion these concepts in the OR. From my perspective, two elements are vital to creating a culture of safety. The first is to establish a nonthreatening environment—one that not only invites team members to question the

processes being used but also does away with the traditional hierarchy that has been present in the OR for many years. The most senior surgeon in the OR should create the right environment by elevating everyone and empowering team members to speak up, which is essential to building a team. The best way to achieve this goal is to ensure that everyone feels that the patient’s welfare is the central focus.

When I am working in the OR, I tell my assistants and the scrub nurse that I would like them to follow every step of the operation, and make sure I don’t make any mistakes. Such a statement is usually met with a little smile, as if I did not mean it. But at a time when we use multiple monitors in the OR and everyone can follow the procedure, I want all members of the team to be involved and to feel empowered to challenge me or to ask a question if they see something they do not understand. I tell them the best way to do that is to ask me any time they find me doing something they don’t follow. There are only two reasons for team members to have these questions: either they do not understand, which gives me the opportunity to teach them; or what I am doing is incorrect, in which case they can make me more alert to a potential error. After eliminating the hierarchy, the other vital element in OR safety is adequate communication. Communication in the OR should be active, constant, focused on what is being done, and always with an emphasis on what is best for the patient—we should never be talking about unrelated matters or allowing our minds to drift. Constant communication about what we are doing keeps us focused and alert.

A culture of safety increases the chance of safely completing an operation. Surgeons should use their influence to create such an environment in their ORs. The right climate will improve the quality of surgical care, enhance the well-being of the members of the surgical team, and result in better outcomes for patients.

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.
Kickback

There are several definitions of the word “kickback,” and most of them have negative connotations. The Merriam-Webster online dictionary defines kickback as (1) a sharp violent reaction, and (2) a return of a part of a sum received often because of confidential agreement or coercion. Kickback, in fact, has several meanings—the Urban Dictionary, an online resource for pop culture terms and phrases, defines the term as “a get-together consisting of close friends, [involving] partying and drinking.” There is also a legal definition for kickback—specifically, the federal law that prohibits health care providers and suppliers from giving or receiving “remuneration” for the referral of patients or services covered by most government-run health programs, such as Medicare and Medicaid.

In addition to these more figurative meanings, kickback can refer to the physical reaction that results from a sudden, powerful force, such as the recoil from using a firearm or from starting an unsteadied power tool. One such popular tool is the chain saw, with which the term kickback describes the unexpected upward motion of the guide bar.

History of the chain saw
The first use of a chain handsaw was recorded in 1785 in John Aitken’s Principles of Midwifery or Puerperal Medicine, in which a fine serrated chain was described as having been used to remove diseased bone. In 1926, Andreas Stihl patented a 116-pound electric chain saw that required two people to operate. Near the end of World War II, chain saws were still heavy and required two people to operate. In 1949, McCulloch Motors Corp. debuted the world’s lightest chain saw at only 25 pounds. In 1973, the Husqvarna company created the automatic chain break, a safety device consisting of a lever that stops the chain after kickback, preventing injury to the operator.

Chain saw injuries
According to the Centers for Disease Control and Prevention, approximately 36,000 people are treated annually in hospital emergency departments for injuries resulting from use of a chain saw.

To examine the occurrence of chain saw-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 code (E-code): E920.1 (injuries from chain saw). A total of 5,570 records were found, of which 4,701 contained a discharge status, including 4,612 patients discharged to home, 58 to acute care/rehab, and 21 sent to skilled nursing facilities; 10 died. Of these patients, 97 percent were male, on average 45.5 years of age, had an average hospital length of stay of 2.5 days, an intensive care unit length of stay of 2.7 days, an average injury severity score of 4.5, and were on the ventilator for an average of 2.6 days. Injury location was available for 4,635, and most occurrences took place at home (65 percent), followed by industry (28 percent) (see Figure 1, page 33).

Wear the right gear
The chain saw is one of the most versatile power tools one can own; however, it cuts both flesh and wood with equal ease. Several safety measures should be taken to avoid injury while operating a chain saw. First,
operate, adjust, and maintain the chain saw according to the manufacturer’s direction. Properly sharpen and oil chain saw blades, and choose the proper size saw for the job. Wear the appropriate protective equipment when operating a chain saw, including helmets, face shields, safety glasses, hearing protection, cut-resistant gloves and chaps, along with boots above the ankle.

Observe the above safety recommendations so that when you are done, you can kick back with your friends and family and enjoy the work that you did.

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

**Acknowledgement**
Statistical support for this article has been provided by Chrystal Caden-Price, Data Analyst, NTDB.

**REFERENCES**
Mailing with this month’s Bulletin of the American College of Surgeons is Strategies to Enhance Survival in Active Shooter and Intentional Mass Casualty Events: A Compendium. This document is being distributed to a wide audience, including not only members and staff of the American College of Surgeons (ACS), but also employees of federal agencies and stakeholders interested in improving the public’s ability to respond at the scene of active shooter and mass casualty events. It was developed under the guidance and leadership of ACS Regent Lenworth M. Jacobs, Jr., MD, MPH, FACS, in response to a Presidential Policy Directive aimed at strengthening the security and resilience of the U.S. at a time when active shooter and mass casualty incidents are occurring all too frequently.

The committee was founded by the ACS in collaboration with the medical community and representatives from the federal government, the National Security Council, the U.S. military, the Federal Bureau of Investigation, and governmental and nongovernmental emergency medical response organizations, among others, and has met regularly in Hartford, CT. In addition to the Hartford Consensus reports, the compendium contains statements from government leaders and individuals who have contributed to the committee’s efforts.

The compendium contains Hartford Consensus reports that have been published previously in the Bulletin and the Journal of the American College of Surgeons. These reports represent the deliberations of the Joint Committee to Create a National Policy to Enhance Survivability from Intentional Mass Casualty and Active Shooter Events. The individuals, agencies, and organizations that dedicated considerable time and expertise to the development of this compendium...hope that the lifesaving techniques described in the articles will help to ensure that when bystanders see something where lives are at stake, they can do something to improve survivability. ♦
In acknowledgement of his commitment to the American College of Surgeons (ACS) and his accomplishments in the field of surgery, John A. Weigelt, MD, DVM, FACS, has been selected to receive this year’s Distinguished Service Award (DSA). An ACS Fellow since 1982, Dr. Weigelt is the Milt & Lidy Lunda/Charles Aprahamian Professor of Trauma Surgery; professor and chief, division of trauma and critical care; and associate dean for quality, Medical College of Wisconsin (MCW), Milwaukee. He also is a general surgeon and medical director of clinical quality at Froedtert Memorial Lutheran Hospital.

The DSA is the ACS’ highest honor and will be presented at the 2015 Clinical Congress Convocation ceremony, Sunday, October 4, in Chicago, IL.

The Board of Regents of the ACS is presenting the DSA to Dr. Weigelt “in appreciation of his continuous and devoted service as a Fellow of the American College of Surgeons” and “in recognition of his superb skills in synthesizing and applying surgical knowledge and conveying effectively critical concepts to learners that have positively impacted the practices of numerous surgeons,” according to the award citation.

**Leadership in the ACS**

In his more than 30 years as a Fellow, Dr. Weigelt has been a member of and held leadership roles in a range of ACS programs and committees. He has been a member of the ACS Committee on Trauma (COT) since 1992 and, in that time, served as COT Chair (1994–1998) and COT Membership Committee Chair (1998–2004). He also was chief, COT Region 6 (1989–1992). He has been on the National Faculty of the Advanced Trauma Life Support® program since 1983.

Dr. Weigelt has been deeply involved in many of the College’s educational programs. He began serving as an author of the Surgical Education and Self-Assessment Program (SESAP®) during SESAP VII, joined the Advisory Committee during SESAP IX, and has served as Medical Director of SESAP since 2001. He helped to start the General Surgery Review course at the Clinical Congress in 2007 and has functioned as Course Director of the lauded Comprehensive General Surgery Review Course since its beginning in 2010. Additionally, he has been a member of the Committee on Education and the Committee on Video-Based Education since 2002, as well as a member of the Committee on Medical Motion Pictures (2002–2004).

Dr. Weigelt also has been a part of state-level ACS activities, becoming a member of the North Texas Chapter in 1983 and serving as Chair, North Texas Chapter COT, and Council Member, North Texas Chapter (both 1983–1989). He has also been a member of the ACS Chapters in Minnesota and Wisconsin.

**Accomplished surgeon and educator**

Dr. Weigelt’s involvement in the College’s educational programs and committees is representative of his dedication to surgical education and practice. He joined the faculty of the MCW in 1999 and, in addition to his previously noted professorships and position as chief of the division of trauma and critical care, he has been a member of MCW’s Residency Education and Evaluation
The Board of Regents of the ACS is presenting the DSA to Dr. Weigelt “in appreciation of his continuous and devoted service as a Fellow of the American College of Surgeons” and “in recognition of his superb skills in synthesizing and applying surgical knowledge and conveying effectively critical concepts to learners that have positively impacted the practices of numerous surgeons,” according to the award citation.

Dr. Weigelt has been recognized as a premier surgical educator. In his tenure as professor at the University of Minnesota (1992–1999), he was twice awarded the Wangensteen Award for Excellence in Teaching (1993, 1999). In 2002, he was awarded the Association for Surgical Education Outstanding Teacher Award. And since joining MCW, he has twice been awarded the Teacher of the Year Award (2004, 2010). In 2013, he was honored by being elected one of the Giants of General Surgery by UT Southwestern and Parkland Foundation, recognizing his excellence and dedication to teaching. Dr. Weigelt also has mentored 88 medical students, residents, fellows, and faculty in his career, and served as program director for surgical critical care at UT Southwestern and University of Minnesota and as general surgery residency program director at MCW.

Other contributions to the field
Beyond his previously noted roles with the ACS, Dr. Weigelt has been an active contributor to the broader field of surgery. In addition to his Fellowship in the ACS, Dr. Weigelt is or has been a member of many other honorary and professional societies, including the Society of Critical Care Medicine; Southwestern Surgical Congress; American Association for the Surgery of Trauma; Western Surgical Association (past-vice-president); American Trauma Society; Parkland Surgical Society (founding member); American Medical Association; Société Internationale de Chirurgie, U.S. Chapter; Central Surgical Association; American Surgical Association; Society of American Gastrointestinal and Endoscopic Surgeons; Association of Program Directors in Surgery; and Association for Surgical Education.

Dr. Weigelt has presented more than 150 local, regional, and national lectures in his career, as well as 20 lectures on the international stage, ranging in location from Istanbul, Turkey, to Beijing, China. He has served as faculty for more than 130 postgraduate courses and symposiums throughout the U.S.

Dr. Weigelt’s research interests include surgical infections, clinical outcomes, and educational approaches to training surgeons. Over the course of his career, Dr. Weigelt has been awarded 19 research grants. His most recent research...
Official notice:

Annual Business Meeting of Members, American College of Surgeons

In accordance with Article I, Section 6, of the Bylaws, the Annual Business Meeting of Members of the American College of Surgeons (ACS) is called for 4:15 pm, the afternoon of Wednesday, October 7, 2015, at McCormick Place, Chicago, IL.

This session constitutes the Annual Business Meeting of Members, at which time ACS Officers and Governors will be elected and reports from officials will be presented. Items of general interest to the Members will also be presented. Members are respectfully urged to be present.

Edward E. Cornwell III, MD, FACS
Secretary
American College of Surgeons
September 1, 2015

Dr. Weigelt’s involvement in the College’s educational programs and committees is representative of his dedication to surgical education and practice.

interests focus on quality of care issues, working closely with the Wisconsin Collaborative for Healthcare Quality.

He is editor-in-chief of the Journal of Surgical Education and of the audio Practical Reviews in General Surgery. He was the editor of the Journal of Surgical Outcomes, 2002–2007. He was an associate editor with Selected Readings in General Surgery (SRGS) when it was published at UT Southwestern Medical Center (1989–1996) prior to the program’s transfer to the College. Additionally, he has served on the editorial boards of the Journal of Trauma, the Pan American Journal of Trauma, the Journal of Critical Care Medicine, and Advances in Therapy.

He is a reviewer for Critical Care Medicine, Surgery, and previously reviewed Archives of Surgery (now Journal of the American Medical Association Surgery). As a contributor, he has published more than 150 medical journal articles, written more than 50 book chapters, and has been a contributing or associate editor of more than 60 entries in SRGS.

Dr. Weigelt graduated from Michigan State University, Lansing, with a bachelor of science degree, and earned his doctor of veterinary medicine degree from the same institution. He completed his medical degree at MCW, and his internship and residency at UT Southwestern. He completed his master’s in hospital administration at the University of Wisconsin-Madison.
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**Pick 25 of 2015**
Select 25 of the 118 webcast sessions from Clinical Congress 2015.

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*Practicing surgeons may earn CME credit and claim self-assessment credit.

For more information, visit [www.facs.org/education/resources/elearning/webcasts](http://www.facs.org/education/resources/elearning/webcasts) or contact Olivier Petinaux at 866-475-4696 or elearning@facs.org.
The Board of Governors’ (B/G) Surgical Volunteerism and Humanitarian Awards Workgroup has announced the recipients of the 2015 American College of Surgeons (ACS)/Pfizer Surgical Humanitarian Award and Surgical Volunteerism Awards. As in previous years, the Workgroup received exceptional nominations, reflecting the remarkable commitment of ACS Fellows to providing care to underserved populations.

The extraordinary contributions of the award recipients are summarized in this article and will be formally recognized at the 2015 Clinical Congress in Chicago, IL, during the annual B/G reception and dinner, on Tuesday, October 6, at the Hilton Chicago Hotel. Clinical Congress attendees are invited to hear the honorees speak at a Panel Session, Humanitarian Surgical Outreach at Home and Abroad:

Reports of the 2015 ACS/Pfizer Volunteerism and Humanitarian Award Winners, Monday, October 5, 9:45 am–12:15 pm, at McCormick Place, Chicago, IL.

**Surgical Humanitarian Award**
The ACS/Pfizer Surgical Humanitarian Award recognizes Fellows who have dedicated much of their careers to ensuring that underserved populations have access to surgical care and have done so without expecting commensurate compensation.

**Dan Poenaru, MD, FACS,** a pediatric surgeon from Montreal, QC, will receive the Surgical Humanitarian Award for starting East Africa’s first pediatric surgical fellowship and for educating and training pediatric surgeons in Africa.

Dr. Poenaru made a life-changing decision to end his full-time academic pediatric surgical practice to move from Canada to Kenya with BethanyKids, a faith-based organization devoted to the holistic care of children with surgical conditions and disabilities. With only seven beds available for children with pediatric surgical conditions upon his arrival, Dr. Poenaru co-founded BethanyKids at Kijabe Hospital (BKKH), a 67-bed pediatric surgery unit with 15 outpatient surgery sites across Kenya, several surgical trainees, specialty nurses, and rehabilitation therapists. He ran multiple pediatric surgical missions in Somaliland and bimonthly clinics in Dadaab, Kenya.

Realizing his general and pediatric surgical training was insufficient to meet the demands of his new environment, Dr. Poenaru sought additional training and recruited volunteer surgeons from North America. Not wanting to turn patients away, he scrubbed in with these...
recruits to learn techniques in pediatric urology, neurosurgery, and plastic surgery. Soon becoming aware of the limitations of surgical practice and training in resource-limited settings, Dr. Poenaru established a pediatric surgery fellowship program in conjunction with the Pan-African Academy of Christian Surgeons (PAACS). In partnership with the College of Surgeons of East, Central, and Southern Africa (COSECSA), he was able to attain accreditation for this fellowship program, making it the first certification in pediatric surgery available in the region. The COSECSA graduates, coming from several African countries, established satellite BethanyKids sites in Madagascar, Ethiopia, Uganda, and Sierra Leone.

Dr. Poenaru remained a strong advocate for increased resources for children’s surgeries in Africa through his research into the global burden of pediatric surgery, at conferences, and through educational and promotional materials. His fundraising efforts contributed to the construction of the new operative block at Kijabe Hospital, an 80-bed children’s center expected to open in 2016, and an upcoming 15-bed inpatient unit at the Mbarara University Teaching Hospital (MUTH) in Uganda.

As clinical director of BethanyKids, Dr. Poenaru oversees the activities of all six African sites. He is closely involved with the local surgeons and staff, regularly visiting the sites to assist in their operation. For the last three years he has also been involved in a new undergraduate medical program in Addis Ababa, Ethiopia, where he acts as part-time academic dean.

**Surgical Volunteerism Awards**

The ACS/Pfizer Surgical Volunteerism Award recognizes ACS Fellows and members who are committed to giving back to society though significant contributions to surgical care as volunteers. This year, three awards will be granted to the following individuals.

**Susan Miller Briggs, MD, MPH, FACS**, a trauma and general surgeon, Massachusetts General Hospital (MGH), Boston, MA, will receive the International Surgical Volunteerism Award for working with not-for-profit organizations and the U.S. National Disaster Medical System to provide surgical care during humanitarian emergencies throughout the world.

Dr. Briggs founded the International Trauma and Disaster Institute at MGH as an educational resource in trauma and disaster medicine to aid the many countries that have little or no organized systems for disaster preparedness and response. She developed and participated in numerous international train-the-trainer courses for multidisciplinary medical providers, which are provided at no cost. The second edition of the *Advanced Disaster Medical Response Manual for Providers* was recently developed and edited by Dr. Briggs with the MGH department of surgery and the Harvard Program in Global Surgery; at present, it is being translated into multiple languages. The first edition
was translated into eight languages, including Chinese, Arabic, Japanese, and Spanish.

In collaboration with the American Refugee Committee and as a founding member of the Durant Fellowship for Refugee Medicine, Dr. Briggs served as a mentor to many of the recipients, both at MGH and in refugee camps throughout the world. Her involvement with Project Hope and the U.S. government included organizing and leading volunteer disaster medical teams to respond to many international emergencies, including earthquake disasters in El Salvador, Armenia, Iran, China, and Haiti, as well as a train disaster in Ufa, Russia. Dr. Briggs also worked with not-for-profit organizations to develop programs addressing gender-based violence, income generation, and austere medical care in low- and middle-income countries.

Dr. Briggs worked as a consultant in trauma and disaster medicine following humanitarian disasters, helping to develop sustainable programs in trauma care and rehabilitation medicine in conjunction with not-for-profit and international medical organizations. These programs provide in-country training of personnel, provision of medical equipment, and collaborative exchange programs. Dr. Briggs is an associate professor of surgery and affiliate faculty in global surgery, Harvard Medical School, Boston.

Rifat Latifi, MD, FACS, a trauma and general surgeon from Tucson, AZ, will receive the International Surgical Volunteerism Award for helping to establish telemedicine and e-health programs in underdeveloped countries, especially those recovering from conflict and in need of major rebuilding of their health care systems.

Dr. Latifi’s telemedicine program began in Kosovo, where the medical infrastructure was destroyed during the war of 1999. He and his collaborators built a state-of-the-art telemedicine program that included technical infrastructure, virtual education programs, videoconferencing capabilities, and an electronic library that uses the Health InterNetwork Access to Research Initiative (HINARI). The Initiate-Build-Operate-Transfer (IBOT) model designed by Dr. Latifi and his collaborators ensures the program’s sustainability and has been successfully replicated in Albania and Cabo Verde, Africa, and is currently present in 44 hospitals.

Being the founder and president of the not-for-profit International Virtual e-Hospital (IVEH), Dr. Latifi was able to introduce telemedicine, telehealth, virtual educational programs, and seminars though the IVEH network to fulfill the need for continuing medical education (CME). The telemedicine centers can be used for disaster preparedness to educate medical staff and improve educational capacities as an e-learning platform. Dr. Latifi and his team trained both physicians and administrators to operate these systems.

Dr. Latifi is professor of surgery, University of Arizona,
Tucson, and is an active member of the American Telemedicine Association, vice-president of the International Society for Telemedicine and e-Health, and Chair of the Health Information Technology Committee of the ACS. In addition, he is an advisor to the Multinational Telemedicine for Disaster Management for the North Atlantic Treaty Organization, and he previously served on the advisory board of the European Space Agency.

Shilpa Shree Murthy, MD, MPH, a PGY-4 general surgery resident at Indiana University, Bloomington, will receive the Surgical Resident Volunteerism Award for developing the Clinical Breast Exam Simulation Training Course to provide care and education in Rwanda, Africa.

While attending the University of Michigan, Ann Arbor, Dr. Murthy founded the Global Medical Relief Program in 2002, one of the first undergraduate global health programs at the university. This program raised funds that were used to send medical supplies to underdeveloped countries around the world. In three years, the organization grew to 100 students from six and is currently one of the largest and most active global health undergraduate groups on campus. In collaboration with Health in Action, a medical student group from the University of Michigan, Dr. Murthy led a group of undergraduate engineer, public health, and medical students to apply health education programs and discover innovative ways to develop a clean water system for several villages outside San Cristóbal, Dominican Republic. Dr. Murthy also co-founded a chapter of Unite for Sight, a not-for-profit organization that provides free vision screenings.

Before graduating from Pennsylvania State University College of Medicine, Hershey, in 2010, Dr. Murthy traveled to Malawi, Africa, with the William Jefferson Clinton Foundation in 2007. There she trained local women to deliver a health survey to more than 450 households. The survey was designed to determine how people accessed water and how this contributed to sanitation habits and nutritional status. She also assisted in and advocated for the creation of the first Global Health Center at Penn State University, Hershey.

In Kigali, Rwanda, Dr. Murthy designed and implemented a clinical breast exam training course for surgical, internal medicine, and obstetrics and gynecology (OB/GYN) residents and medical students at the University of Rwanda. She taught more than 230 students how to evaluate and examine patients presenting with a breast complaint. She used a low-fidelity breast simulation model created by a local women’s cooperative, Ineza, to provide care to impoverished women who survived the Rwanda genocide. Dr. Murthy also developed the curriculum and coordinated an ultrasound-guided breast core needle biopsy course for surgery and OB/GYN residents. In collaboration with Rwanda’s Ministry of Health, Partners in
Health, and the University of Rwanda, Dr. Murthy was a key leader in planning and executing Rwanda’s inaugural national breast cancer symposium. This program led to the creation of multidisciplinary tumor boards at university hospitals and further supported breast training programs throughout the country, and procurement of breast core needle biopsies. Dr. Murthy plans to pursue an academic career where she can continue her work in medical education and improve access to quality surgical cancer care in the most disenfranchised patient populations.

**Bleeding control spotlighted at new ACS Theater Sessions at Clinical Congress**

A new bleeding control (B-Con) course has been developed in response to the call from the American College of Surgeons (ACS)-led Hartford Consensus for direct training of lay personnel (immediate responders) in external hemorrhage control (see compendium enclosed with this month’s Bulletin). The U.S. Department of Homeland Security and the U.S. Department of Health and Human Services also have been involved in these efforts to increase collaboration between tactical law enforcement, non-tactical law enforcement, fire service, and emergency medical services personnel (professional first responders) when responding to the scene of a casualty incident.

The new B-Con course will be spotlighted at the ACS Theater at the ACS Clinical Congress, October 4–8, in Chicago, IL. This session, which will be presented twice during the Clinical Congress (2:00–2:25 pm, Monday, October 5, and 11:15–11:40 am, Wednesday, October 7) is a preview of the 2.5 hour course that meets the requirements of basic training in hemorrhage control. Course participants will learn fundamental lifesaving medical interventions, including bleeding control with a tourniquet, bleeding control with gauze packets and topical hemostatic agents, and opening an airway properly to allow the victim to breathe.

The B-Con course PowerPoint presentation can be accessed via the ACS website at www.facs.org/quality-programs/trauma/education/affiliate.
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The American College of Surgeons (ACS) Foundation Board of Directors will present the longstanding Distinguished Philanthropist Award and a new Distinguished Organization Award at the 2015 Clinical Congress. This year’s recipient of the Distinguished Philanthropist Award will be Danny R. Robinette, MD, FACS, and his wife, Paula. The Foundation Board will present the newly established Distinguished Organization Award to the Norman M. Rich Department of Surgery at Uniformed Services University of the Health Sciences (USUHS), Bethesda, MD. Both awards will be presented at the Foundation’s annual Donor Recognition Luncheon, Monday, October 5, at the Hyatt Regency McCormick Place.

The Robinette’s outstanding philanthropy
The 2015 Distinguished Philanthropist Award will be presented to Dr. Robinette and Paula Robinette of Fairbanks, AK, in recognition of their philanthropic endeavors and service to the surgical profession, the medical community, and the ACS.

Through their membership in the Fellows Leadership Society, the ACS major donor recognition program, and the Mayne Heritage Society—the ACS planned giving program—Dr. and Mrs. Robinette are helping to ensure that the College remains a strong advocate for future surgeons. Their 1913 Legacy Campaign gift will support the Codman Quality and Safety Fund and the Rural Surgery Fund. Both initiatives align closely with Dr. Robinette’s work as a surgeon in a small community and his commitment to providing the best care and service to his patients.

“Paula and I can think of few other organizations that deserve our strong support,” Dr. Robinette said. “We see many things the College is doing, thanks to philanthropy, that are improving the education and training of young surgeons. A gift to the ACS Foundation is a gift to future surgical patients and their surgeons.”

Dr. Robinette is medical director, Surgery Center of Fairbanks, and clinical assistant professor, department of surgery, University of Washington, Seattle. He attended the University of Louisville Medical
The ACS Foundation promotes voluntary philanthropy from Fellows and friends to support the College’s goals for improving surgical patient care and ensuring the professional standing of surgeons wherever they practice.

School, KY, and completed his residency at Wright State University, Dayton, OH. Mrs. Robinette graduated from Morehead State University, KY.

Dr. Robinette’s voluntarism activities within the ACS include service as Alaska Chapter President, Alaska Commission on Cancer State Chair, ACS Governor, member of the Board of the ACS Professional Association’s political action committee (ACSPA-SurgeonsPAC), and ACS Foundation committee member.

Danny and Paula Robinette are the 25th recipients of the Foundation’s Distinguished Philanthropist Award. The award recognizes individuals who have demonstrated exemplary commitment to philanthropy and to the ACS mission. In addition to their philanthropic support of the ACS, they contribute to several not-for-profit organizations within the Fairbanks community.

Through the advocacy of retired U.S. Army Colonel Norman M. Rich, MD, FACS, MC, DMCC, the Leonard Heaton and David Packard Professor at USUHS, the Uniform Services University Surgical Associates Military Professor of Surgery Fund was established in 2011 and is administered by ACS. This fund will be used to improve surgical care for current and former members of the U.S. Armed Forces and their families and to ensure the professional standing of surgeons in the military and public health services.

Congress established USUHS as part of the Uniformed Services Health Professions Revitalization Act, which President Richard M. Nixon signed into law on September 21, 1972. It was created to fill a void that existed in hospitals and clinics, on military bases and battlefields, and other places where service members needed—and deserved—specially trained physicians to care for their wounds.

The mission of USUHS is to educate, train, and prepare uniformed services health professionals, officers, and leaders to directly support the military health system, the National Security and National Defense Strategies of the U.S., and the readiness of the U.S. Armed Forces. USUHS is located in Bethesda, MD, on the grounds of the Naval Support Activity Bethesda, near the Walter Reed National Military Medical Center.

Before this funding partnership was established, the ACS and USUHS were longtime informal collaborators and have shared several volunteer leaders, including the late Oliver H. Beahrs, MD, FACS, and the late George F. Sheldon, MD, FACS, both Past-Presidents of the ACS.

Dr. Rich will accept the award, in his words, “on behalf of the thousands of individuals who have contributed to our collective efforts over the past nearly 50 years.”

The ACS Foundation promotes voluntary philanthropy from Fellows and friends to support the College’s goals for improving surgical patient care and ensuring the professional standing of surgeons wherever they practice. For more information on the Foundation and the awards, visit the ACS Foundation’s website at www.facs.org/acsfoundation.

First Distinguished Organization Award
This year, the ACS Foundation Board of Directors will also present the first Distinguished Organization Award to the Norman M. Rich Department of Surgery at USUHS in honor of its generous philanthropic partnership with the College.
Same great meeting, exciting new locations

In the coming years, the American College of Surgeons Clinical Congress will be held in two brand-new cities.

PLAN NOW TO ATTEND!

CHICAGO, IL
October 4–8, 2015

WASHINGTON, DC
October 16–20, 2016

SAN DIEGO, CA
October 22–26, 2017

BOSTON, MA
October 21–25, 2018

SAN FRANCISCO, CA
October 27–31, 2019
Renewed Excelsior Surgical Society hosts first meeting at 2015 ACS Clinical Congress

With the experiences from the most recent conflicts in the Middle East and the renewed interest in combat casualty care, there is a strong desire among military surgeons who are members of the American College of Surgeons (ACS) to resurrect the Excelsior Surgical Society and to make the College its official home. The newly reformed Excelsior Surgical Society will meet from 7:30 am to 12:45 pm, Sunday, October 4, at the Hilton Chicago, IL, International Ballroom South, Second Floor, in conjunction with the ACS Clinical Congress 2015.

The original Excelsior Surgical Society was founded in 1945 by a group of American surgeons who had served during World War II. Among the founders were Edward D. Churchill, MD, FACS, and Michael E. DeBakey, MD, FACS. The first meeting took place at the Excelsior Hotel in Rome, Italy. The last official meeting of the Society convened in 1986 at the ACS Clinical Congress in New Orleans, LA.

This first meeting of the revitalized society will focus on the theme The Way Forward. The program has been organized by U.S. Navy Commander Gordon Wisbach, MD, FACS, director of minimally invasive, bariatric, and robotic surgery, and vice-chairman, department of surgery, Naval Medical Center San Diego, CA; and U.S. Army Commander Yong Choi, MD, FACS, chief, laparoscopic surgery, Eisenhower Army Medical Center, Fort Gordon, GA.

Surgical consultants who will speak on the state of U.S. military surgical communities include:

- U.S. Army Colonel Mary J. Edwards, MD, FACS, a pediatric surgeon at San Antonio Military Medical Center, TX
- U.S. Air Force Colonel Gregory York, MD, FACS, commander of the 51st Medical Group, 51st Fighter Wing, Osan Air Base, Republic of Korea
- U.S. Navy Captain Craig Shepps, MD, FACS, a general surgeon at Naval Medical Center, Jacksonville, FL
- C. William Schwab, MD, FACS, FRCS, professor of surgery, University of Pennsylvania; director, University of Pennsylvania Trauma Network; and director, fellowship program in trauma surgery and critical care, University of Pennsylvania.
This first meeting of the revitalized society will focus on the theme The Way Forward.


In addition, Jonathan Woodson, MD, FACS, Assistant Secretary of Defense for Health Affairs, U.S. Department of Defense, will discuss the Military Health Service Strategic Partnership with the ACS.

Attendees will be able to participate in the Committee on Trauma’s Region 13 (Military Region) Resident Paper Competition, as well as in an interactive panel discussion on the way forward for the Excelsior Surgical Society.

ACS CoC bestows National Achievement Award on 21 cancer care facilities

The Commission on Cancer (CoC) of the American College of Surgeons (ACS) has granted its mid-year 2015 Outstanding Achievement Award to 21 accredited cancer programs throughout the U.S. Award criteria were based on qualitative and quantitative surveys conducted during the first half of 2015.

For a list of these award-winning cancer programs, go to www.facs.org/quality-programs/cancer/accredited/about/outstanding/2015.

The award raises the bar on quality cancer care, with the ultimate goal of increasing awareness about quality care choices among cancer patients and their loved ones. In addition, the award is intended to:

• Recognize cancer programs that achieve excellence in providing quality care to cancer patients

• Motivate other cancer programs to work toward improving their level of care

• Facilitate dialogue between award recipients and health care professionals at other cancer facilities for the purpose of sharing best practices

• Encourage honorees to serve as quality-care resources to other cancer programs

Cancer programs were evaluated on 34 program standards categorized within one of four cancer program activity areas: cancer committee leadership, cancer data management, clinical services, and quality improvement. The programs were further evaluated on seven commendation standards. To be eligible, all award recipients must have received commendation ratings in all seven commendation standards, in addition to receiving a compliance rating for each of the 27 other standards.

“More and more, we’re finding that patients and their families want to know how the health care institutions in their communities compare with one another,” said Daniel P. McKellar, MD, FACS, Chair of the CoC. “They want access to information in terms of who’s providing the best quality of care, and they want to know about overall patient outcomes. I’d like to think that this recognition program assumes a small but vital role in helping patients and families make informed decisions on their cancer care.”

The 21 award-winning, cancer-care programs represent approximately 11 percent of programs surveyed January 1–June 30 by the CoC in 2015. “These 21 cancer programs currently represent the best of the best when it comes to cancer care,” added Dr. McKellar. “Each of these facilities is not just meeting nationally recognized standards for the delivery of quality cancer care but is actually exceeding them.”

♦

NEWS

SEPT 2015 BULLETIN American College of Surgeons
James N. "Jim" Haug, Past-Director, American College of Surgeons (ACS) Socioeconomic Affairs Department (now the Division of Advocacy and Health Policy), died at his home in Lena, IL, June 18, at age 78. Fellows and staff who worked with Mr. Haug remember him as a dedicated professional who delighted in fostering the careers of the people who worked for him and in spending time with his family.

"Jim was a complex character," said Cynthia A. Brown, Past-Director, ACS Division of Advocacy and Health Policy, now vice-president, government affairs, American Medical Association (AMA). "He could be adversarial but was extraordinarily supportive of his staff and his family. Some might say he was a little 'old school,' but then he was always looking for new and better ways of doing things. He was an early promoter of women and took great joy in growing and arranging strawflowers."

Idea man
Mr. Haug began working at the College in December 1974. One of the first activities he led was the development of the ACS Socioeconomic Factbook for Surgery, which contained health care data, summaries of pertinent federal legislation, and ACS position statements.

In March 1979, the ACS opened its Washington, DC, office. Under Mr. Haug's direction, the office was charged with maintaining liaison with congressional staff, government agencies, and medical and surgical societies. The Washington Office also developed a pool of key contacts to offer advice and congressional testimony on relevant issues. As the government continued to play an increasingly prominent role in surgical practice in the 1980s and 1990s, the Washington Office staff expanded to include several registered lobbyists.

"Jim was an idea man and was always looking for ways to improve efforts to enhance the College's reputation in Washington, DC, and in the medical community at large," said Linn Meyer, Past-Director of the ACS Division of Integrated Communications and now Executive Consultant to the College.

W. Gerald Austen, MD, FACS, ACS Past-President, Past-Chair of the ACS Board of Regents, and Past-Chair of the Health Policy and Reimbursement Committee, remembers Mr. Haug as “very enjoyable to work with and very intelligent.” He had a great sense of what the College could accomplish in Washington, Dr. Austen noted, adding, "He was very practical, but also quite passionate about the American College of Surgeons."

John O. Gage, MD, FACS, Past-Chair of the ACS Board of Governors Committee on Socioeconomic Issues, Past-Chair of the General Surgery Coding and Reimbursement Committee, and Distinguished Service Award recipient, recalls that when the College sent him and other ACS leaders to the first meeting of the AMA Relative Value Scale Update Committee, they were ill-prepared. However, they also saw an opportunity to have an impact on the committee's decisions. With that, "Jim got us staff—Pat Parks [then-Manager of the Socioeconomic Affairs Department] and her staff—to give us background information and to work with us at the meetings.”

Mentor
“Jim knew people well,” Dr. Gage added. He was adept at appointing people to the roles for which they were best-suited and cultivated a hard-working, loyal staff.

“I was the first person that Jim hired when he started the department in 1974. At the
“Jim was an idea man and was always looking for ways to improve efforts to enhance the College’s reputation in Washington, DC, and in the medical community at large.”

—Ms. Meyer

time, I thought I was going to write the great American novel, but Jim was very pragmatic. He told me that if I worked hard, I could have a gratifying career in this field. He was right,” said Rebecca M. Maron, CAE, now executive director, Society for Vascular Surgery.

“Always his authentic, straightforward, and candid self, Jim was genuinely interested in all of his employees—professionally and personally,” noted Catherine Jeakle Hill, who worked in the ACS Washington Office and now is senior manager, regulatory affairs, American Association of Neurological Surgeons/Congress of Neurological Surgeons. “He was a great boss for working parents and ahead of his time as a champion for work/life balance, although he may have bristled at the ‘politically correct’ term.”

Dedication to family and country
Mr. Haug’s commitment to the College and his team was exceeded only by the pride and love he exuded when talking about his family. “It was more than clear to anyone who knew Jim how much he loved and admired his wife, Norma, and his three sons, Doug, Curt, and Matt,” Ms. Meyer said.

Having served in the U.S. Air Force from 1955 to 1957, stationed in Okinawa, Japan, Mr. Haug also was fiercely loyal to the military and the people who defend our nation. After retiring from the ACS in 1998, Mr. Haug was active in the Veterans of Foreign Wars post in Freeport, IL, and on Lena’s economic development and planning committee. He also found time to pursue his other passions—including golf, cards, yard work, and coin collecting.

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SEPT 2015 BULLETIN American College of Surgeons
Dr. Judson Graves Randolph, pediatric surgeon, leaves lasting legacy

by Kurt D. Newman, MD, FACS, and Mary Fallat, MD, FACS

Judson Graves Randolph, MD, FACS, a Past-Member of the American College of Surgeons (ACS) Board of Governors, died May 17, 2015, at his home in Nashville, TN. He was 87 years old. The surgical community, and particularly the pediatric surgery family, lost a true friend, colleague, and mentor with his passing.

Nashville roots
Dr. Randolph was born July 19, 1927. He grew up in Nashville, where he attended Hillsboro High School and was an Eagle Scout. He served in the U.S. Navy, 1945–1946, aboard the USS Alabama. He returned to Nashville, where he graduated from Vanderbilt University in 1950 and from Vanderbilt Medical School in 1953. In his professional life, Dr. Randolph trained in general surgery at the Massachusetts General Hospital, Boston. He trained in pediatric surgery at the Boston Children’s Hospital under the tutelage of Robert Gross, MD, FACS, whom Dr. Randolph considered an esteemed mentor. He remained in Boston on the faculty of Harvard Medical School at Boston Children’s until 1963, when he accepted the position as surgeon-in-chief of the Children’s National Medical Center in Washington DC, a post he held for nearly 30 years.

Champion for pediatric surgical education
Dr. Randolph was the first full-time pediatric surgeon in Washington, DC, and he achieved the rank of professor of surgery and pediatrics at George Washington University. Dr. Randolph was adored by his patients and families and played an active role in the care of complicated patient cases well into their adulthood. He was one of the first pediatric surgeons to focus on children’s burn care, and was a leader in the advancement of surgical care of children with cancer. He was also well known for his creativity in the care of children with complex anomalies.

Dr. Randolph provided significant leadership in developing the specialty of pediatric surgery in the U.S. Along with William Clatworthy, MD, who chaired a newly formed education committee within the surgical section of the American Academy of Pediatrics, Dr. Randolph was instrumental in establishing the requirements for the two-year training program for pediatric surgery in the U.S. and Canada in the late 1960s.

At the time, only 12 programs in North America were training pediatric surgeons. The Children’s National Medical Center program became the 13th when Dr. Randolph recruited John Lilly, MD, FACS, to come to Washington to train. Dr. Randolph was on the committee that successfully approached the American Board of Surgery to obtain specialty board certification, resulting in the Certificate of Special Competence in Pediatric Surgery.

Furthermore, Dr. Randolph was the first pediatric surgeon to represent the specialty of pediatric surgery as a director on the American Board of Surgery (1973–1979). He, along with Harvey Beardmore, MD, FACS, of McGill University, Montreal, QC, and Marc Rowe, MD, FACS, of Children’s Hospital of Pittsburgh, developed the first written examination in pediatric surgery.

Leader of organizations
Dr. Randolph was a long-term Fellow of the American College of Surgeons. He served as President of the Metropolitan Washington, DC, Chapter (1981–1983) and as a Governor (1971–1974). He also served on the Medical Student Education Committee (1978–1988).

He valued his membership in the ACS and enjoyed participating in ACS meetings and presenting...
It was a source of great satisfaction to Dr. Randolph that he trained more than 40 of the finest pediatric surgeons in this country and abroad, many of whom have become chiefs and training program directors.

papers for discussion. While in Washington, Dr. Randolph served as President of the Washington Academy of Surgery, Chairman of the Surgical Section of the American Academy of Pediatrics, and President of the American Pediatric Surgical Association. He was a member of the American Surgical Association and the Southern Surgical Association.

He was awarded the Ladd Gold Medal by the American Academy of Pediatrics for his surgical service to children and the Distinguished Graduate Medal by Vanderbilt Medical School.

It was a source of great satisfaction to Dr. Randolph that he trained more than 40 of the finest pediatric surgeons in this country and abroad, many of whom have become chiefs and training program directors. ACS Past-President Kathryn D. Anderson, MD, FACS, for example, was one of his trainees and then partner. Dr. Randolph always enjoyed quoting Dr. Gross: “A good pupil will always outshine his teacher.”

Dr. Randolph was a member of the Board of Trust of Vanderbilt University from 1981 to 2004, at which time he became an emeritus member. He was active in Leadership Nashville, an independent executive leadership program, and in 2007 he was elected to the Nashville Public Schools Hall of Fame.

Dr. Randolph’s wife of nearly 50 years, Comfort Adams Randolph, died in 2001. Dr. Randolph is survived by his five children: Somers of Santa Fe, NM; Garrett of Belfast, ME; Judson Jr. (Catherine) of Seattle, WA; Adam of Sewanee, TN; and Comfort (Bradford Belbas) of Edina, MN; and his eight grandchildren.

Two memorial services for Dr. Randolph were held—the first on July 25 in Nashville, and the second on August 22 in Washington, DC—to celebrate his personal and professional life there for 30 years.

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

The program is free to members and contains:

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

To order, visit www.facs.org/education/patient-education.
With Chicago, IL, hosting this year’s Clinical Congress, the ACS Archives invites Fellows and their colleagues and families to visit one of the city’s unique attractions—Graceland Cemetery. Known as “the cemetery of architects” for housing the burial sites of some of the visionaries whose buildings have defined Chicago’s skyline for generations, Graceland is also the final resting place of ACS Founder Franklin H. Martin, MD, FACS. Dr. Martin is buried with his wife, Isabelle, and her parents, Dr. and Mrs. John Hollister.

The park-like Graceland Cemetery was reimagined by noted landscape architect Ossian Simonds in the 1880s, featuring plants and trees native to Chicagoland. Resting atop the flat plains and gentle hills are some of the most spectacular grave markers in Chicago, including the Graves Family’s Eternal Silence, by sculptor Lorado Taft, and Marshall Field’s Memory, by sculptor Daniel Chester French.

In addition to Dr. Martin, Graceland is the final resting place of Daniel Hale Williams, MD, FACS, the first African-American Fellow of the College, and Lucius Fisher, president of the Union Bag & Paper Company. Mr. Fisher was the last owner of the Nickerson Mansion before it became the College’s first headquarters.

Graceland Cemetery is open every day, 8:00 am–4:00 pm, and is located at 4001 N. Clark Street. If you are interested in planning a self-guided tour of the Graceland Cemetery or in seeing artifacts owned by Dr. Martin, visit the Archives booth in the ACS Resource Center in McCormick Place West, Hall F2, at this year’s Clinical Congress. ♦
Join Us in the Windy City for Education, Networking, and Fun!

This year’s Clinical Congress is taking place in Chicago, IL—a location sure to provide a much-needed break from your busy schedule and offer many exciting options for the whole family to enjoy. In addition to five days of outstanding education and networking opportunities, a number of fun activities have been planned during this year’s meeting. Relax after a day of sessions and enjoy one of these tours and events.

Sunday, 10/04, 2:00 pm
ST03 White Sox vs. Detroit Tigers
Price per person: $85

Monday, 10/05, 5:00–10:30 pm
ST08 Second City and Chicago Deep Dish Pizza
Price per person: $135

Tuesday, 10/06, 7:30 pm
ST13 Broadway in Chicago:
A Gentleman’s Guide to Love & Murder
Price per person: $125 (tickets only)

Wednesday, 10/07, 1:00–5:00 pm
ST15 Bottle and Bottega
Price per person: $140

PLAN NOW TO JOIN US. REGISTER TODAY!
facs.org/clincon2015
Jorge Cervantes, MD, FACS(Hon), of Mexico City, Mexico, was recognized in June by the Colegio Dominicano de Cirujanos as an honorary member during the Latin American Congress of Surgery in Punta Cana, Dominican Republic. Dr. Cervantes, former president of FELAC (Federacion Latinoamericana de Cirugia), also is an Honorary Member of the International Society of Surgery/Société Internationale de Chirurgie.

Ronald M. Fairman, MD, FACS, Hospital of the University of Pennsylvania, Philadelphia, was elected president-elect of the Society for Vascular Surgery (SVS) at the society’s 2015 annual meeting in June. Dr. Fairman has a multidimensional practice at the University of Pennsylvania’s Penn Medicine. He is chief of vascular surgery and endovascular therapy and has a dual faculty appointment as the Clyde F. Barker–William Maul Measey Professor in Surgery and a professor in radiology. In addition, Dr. Fairman’s research has been pivotal to key clinical trials and lifesaving improvements in stent technology.

Bruce A. Perler, MD, MBA, FACS, the Julius H. Jacobson II, MD, Professor of Vascular Surgery, Johns Hopkins University School of Medicine, Baltimore, MD, was elected president of the SVS at the society’s annual meeting. Dr. Perler is also vice-chair, clinical operations and financial affairs, department of surgery, and chief emeritus, division of vascular surgery and endovascular therapy, Johns Hopkins Hospital. As president of the 5,300-member organization, Dr. Perler will chair a board of directors of more than two dozen vascular surgery leaders and will oversee four governing councils, 26 committees, and 400 volunteer members.

Peter S. Richman, MD, FACS, a general surgeon in Mission Hills, CA, was installed as 2015–2016 president of the Los Angeles County Medical Association (LACMA) at a reception and dinner June 24. LACMA is a professional association representing Los Angeles County physicians from every medical specialty and practice. Dr. Richman serves on the Community Board of Directors for Facey Medical Foundation and Providence Health Services and is a trustee of the California Medical Association.

Barry J. Silverman, MD, FACS, an orthopaedic surgeon in Aventura, FL, and his wife Judy, earlier this year received the
American College of Surgeons Official Jewelry & Accessories designed, crafted and produced exclusively by Jim Henry, Inc.

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

Cuff Links
- S3 Gold-Filled $200
- S4 Solid 14K Gold $1,150

Key (shown actual size of 3/4")
- S5 Gold-Filled $85
- S6 Solid 14K Gold $700

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

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

Miniature Charm
- S11 Gold-Filled $60
- S12 Solid 14K Gold $350

Sterling Silver w/ 18" Sterling Silver Neckchain $65
- S13-1 Sterling Silver Charm $50

Ring
- S14 Solid 14K Gold $2,250
- S14.1 Solid 10K Gold $1,075 (Indicate finger size)

Tie Bar
- S15 Gold-Filled Emblem $75

Necktie
- S16A Dark Blue $35
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Nova Southeastern University President’s Excellence in Community Service Award. The award recognizes professional engagement by members of the South Florida community and encourages the ongoing pursuit of service. Dr. Silverman is a retired physician whose early work with the U.S. Army during the Vietnam War inspired him to pursue a life of community service. In the past 40 years, he has helped create the scoliosis screening program for Miami-Dade County Public Schools, served as chair and medical adviser to the Easter Seals of South Florida, and founded Camp YoFi, a camp for children with autism and their families. ♦
Cutting junior doctors’ hours may not lower risk of surgical deaths

Reuters, July 30, 2015

“Over the past decade, concern for patient safety and the wellbeing of doctors in training, known as residents, has driven reductions in work hours and more rest between shifts for residents. But these changes have in turn raised questions about whether more frequent handoffs of patient care from one clinician to the next might lead to mistakes, said lead study author Dr. Ravi Rajaram, a researcher at the American College of Surgeons and Northwestern University’s Feinberg School of Medicine in Chicago.”

Do cellphones belong in the operating room?

Washington Post, July 13, 2015

“Such incidents are why physicians and medical groups including the American College of Surgeons, the American Academy of Orthopaedic Surgeons and doctors who published an April paper for the American Society of Anesthesiologists have been issuing warnings about phones in the OR and calling for clear rules on whether and how they can be used. Many raised red flags about the potential for noise or distraction, while some also pointed to the possible challenge of infection control.”

Surgeons to review profusion of quality improvement initiatives

Modern Healthcare, July 11, 2015

“These various initiatives will be discussed at the American College of Surgeons’ annual National Surgical Quality Improvement Program meeting July 25–28 in Chicago[, IL]. About 1,400 are expected to attend the conference, which will include sessions focused on value- and evidence-based care, the demand for greater teamwork in surgical care, and process improvement. While he’s supportive of the CMS’ efforts to boost quality, Dr. Frank Opelka [MD, FACS], Medical Director for [Q]uality and [H]ealth [P]olicy for the American College of Surgeons, strikes a cautious note. There are risks about going down the wrong paths, he said. ‘Then
it’s hard to recover. The pros are that we are moving forward trying to match advances in medicine with potential business systems. The simple con is that it’s hard to know which one is going to work and do they work in every market.”

Resident work-hour restrictions don’t help patient outcomes
FierceHealthcare, July 8, 2015

“Although restrictions on the number of hours resident physicians work are meant to reduce medical errors, the work-hour limits do not improve patient safety, according to a study published in the Journal of the American College of Surgeons.

“The idea was pioneered in 1990 by Harold P. Freeman, a doctor at Harlem Hospital who realized that his largely poor and uninsured patients were not receiving quality cancer care because they often got lost in the disjointed system. The programs spread to cancer centers across the United States, as well as some treatment facilities for a small number of other diseases.”

When new doctors ‘train’ during surgery, risks don’t rise: Study

“Researchers found that residents are supervised and their assistance doesn’t increase the risk for complications or death.

“To see if there was any basis for the concern, the researchers looked at results of more than 16,000 brain and spine surgeries performed between 2006 and 2012. The information was from the database of the American College of Surgeons National Surgical Quality Improvement Program.”

“Navigators” for cancer patients: A nice perk or something more?
Washington Post, July 3, 2015

“The programs have been proliferating; since [January] 1, they have been required for cancer centers seeking accreditation by the American College of Surgeons.

“The idea was pioneered in 1990 by Harold P. Freeman, a doctor at Harlem Hospital who realized that his largely poor and uninsured patients were not receiving quality cancer care because they often got lost in the disjointed system. The programs spread to cancer centers across the United States, as well as some treatment facilities for a small number of other diseases.”

Trauma registry yields significant increase in traumatic injury survival rates
U.S. Army, June 23, 2015

“JTS [Joint Trauma System] is one of five directorates at USAISR [U.S Army Institute of Surgical Research]. Its additional responsibility is to write clinical practice guidelines and provide a source of institutional knowledge to inform future operations. The agency shares a strategic partnership with the American College of Surgeons, or ACS, Committee on Trauma and the Defense Health Agency, DHA, to ensure all surgeries, including trauma surgeries, in civilian and military environments are registered. JTS has also partnered with United Kingdom medical officers to establish data sharing agreements.”

Walking could lower fatigue in cancer patients, study shows
Huffington Post, June 22, 2015

“The new research shows that an activity as simple as walking could help to lessen this fatigue. The study, published in the Journal of the American College of Surgeons included 102 people who had just had surgery done for their pancreatic or periampullary cancers. Eighty-five percent of them reported having fatigue at a moderate to severe level.”

Breast-conserving Tx keeps growing, but disparities persist
MedPage Today, June 21, 2015

“The [ACS] National Cancer Data Base (NCDB) includes...
facility-level data (such as type of practice), in addition to clinical variables and demographics, providing a basis for revisiting the issue of practice-related disparities and their influence on use of BCT [breast conserving therapy].

“Investigators reviewed NCDB records for women with newly diagnosed T1-2 breast cancer during 1998 to 2011. The resulting data encompassed 727,927 patients. The principal objective was to identify factors associated with an increased or decreased likelihood of BCT.”

More women with breast cancer choose lumpectomy
CBS News, June 18, 2015

“The new study draws from a database that’s more complete than those used in other research, [Dr. Isabelle] Bedrosian said. Her team looked at data on women treated for early stage breast cancer between 1998 and 2011. All were entered into the National Cancer Data Base, sponsored by the American College of Surgeons and the American Cancer Society. It captures about 70 percent of newly diagnosed cancer cases in the United States, the study authors said.”

Surgery may boost survival in certain advanced lung cancers
HealthDay, June 4, 2015

“In their research, [Dr. Varun] Puri and his colleagues evaluated data from the National Cancer Database on almost 9,200 patients with stage 3b non-small cell lung cancer who underwent a combination of treatments between 1998 and 2010.”

Register for ACS TQIP Conference, November 15–17, in Nashville, TN

The sixth annual Trauma Quality Improvement Program (TQIP®) Scientific Meeting and Training will take place November 15–17, at the Omni Nashville Hotel, TN. Register online for the meeting by October 22 at www.acstqip.org.

The meeting will convene trauma medical directors, program managers, abstractors, and registrars from participating and prospective TQIP hospitals. The program will begin with a half-day preconference session on the basics of the TQIP program, intended for new TQIP centers, new staff at existing centers, and participants in need of a TQIP refresher.

At the conference, representatives from trauma centers will lead a number of sessions to highlight how they are using TQIP and convey to attendees the benefits of TQIP participation. Breakout sessions focused on registrar and abstractor concerns, matters that relate to the trauma medical director, and trauma program manager-focused issues will enhance the learning experience and instruct participants about their role on the TQIP team.

Conference topics of note for 2015 will include the integration of Verification, TQIP, and Performance Improvement Programs, as well as Pediatrics. The TQIP project team will present best practice guidelines on care of the orthopaedic patient, followed by a discussion by a panel of experts.

Visit the TQIP annual meeting website at www.facs.org/quality-programs/trauma/tqip/meeting, to view the conference schedule and obtain information about lodging and transportation, the keynote speaker, and a social outing to the Grand Ole Opry.”
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Report on ACSPA/ACS activities, June 2015

by Fabrizio Michelassi, MD, FACS

The Board of Directors of the American College of Surgeons Professional Association (ACSPA) and the Board of Regents (B/R) of the American College of Surgeons (ACS) met June 5–6 at the College's headquarters in Chicago, IL. The following is a summary of their discussions and actions.

**ACSPA**

At the time of the meeting, the American College of Surgeons Professional Association's political action committee (ACSPA-SurgeonsPAC) has raised $267,483 in both personal and corporate funds from 825 members of the College and staff; the average contribution is $324. Of the total raised, $248,414 is personal (hard) dollars and $19,069 is corporate (soft) dollars.

During the 2015–2016 election cycle, SurgeonsPAC has disbursed $198,000 to 42 candidates, leadership PACs, and party committees. Of the amount given, 66 percent went to Republicans and 34 percent to Democrats.

In March, the SurgeonsPAC sponsored a “Pizza and Politics” reception in conjunction with the 2015 Residents as Teachers and Leaders Course. Brian Gavitt, MD, the Resident and Associate Society of the American College of Surgeons (RAS-ACS) PAC Board Representative, and SurgeonsPAC staff led a discussion on the importance of surgical advocacy and political engagement. Attendees networked and learned more about political advocacy.

SurgeonsPAC launched its first PAC Captain Program on May 26. This six-week, peer-to-peer campaign, aimed at disseminating SurgeonsPAC’s message to a broader audience, ended in early July. More than 40 PAC Captains participated in the program launch. These PAC Captains will remain our “champions” in the states, working to increase the SurgeonsPAC membership base throughout the 2015–2016 election cycle.

The 2015 goals of the ACSPA-SurgeonsPAC include:

- Launch additional peer-to-peer focused solicitations, focused on lapsed and low donors, as well as surgeons who have not contributed, using Health Policy and Advocacy Councilors and other SurgeonsPAC advocates.
- Increase awareness of PAC efforts to achieve a market share goal of 10 percent.
- Increase RAS-ACS SurgeonsPAC involvement throughout the country with a goal of 100 percent participation. Efforts and related events would be carried out in coordination with the RAS committee and Dr. Gavitt.

**ACS**

The Board of Regents (B/R) approved the addition of two new Regents’ seats for representatives of specialties that are certified under the auspices of the American Board of Surgery (ABS). The B/R will, therefore, have 14 instead of 12 members from the ABS community, plus an additional nine members from each specialty board.

The subspecialties recognized by the ABS include:

- Burn and critical care surgery
- Gastrointestinal surgery
- General surgery
- Pediatric surgery
- Surgical oncology
- Transplantation
- Trauma
- Vascular surgery

One new position will be filled in 2015, and the other in 2016. The Nominating Committee of the Board of Governors will convene this...
Advocacy and Health Policy

The ACS Division of Advocacy and Health Policy (DAHP) continues to support surgeons' interests at the federal and state levels, advocating on the following issues.

The Critical Access Hospital Relief Act (96-hour rule)

The Centers for Medicare & Medicaid Services (CMS) recently indicated it would begin enforcing a long forgotten regulation requiring that physicians who admit patients to Critical Access Hospitals (CAHs) certify that it is reasonable to anticipate that each will be discharged or transferred within 96 hours. Previously, CAHs operated under a similar but separate condition of participation that required patient stays to be less than 96 hours on average. CMS' recent action will prevent surgeons from being able to admit many patients for procedures routinely performed in CAHs and will force many rural patients to travel further from home for treatment.

To address the issue, Rep. Adrian Smith (R-NE) and Sens. Pat Roberts (R-KS) and Jon Tester (D-MT) have introduced legislation to eliminate the certification requirement for admitting physicians while maintaining the long-enforced 96-hour average stay requirement. The College has endorsed the Critical Access Hospital Relief Act (H.R.169/S.258).

CAH 96-hour rule and EMTALA

ACS staff received questions from rural surgeons regarding compliance with the 96-hour rule in emergency cases as it related to the Emergency Medical Treatment and Labor Act (EMTALA). To help resolve these issues, the ACS scheduled a call with experts from CMS to (a) ensure that they understood that their regulations were in conflict with the reality of practice in the rural setting and (b) to highlight that the regulations for which the agency is responsible could be forcing CAHs to provide care to Medicare patients without payment.

CMS confirmed the outcomes created by the two regulations (the 96-hour rule and EMTALA) taken together. Specifically, CMS stated that if a CAH has the capability to perform surgeries that would result in a patient stay of longer than 96 hours, and if the patient requires that operation in order to be stabilized, then transferring a patient with an emergency medical condition (EMC) to a different facility simply because a physician cannot certify that the patient will be in the hospital for less than 96 hours could result in an EMTALA violation for the CAH.

In addition, if a CAH performs surgeries on non-Medicare patients that commonly result in patient stays of longer than 96 hours, even if the patient does not have an EMC (and thus there are no EMTALA implications), transferring the patient because of the 96-hour rule could jeopardize the CAH's Medicare status because of a potential violation of the CAH's Medicare Conditions of Participation, sometimes resulting in the CAH not being paid for an expensive surgery performed there. Importantly, the 96-hour certification criteria relates to the CAH payment and does not prohibit surgeons from submitting claims to Medicare for professional services.

Given this response from CMS, the best remedy for this situation is passage of the Critical Access Hospital Relief Act of 2015. The bill, introduced in the Senate as S. 258 and in the House as H.R. 169, removes the 96-hour certification requirement, which would alleviate the problems rural surgeons have expressed. The ACS strongly supports this legislation and has included it in our legislative agenda at the annual Advocacy Summit for the past two years.
**Cancer**

At the time of the Board meeting, the DAHP was working with the Commission on Cancer (CoC) to host a congressional briefing on June 9. This second briefing hosted by the CoC focused on accreditation. The briefing featured CoC Chair Daniel McKellar, MD, FACS, and CoC Legislative Committee Chair James Hamilton, MD, FACS, as well as a patient treated at a CoC-accredited facility. The briefing was scheduled to complement the annual One Voice Against Cancer (OVAC) lobby day.

Reps. Charlie Dent (R-PA), Joe Courtney (D-CT), Michael Fitzpatrick (R-PA), and Donald Payne (D-NJ), introduced the Removing Barriers to Colorectal Cancer Screening Act, H.R. 1220. This bill would correct an oversight in current law that requires Medicare beneficiaries to make a copayment when a colonoscopy also involves a polyp removal. The College advocated for including this legislation in the 21st Century Cures Act, which the House passed soon after the Board meeting.

Rep. Anna Eshoo (D-CA) introduced the American Cures Act (H.R. 2104), which seeks to expand support for future cancer and other health care research at the National Institutes of Health (NIH), the Centers for Disease Control, the Department of Defense (DoD) Health Program, and the Veterans Medical and Prosthetics Research Program. Sen. Richard Durbin (D-IL) introduced companion legislation, S.289. The College supports these bills, which would create a trust fund to support a mandatory funding stream for this type of research.

Reps. Jackie Speier (D-CA) and Cynthia Lummis (R-WY) introduced the Breast Cancer Research Stamp Reauthorization Act, H.R. 2191, which would extend by four years the U.S. Postal Service’s authority to issue a fundraising stamp for breast cancer research. The Breast Cancer Research Stamp is available for purchase at 11 cents more than the cost of a regular first-class stamp. The revenues cover the post office’s administrative costs and fund breast cancer research programs at the NIH and the DoD. Sens. Dianne Feinstein (D-CA) and Mike Enzi (R-WY) introduced the Senate version, S.1170. The ACS supports these bills.

**Medical liability reform**

The legislation described in earlier reports and that repealed the sustainable growth rate (SGR) formula—the Medicare and Children’s Health Insurance Program Reauthorization Act (MACRA)—also included ACS-supported legislation known as the Standard of Care Protection Act. This legislation clarifies that no standard or guideline in federal health programs, including Medicare, Medicaid, or the Affordable Care Act, may be used to establish the standard of care that a health care professional must provide to a patient; therefore, these mandates cannot be used as a cause of action in liability lawsuits.

The Saving Lives, Saving Costs Act was recently reintroduced by Rep. Andy Barr (R-KY), and for the first time, a companion bill was introduced by Sen. John Barrasso (R-WY). This bill was first introduced last Congress by Reps. Barr and Ami Bera (D-CA), and combines elements of pretrial screening panels and safe harbors for adhering to practice guidelines to provide liability protections, promote evidence-based medicine, and improve patient safety. The College worked with the bill’s sponsors to make refinements and improvements, including removal of a “loser pays” provision.

In December, the DAHP and the ACS Legislative Committee released a new primer, *Surgeons and Medical Liability: A Guide to Understanding Medical Liability Reform*. This document explores the history and inefficiency of the nation’s medical liability system and analyzes both traditional and alternative reform
proposals. The primer informs Fellows of ongoing challenges and outlines opportunities for implementation of alternative reforms that have been proposed or studied at the local, state, and federal levels. This document is expected to be followed later this year by a Surgeon’s Guide to a Medical Liability Lawsuit and early next year by a Surgeon’s Guide to Avoiding Medical Liability Litigation.

Trauma funding
The House Energy and Commerce Committee approved two pieces of trauma legislation, sending them to the full House for consideration. H.R. 648, the Trauma Systems and Regionalization of Emergency Care Reauthorization Act, would reauthorize the trauma systems planning grants and the regionalization of emergency care pilot projects; H.R. 647, the Access to Life-Saving Trauma Care for All Americans Act, would provide critically needed federal funding to help cover uncompensated costs in trauma centers, support core mission trauma services, provide emergency funding to trauma centers, and address trauma center physician shortages. Both of these bills then passed the full House under suspension rules.

On March 17, Sen. Jack Reed (D-RI) introduced the Senate companion bill, S. 763, to H.R. 648. At press time, Sen. Patty Murray (D-WA) was expected to introduce the Senate companion bill to the trauma centers legislation. In addition, the ACS is meeting with members of the House and Senate Appropriations Committees to ask that they include funding for these programs, which have been unfunded since 2005.

The Coalition for National Trauma Research (CNTR) advocated for $30 million in fiscal year (FY) 2016 Defense Appropriations to create and fund research topics through a coordinated, multi-institutional, clinical research network to advance military-relevant topics in trauma care and trauma systems that will allow the Department of Defense to maintain the advancements and skill sets critical to moving this area of research forward, even as combat deployments decrease. The ACS Committee on Trauma (COT) is a founding member of CNTR and supports the establishment of a National Trauma Clinical Research Program, which would fund research to improve treatment for the most deadly and commonly seen battlefield injuries, many of which also affect civilians. Research would be conducted through multi-institution clinical studies at a network of civilian and military trauma centers established through this initiative. The request was sent to the committees from several members of Congress, but it is not known if the funds will be included in the bill.

Regulatory and policy issues
The ACS has long highlighted issues related to the Berenson-Eggers Type of Service (BETOS) coding system. CMS and other agencies have used the BETOS coding system primarily to track resource utilization and to analyze growth in Medicare expenditures. In recent years, it also has been used to study the effect of bundled payments, accountable care organizations, and other alternative payment methodologies. Given increased national requirements for the development of new approaches to Medicare payment for provider services, the BETOS coding system could play a larger role in provider reimbursement in the future; however, many aspects of the BETOS classifications are outdated, inconsistent, or no longer optimal. On May 8, the ACS submitted a letter to CMS with detailed recommendations on how to improve and modernize the BETOS coding system. The ACS will continue to work with CMS and the AMA Relative Value Scale Update Committee with the goal of overcoming weaknesses of the...
BETOS classification system to develop a more reliable and useful research and payment policy tool.

CMS released the Medicare physician fee schedule (MPFS) proposed rule in early July, with plans to release the final rule in early November. At press time, ACS staff was reviewing the proposed rule and developing comments based on feedback from the ACS General Surgery Coding and Reimbursement Committee and the Performance Measures Committee.

CMS released its fiscal year (FY) 2016 Inpatient Prospective Payment System (IPPS) proposed rule on April 17. Under the proposed rule, average inpatient payments would increase by about 0.3 percent in FY 2016 (October 1, 2015–September 30, 2016). This update is contingent on hospitals reporting specified quality data established in the Hospital Inpatient Quality Reporting Program. The proposed rule also includes potential changes to programs that apply incentives and/or penalties to inpatient hospitals. These include the Hospital Value-Based Purchasing Program and others aimed at reducing unnecessary readmissions and the prevalence of hospital-acquired conditions.

CMS also proposed changes to policy and operational issues surrounding the potential expansion of its Bundled Payments for Care Improvement initiative (BPCI), which links payments for multiple services. ACS staff submitted comments to CMS in June.

CMS released the proposed Outpatient Prospective Payment System/Ambulatory Surgical Center (OPPS/ASC) rule this summer. The proposed rule would increase Medicare payment for health care services delivered in most outpatient department sites of care by an estimated 2.1 percent for CY 2015.

The ACS continues to provide educational materials and resources on the Physician Quality Reporting System (PQRS) to Fellows and office staff through the website, meetings, and publications. The April 2015 issue of the Bulletin provides an overview of the PQRS programs and College resources that assist members in complying with 2015 PQRS program requirements.* The PQRS section of the website, www.facs.org/advocacy/regulatory/pqrs, is continuously updated with new information, including how to report measures via claims, registries, and electronic health records.

In addition, CMS has made Quality and Resource Use Reports (QRURs) available to help solo practitioners and group practices understand their performance in relation to Medicare’s quality and cost metrics. ACS staff created a Web page on QRURs that includes educational material and resources to help Fellows access and understand their report. The ACS and CMS also hosted a webinar, available on the ACS QRUR website, on how to interpret reports.

The Physician Clinical Registry Coalition is a group of more than 20 medical society-sponsored or physician-led registries advocating for public policies that facilitate registry development and remove regulatory burdens. In February 2015, the College worked with the coalition to develop a resource titled Guidance on Legal Challenges and Regulatory Obligations for Clinical Data Registries, which provides guidance on privacy issues, data ownership, device reporting, liability risk, and legal discovery.

State Affairs

Last year, ACS State Affairs staff assessed which states require that insurers provide coverage for bariatric surgery, particularly through the state health exchanges created in the ACA. This assessment showed

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that 28 states do not require bariatric surgery coverage, and that of those states, about half were states that had created exchanges, and about half were part of the federal exchange. The ACS has been partnering with the American Society of Metabolic and Bariatric Surgeons to address the issue with CMS.

The popular Chapter Lobby Day Grant Program entered its fifth year in 2015; a total of 12 chapters received grants for their lobby days, including Alabama, Brooklyn/Long Island, California, Connecticut, Florida, Georgia, Indiana, Kansas, Massachusetts, Michigan, Tennessee, and Virginia. The chapters applied various models to conduct the activities, including dinners with legislative leaders, receptions for legislators and state Supreme Court justices, and briefings and visits with legislators in the capitol.

**Division of Education**

The ACS Division of Education continues to provide learning opportunities to surgeons in practice, training, and medical school and leads several other important activities related to surgical education.

For example, the ACS, the Association of Program Directors in Surgery, and the Association of Surgical Educators (ASE) have developed an innovative, modular Surgery Resident Prep Curriculum, which relies heavily on simulation. It is currently being pilot tested at 47 institutions across the country with a formal launch scheduled for 2016.

The ACS and ASE also have developed a Medical Student Core Surgery Curriculum, a simulation-based modular curriculum addressing the cognitive skills of medical students during the core surgery clerkship. The goal is to formally launch the program in 2017.

The Committee on Ethics continues to pursue projects identified during its 2014 strategic planning meeting. Specifically, the ACS Division of Education and MacLean Center for Clinical Medical Ethics at the University of Chicago, IL, have established a new Fellowship in Surgical Ethics, which the B/R approved in February 2015. The program will prepare surgeons for careers that combine clinical surgery with scholarly studies in surgical ethics.

Furthermore, the College has selected Alberto R. Ferreres, MD, PhD, MPH, FACS, to serve as Editor of a new book, *Ethical Issues in Surgical Care*, which will establish boundaries of the important domains and organize the essential components of surgery ethics.

**Division of Member Services**

The B/R accepted resignations from eight Fellows from the following specialties:

- Neurological surgery (one)
- Obstetrics and Gynecology (two)
- Ophthalmic surgery (two)
- Otolaryngology (one)
- Plastic and Reconstructive (one)
- Urologic (one)

The B/R also approved a change in status from Active (dues paying) to Retired for 72 Fellows, and from Senior (non-dues paying) to Retired for 12 Fellows, for a total of 84 Fellows.

The College’s Nigerian Fellows have requested the formation of a Nigeria Chapter. Emmanuel A. Ameh, MB, BS, FACS, FWACS, is the current Governor for Nigeria. Provisional officers include:

- Stanley N. C. Anyanwu, MB, BS, FACS, President
- Bello Bala Shehu, MB, BS, FACS, Vice President
- Lukman Olajide Abdur-Rahman, MB, BS, FACS, Treasurer
• Samuel Adesina Ademola, MB, BCh, FACS, Secretary
• Adesoji O. Ademuyiwa, MB, BS, FACS, Councilor-At-Large

The Nigeria Chapter is the College's 41st international chapter, bringing the total number of chapters to 108, with 67 domestic (including two Canadian chapters) and 41 international.

Division of Research and Optimal Patient

A total of 630 hospitals participate in ACS National Surgical Quality Improvement Program (NSQIP®); 564 of those sites participate in adult ACS NSQIP. The Essentials option, which is the conventional sampling frame, has the highest enrollment of all the adult participation options with 269 sites; however, the Procedure Targeted option, which allows hospitals to “target” the sampling to a list of focused procedures of their choosing, has 233 hospitals and is experiencing the highest level of growth. The Pediatric option represents slightly more than 10 percent of participation.

The following is a breakdown of participating sites by ACS NSQIP option:

• Essentials: 269
• Procedure Targeted: 233
• Measures (National Quality Forum-endorsed measures only): 12

ACS NSQIP continues to enhance its feedback reports, specifically the real-time, risk-adjusted reporting capabilities, in an effort to improve the relevance of data. As of July 2015, a new Accelerated-on-Demand application provides risk- and shrinkage-adjusted rates using a more accurate and more robust methodology. This new application has the same look and feel of the old application but reports “rates” rather than “odds ratios,” providing a better application of the data.

The 2015 ACS NSQIP National Conference took place July 25–28 at the Hilton Chicago. A major theme at the conference’s 10th anniversary was recognition of ACS NSQIP hospitals and providers and their dedication to improving the care of the surgical patient.

At present, 787 health care institutions participate in the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP). Of those centers, 621 are fully accredited, 45 are data collection centers, and 115 are initial applicants. The MBSAQIP was again selected as a PQRS Qualified Clinical Data Registry in March 2015 for the current reporting year.

Kamal M. F. Itani, MD, FACS, will again chair the biennial Clinical Trials Methods Course, November 6–10, at the ACS headquarters in Chicago. This five-day intensive course is based on four successfully conducted and published clinical trials, which are used to teach the methodology of design and implementation of a controlled clinical trial. A combination of didactic lectures and hands-on breakout sessions will be used to apply concepts learned throughout the course, including the development of concepts and skills in the design, implementation, and analysis of randomized clinical trials’ funding mechanisms and budget development; outcomes (medical and patient-centered); and dissemination of results through publications.

The ACS and the Armstrong Institute for Patient Safety and Quality are developing a surgeon leadership course. A one-day event was piloted at the ACS Clinical Congress 2014. The course intended primarily to introduce quality improvement and data review, present engagement strategies and quality improvement models, and discuss strategies for overcoming barriers. The
course will be offered again at Clinical Congress 2015.

**Cancer Programs**

The Commission on Cancer (CoC) engaged in the following activities recently:

- A cumulative total of 1,507 cancer programs in the U.S. and Puerto Rico were accredited by the CoC. CoC accreditation encourages hospitals, treatment centers, and other facilities to improve their quality of care through various cancer-related programs and activities.

- A total of 481 cancer program accreditation surveys were conducted in 2014.

- 33 new cancer programs joined the Accreditation Program in 2014.

- 75 cancer programs received the Outstanding Achievement Award.

- 73 percent of CoC-accredited cancer programs participated in the Rapid Quality Reporting System.

- CoC leadership and ACS Fellows who are members of Optimizing Surgical Treatment of Rectal Cancer are developing standards and performance measures that will form the basis of a Rectal Cancer Accreditation module. The work is modeled on European success with decreasing disparities in the quality of rectal cancer care by promoting proper surgical technique, evidence-based treatment, and a multidisciplinary team approach to care.

The National Cancer Data Base (NCDB) Cancer Program Practice Profile Reports (CP3R) have been expanded to include three new quality measures and one replacement quality measure. Two cervical, one non-small cell lung, and one rectal measure were released in March 2015. CP3R currently reports 15 quality measures across six primary sites.

The Quality Integration Committee approved nine new quality measures to be added to the NCDB reporting tools. Three bladder, one pediatric, and five melanoma measures were proposed and approved. These measures were developed in conjunction with the Society of Urologic Oncology/American Urologic Association Pediatric Accreditation Committee, and the Society of Surgical Oncology.

The CoC’s second annual legislative briefing, *Accreditation Makes a Difference*, took place June 9 and included remarks from the CoC leadership and from the patient perspective regarding the importance of receiving care from an accredited program.

In addition, One Voice Against Cancer Lobby Days took place June 8–9.

Survey Savvy took place June 18–19 in Chicago with approximately 225 participants in attendance. Accreditation 101 will be held September 22 in Baltimore, MD.

The National Accreditation Program for Breast Centers has verified more than 630 breast centers in the U.S. A total of 28 new programs have been added in 2015. Reaccreditation rates for 2015 remain at 99 percent. Approximately 20 percent of centers request to be surveyed with their CoC program. Plans for expansion to international sites in 2015 include two Canadian breast centers and five centers from the U.K.

The CoC’s Advocacy and Outreach Committee was reorganized to add representation from major breast cancer advocacy groups, including:

- Young Survivors Coalition
- Living Beyond Breast Cancer
- Lymphedema Network
- Inflammatory Breast Cancer Research Foundation
- Susan G. Komen for the Cure
- American Cancer Society
American College of Surgeons Foundation

The Kenneth L. Mattox International Lectureship and Scholar Program in Acute Care Surgery (KLM Program) is proposed as a joint initiative of the ACS and the COT. The program honors Kenneth L. Mattox, MD, FACS, for his national and international contributions to acute care surgery and his many decades of ACS leadership. The award also extends the ACS vision and the reputation of COT internationally, while mentoring academic surgeons for leadership positions in acute care surgery. This proposal was endorsed unanimously by the COT Executive Committee.

The ACS COT will confer one or more Mattox awards each year, contingent on the ultimate success of the fund-seeking effort and investment return. These awards may be granted to surgeons practicing in the U.S. and Canada, as well as to surgeons practicing outside North America. The COT, in conjunction with the ACS Executive Director and B/R, will guide the selection process for the Mattox Awards in Acute Care Surgery. Responsibilities of the recipient may include travel to international ACS chapters for scholarly and promotional purposes; travel support to international surgeons to visit American academic centers and participate in scholarly programs; development of reports and publications for presentation at Clinical Congress; and/or a COT-sponsored Mattox Lectureship.

Journal of the American College of Surgeons (JACS)

The JACS continuing medical education (CME) website is now fully integrated into the College’s membership database, and is easily accessible after login. The new JACS CME platform, developed by the College’s Information Technology area, is mobile-ready for smartphones, iPads, and tablets. JACS CME is a quick and convenient way for ACS members to earn credit for Maintenance of Certification.

In the last year, 3,660 Fellows earned credit toward maintenance of certification from the JACS CME program, with 84,348 CME credits granted. There are now more than 1,000 followers of @JAmCollSurg on Twitter—a 50 percent increase since the beginning of the year. The app for reading JACS on smartphones, iPads, and tablets has been downloaded almost 9,000 times since the app launched in October 2014.

A few examples of media coverage of JACS articles from the recent months include the following:

- “Too few breast cancer patients getting radiation after mastectomy: Study,” U.S. News & World Report, discussing an article in the April 2015 issue
- “Patients bounce back faster from surgery with hospitals’ new protocol,” Wall Street Journal, also regarding an article in JACS’ April 2015 issue
- “Blood transfusion during flight to trauma center boosts survival: Study,” Medline Plus, covering an article in JACS in May 2015
- “Worse survival after lung cancer surgery for residents of poor neighborhoods,” Reuters, discussing an article published online April 15, 2015 ♦
To Apply: Call 1-800-433-1672 or Visit acs-insurance.com

American College of Surgeons Members can save 30% on annual premiums

Current Long Term Disability Rate Chart
Annual Cost for benefits of $10,000 a month with a 90 day waiting period.

<table>
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Lose your ability to practice due to a disabling sickness or injury and you could lose everything you’ve worked so hard to acquire. The ACS Long Term Disability plan can help you maintain your current lifestyle and help protect you and your family from serious debt by replacing a portion of your income with monthly benefits up to $15,000 for covered disabilities.

You can save even more on all your coverages if you are covered under a Group Disability, a Group Term Life and the Group Accidental Death & Dismemberment Insurance at the same time. Our package discount will save you an additional 25%!

*Rates displayed include the 30% premium discount currently in effect for 2015 (not applicable to residents of CA and FL). All rates and discounts can be found on ACS-Insurance.com.

Underwritten by New York Life Insurance Company, New York, NY 10010, under Group Policy Form GMR, Complete terms, conditions, definitions, exclusions, limitations and renewability are outlined in the Certificate of Insurance provided to each insured for each coverage. This material not intended for use in New Mexico.
MEETINGS CALENDAR

Calendar of events*

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

**SEPTEMBER**

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

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

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

**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**

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

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

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

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

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

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

**DECEMBER**

Massachusetts 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

**FUTURE CLINICAL CONGRESSES**

2015
October 4–8
Chicago, IL

2016
October 16–20
Washington, DC

2017
October 22–26
San Diego, CA