Face forward:

Transplant surgeon overcomes challenges with teamwork and technology
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continued on next page
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Looking forward

by David B. Hoyt, MD, FACS

Communication is the key to maintaining a positive relationship of any type, including the one between the Fellows of the American College of Surgeons (ACS) and the organization’s leadership. Hence, the ACS continually strives to develop new, state-of-the-art communications vehicles that meet the needs of today’s time-pressed surgeon.

Like most organizations, the ACS faces several challenges in its efforts to share information with the membership. Three questions that are at the forefront of our efforts to develop improved communications vehicles are as follows:

• How do we cut through the “noise” when members are inundated with e-mail, publications, and social media from a range of sources, all competing for their attention?

• How do we effectively deliver our message to a multi-generational audience?

• How do we keep our communications about an ever-growing range of products and services concise yet powerful?

This month’s column highlights some of the innovations, initiatives, and projects that the ACS Division of Integrated Communications, under the leadership of Lynn Kahn, has undertaken in recent years to address these challenges.

ACS Communities and social media

Launched in August 2014 under the stewardship of Tyler G. Hughes, MD, FACS, the ACS Communities have proven to be a valued member benefit. The ACS Communities provide a forum in which Fellows can discuss the issues that affect them professionally and personally and bend the ear of the College leadership.

Many Fellows turn to the communities for advice on solving clinical problems. Others relish the opportunities that the communities provide to interact with surgeons who share their nonsurgical interests. For example, one of our newest communities is composed of surgeon writers.

Perhaps most importantly, the communities provide a two-way exchange of information between ACS members and the College Officers, Regents, Governors, and Executive Staff. Many of these individuals participate in multiple communities and are eager to learn how to better serve your interests. Moreover, Dr. Hughes regularly monitors these online discussions and provides the leadership with feedback on the hot topics of the day.

At present, the College has 98 online communities, of which 66 are open to all members and 32 are closed. Closed communities largely serve as work forums for ACS leadership bodies, such as the Board of Governors and the Advisory Councils. As of January, more than 3,475 contributors had posted more than 28,675 messages in the communities, and these data do not fully reflect the number of members who read the posts.

Furthermore, the College is active on all major social media outlets. The College’s social media reach has grown rapidly in recent years, particularly on Twitter (see Table 1, page 8). We are continually exploring ways to use these vehicles more effectively to provide avenues of communication between the fellowship, the leadership, and the public. I would encourage you to start tweeting or posting about the issues that affect your practices.

Longstanding ACS communications vehicles

Three longstanding modes of communication between the ACS leadership and the fellowship include the newsletters distributed by the ACS divisions and committees, the ACS website, and the Bulletin.

The newsletters distributed by the College’s divisions and committees have played a vital role in relaying information regarding ACS activities to the membership. All of these newsletters have been published electronically for many years now. Approximately one year ago, the ACS embarked on a performance improvement initiative to identify and standardize the College’s e-newsletter portfolio. We determined that the College was distributing nearly 30 newsletters to various audiences—some to all Fellows, but many to
smaller target audiences. The Division of Integrated Communications team worked with the staff of the divisions and committees that produced these publications to determine which ones were still relevant to our membership.

We also worked with a vendor to develop a standard template for designing and developing content for the newsletters, ensuring that they all have a consistent look and feel. Furthermore, these publications have been formatted for easy viewing on a desktop, laptop, tablet, and smartphone, so you can read them anytime, anywhere. The redesigned newsletters launched in April with our most widely distributed newsletter, ACS NewsScope.

For more than two decades, Fellows have turned to the ACS website for up-to-the-minute information about the College’s efforts to meet their needs. Approximately two years ago, the ACS launched a fully redeveloped website, facs.org. Since then, the College has sought to keep the site constantly updated, vibrant, and technologically sound. To that end, the Web team continually works to update the functionality, design, and content of the site in an effort to be responsive to your evolving needs. For example, based on feedback from users, we recently made improvements that allow for easier access to content using drop-down menus.

Lastly, the Bulletin began publication 100 years ago and has since served as an important means of communication between the Fellows and the leadership. In recent years, the Bulletin has become more accessible online, starting with the launch of the Bulletin website, bulletin.facs.org, in spring 2013. Earlier this year, we launched an interactive version that reads and looks just like the print version, with the same images and content you have come to expect from the Bulletin each month. At the same time, a Bulletin app became available.

Stay tuned
We intend to continue to be innovative in our efforts to communicate with the ACS membership, and our experience with the Communities has sent a clear message that Fellows are interested in having more direct contact with the leadership. To this end, we are planning to start offering regularly scheduled online “fireside chats” with the ACS Officers, Regents, Governors, and Executive Staff. As many as 1,000 people will be able to participate in each of these programs, with up to six people visible by video.

It’s truly amazing to reflect on the degree to which new technology is enabling us to communicate more openly and freely with each other. I encourage you to take advantage of these growing opportunities to share your interests and perspectives with your colleagues and the ACS leadership. We always look forward to hearing from you.

If you have comments or suggestions about this or other issues, please send them to Dr. Hoyt at lookingforward@facs.org.
Face forward:

Transplant surgeon overcomes challenges with teamwork and technology

by Tony Peregrin
When Eduardo D. Rodriguez, MD, DDS, FACS, and his team of more than 100 health care professionals at New York University (NYU) Langone Medical Center, New York, successfully completed the most extensive facial transplant to date last August, they not only gave a patient a new lease on life, but also helped establish new standards of care in this emerging field.

The patient, volunteer firefighter Patrick Hardison, 41, suffered disfiguring burns across his entire face—including the loss of his eyelids, ears, lips, most of his nose, and his entire scalp—when he entered a burning home in a rescue search in September 2001. During the 26-hour operation, Dr. Rodriguez and his team were able to, among other important successes, transfer a donor’s eyelids and transplant the muscles that control blinking—a notable accomplishment, as the procedure had not been performed previously on a seeing patient.

Despite achieving these surgical milestones, the process involved in providing Mr. Hardison with a new face had its challenges. These hurdles were overcome, according to Dr. Rodriguez, through highly orchestrated teamwork and innovative technology—specifically the use of three-dimensional (3-D) modeling to create a precise “snap-fit” of the skeleton.

Listing the patient
Before arriving at NYU Langone, Mr. Hardison had already endured more than 70 operations, including the transfer of skin grafts from his thigh to his face, but unfortunately, he was unable to return to the life he had before the accident. He was disfigured with “no semblance of normal anatomy,” according to Dr. Rodriguez, and eating and speaking caused Mr. Hardison significant pain due to the extensive scar contracture.

“There were a couple of factors that led me to the decision to take on Mr. Hardison’s case,” said Dr. Rodriguez, who joined the faculty at NYU Langone in November 2013 as chair of the Hansjörg Wyss department of plastic surgery with the goal of developing a face transplant program. “When I considered Patrick’s personal story along with the inability to improve his current physical state, I thought he would be an ideal candidate to enlist in our program,” Dr. Rodriguez said. “Most importantly, his surgeons had been able to preserve his sight despite the scarred tissue around his eyelids.” Specifically, surgeons had sutured Mr. Hardison’s eyelids together, leaving tiny pinholes to preserve his sight.

“They were very good surgeons and there were no other improvements that they could provide,” said Dr. Rodriguez. “There was nothing [more] that I could do short of a face transplant.”

Dr. Rodriguez’s team began vetting Mr. Hardison in 2012, a process that included interviews with the Mississippi firefighter and his family and friends to assess his comprehension of risks—there was a baseline 50 percent chance of success for the operation—and to ensure that he and his caregivers would be able to comply with postoperative responsibilities, including being able to keep medical appointments and adhere to a daily medicine regimen.

The next step was finding a donor who matched Mr. Hardison’s skin tone, hair color, blood type, and skeletal structure. NYU Langone partnered with LiveOnNY, the New York metropolitan organ procurement organization, to locate the donor, David P. Rodebaugh, a 26-year-old BMX cycling enthusiast and a registered organ donor. Mr. Rodebaugh’s face was the fourth offered to Mr. Hardison: one donor was a man who did not have a favorable crossmatch, one was a man whose family withdrew consent; the other was from a woman, which Mr. Hardison declined.

Challenges in an emerging field
An overarching concern regarding Mr. Hardison’s case, according to Dr. Rodriguez, centered on the fact that the surgical team would need to “recreate the defect” in order to successfully perform the face transplant. “We had to make him worse in order to make him better,” said Dr. Rodriguez. “In other words, everything his...
previous surgeons had done to protect his vision, we would have to remove. Removing all the scar tissue around his scarred eyelids and face would basically expose the globes and the eye sockets, so this would have to work. If it didn’t work, it would leave him worse than he was beforehand.”

Additionally, Dr. Rodriguez pointed out, Mr. Hardison’s entire face and scalp had been resurfaced with split-thickness skin grafts taken from his thighs and neck and shoulder areas, and all that work that had been done would also have to be removed to re-drape his facial skeleton with a new face.

Some of these challenges, including the transplantation of the ears and ear canals, were unique to Mr. Hardison’s case, but others were more familiar to Dr. Rodriguez, who, in March 2012, performed the most extensive full-face transplant on record up to that point while at the University of Maryland Medical Center (UMMC), Baltimore.6 The patient in that case, Richard Lee Norris, who was 37 years old at the time of the surgery, was injured in a gun accident and suffered the loss of his lips, nose, and his jaws and had limited movement of his mouth. The 36-hour procedure involved a multidisciplinary team of faculty physicians and a team of more than 200 nurses and professional staff.6

Facial transplants are rare, with 37 patients worldwide having undergone the procedure.4 The first partial face transplant was performed in 2005 in France on Isabelle Dinoire, 38, who had been mauled by her dog.3 The first full-face transplant took place five years later in Spain on a man identified only as “Oscar.” The first face transplant in the U.S. was performed in 2008 on Connie Culp, 46, who had been shot by her husband four years earlier.3

The primary technical challenge in Mr. Hardison’s case, and in all of the face transplants that have occurred over the last decade, according to Dr. Rodriguez, is ensuring functional return.7 “When you look at someone’s face it’s not just the appearance of a face on a still photograph, but it’s the normal function and movement of a face that gives the person a sense of normalcy. If you don’t have that, it’s just like wearing a mask. We don’t want to create mask-like features. We want these transplants to animate and have normal movement, so that they can smile, blink, the lips pucker, and that they have the ability to speak, eat, and swallow normally,” explained Dr. Rodriguez, who is dually board-certified by the American Board of Oral and Maxillofacial Surgery and American Board of Plastic Surgery.

Dr. Rodriguez earned his bachelor of science in neurobiology from the University of Florida, Gainesville, in 1988, followed by a doctor of dental surgery degree from New York University, NY, in 1992.8 He then completed his residency in oral and maxillofacial surgery at Montefiore Medical Center/Albert Einstein College of Medicine, Bronx, NY, in 1997 and received his medical degree from the Medical College of Virginia, Richmond, in 1999. In 2003, Dr. Rodriguez graduated from the combined plastic surgery program at Johns Hopkins Hospital/UMMC, Baltimore. He subsequently completed an international reconstructive microsurgery fellowship at Chang Gung Memorial Hospital in Taipei, Taiwan, in 2004.

Teamwork first, then technology
Developing a synchronous 100-plus member multidisciplinary team working between two operating rooms (ORs) provided an optimal environment for Mr. Hardison’s complex transplant procedure. All
different levels of staff needed to communicate effectively and efficiently, including Dr. Rodriguez, other plastic and reconstructive surgeons, cardiologists, a transplant immunologist, a medical ethicist, a clinical psychiatrist, a clinical psychologist, nurses, social workers, and other health care professionals.

“I was fortunate enough to have performed a transplant in Baltimore before I was recruited to NYU Langone, so I had some experience putting together a team and organizing this complex surgical event,” said Dr. Rodriguez. “When I came to NYU Langone, I already had something of a ‘recipe’ for how to do it. But I had to recreate the team once again. I began at NYU Langone in November 2013, and from the first day I arrived, I started to work with our department administrator Leslie Bernstein, personally meeting with and interviewing every member who was going to be on this team, including the nursing staff, anesthesiologists, scrub technicians—all of the individuals who were going to be in the surgical event, as well as the core surgical team.”

Once the team was assembled, Dr. Rodriguez led a series of meetings in the surgeons’ lounge with all participants present to clearly define everyone’s specific role. “We described exactly how we would position the patient, which arm would be used for the IVs, where we would place all of the instrumentation, and how many personnel would be allowed in the room at one time. We went through every step…and we would actually practice them in our intraoperative cadaver simulations.” Following the simulations, the team met again in an open forum where every member was invited to offer insight for improving the timeline and flow and for enhancing best surgical practices, with the ultimate goal of ensuring maximal patient safety.

Fostering open communication among team members was important in all phases of Mr. Hardison’s procedure, but particularly with regard to ensuring complete cohesion in the maintenance of certain donor organs. “We knew the donor for the face transplant recipient would likely be a young male. Based on that fact, the likelihood of procuring other organs for a number of different recipient operations would be high,” said Dr. Rodriguez. “We had to ensure that the fluid management of the donor in the OR would not only maximize profusion to the kidneys, but also limit over-hydration of the lungs. That required direct communication with lung transplant surgeons, kidney surgeons, representatives from the organ procurement organizations, and finally the anesthesiologist who is responsible for the care and maintenance of that patient in the OR.”

**CT scans and 3-D modeling**

While enhanced communication and team-building are processes that function to improve care in this field, the application of innovative technology is another notable milestone in the continually evolving field of facial transplant surgery.

Because a facial transplant procedure involves two individuals, size discrepancies between the facial structure of the recipient and of the donor are inevitable. Computed tomography (CT) scans of both
Mr. Hardison and Mr. Rodebaugh allowed Dr. Rodriguez and his team to precisely determine how they would approach the reconstruction.

According to Dr. Rodriguez, Mr. Hardison had significant segments of the facial skeleton, including the cheekbones, nasal bones, and the mandible, that needed to be replaced or augmented. “CT scans and 3-D technology allow us to fit the skeleton of a donor on a recipient in a way that is very similar to a puzzle,” said Dr. Rodriguez. “Planning what portions of the facial skeleton we are going to include allows us to design how we are going to make our access incisions to these portions of the skeleton, and it also allows us to define what portions of the skeleton we would like to replace or improve.”

In addition to planning the surgery on a computer screen by receiving a stereolithic graphic model of the recipient and donor, Dr. Rodriguez can actually make instruments or cutting guides that are patient-specific to the recipient and the donor via 3-D modeling. “We already knew Patrick Hardison—he had been our patient for over a year—but the limiting factor was the donor, and the donor was only identified for facial procurement within 24 hours of the operation,” said Dr. Rodriguez. As soon as we had the CT scan of the donor, we worked with a company, and within 24 hours they generated a 3-D print of these specific cutting guides that were shipped to the OR. It’s amazing technology.

In the final hours of surgery, signs of success became apparent, according to a press release issued by NYU Langone. Mr. Hardison’s new face, specifically his lips and ears, were “robust with color, indicating circulation had been restored.” He was able to use his new eyelids and blink on the third day of recovery, and he was sitting up in a chair within a week. Mr. Hardison continues to engage in extensive rehabilitative therapy and, as is the case with all transplant patients, will remain on anti-rejection medication for the rest of his life. However, it is important to note that nearly 180 days post-op, Mr. Hardison had yet to experience an anti-rejection episode, which, according to Dr. Rodriguez, typically occurs within the first 90 days after surgery in face transplant patients.

**Cost of care**

Financial support for Mr. Hardison’s care, estimated to cost between $850,000 and $1 million, was provided through a grant from NYU Langone and included the pre-surgical workup, the procedure, and the entire care of the surgical patient up to 90 days. “We felt it was important that this grant include the care of the patient at all these stages,” said Dr. Rodriguez. “We worked with Patrick’s third-party payor, who agreed to cover financial responsibilities beyond the 90 days, which in his case is primarily the cost of the immunosuppression medication.”

Dr. Rodriguez said NYU Langone is currently working with a number of third-party payors to help define how these procedures could ultimately become standard of care. “The [American College of Surgeons (ACS)] can help us define the criteria of this procedure for select patients as standard of care. I think there could be no stronger lobbying group [than the ACS] to make this happen, since they were pivotal in making liver transplants, cardiac transplants, [and] lung and kidney [transplants] part of standard medical practice.”
Conclusion

The first comprehensive study of all known facial transplants, published by Dr. Rodriguez in an April 2014 issue of *The Lancet*, concluded that the procedure is “relatively safe, increasingly feasible, and a clear life-changer that can and should be offered to far more carefully selected patients.” The study includes an analysis of medical journals and interviews with surgeons who had performed face transplant procedures up to that point.

The study also highlights the fact that face transplants continue to be experimental and pose lifelong risks associated with infection and reactions to toxic immunosuppressive drugs. Despite those risks, Dr. Rodriguez said, advances in immunomodulatory and immunosuppressive protocols, microsurgical techniques, and computer-aided surgical planning, such as 3-D modeling and CT scans, are key to establishing new standards of care for this field.

Dr. Rodriguez compared the first decade of facial transplantation to the beginning stages of liver transplantation in the 1960s, when recipients lived less than one year. Today, he says, liver transplantation is performed at more than 100 medical centers in the U.S. alone, and the vast majority of patients, including children, survive beyond a year, with outcomes continuously improving despite liver transplantation’s frequent complications. “We are still very much in the early days of facial transplantation,” said Dr. Rodriguez. “So long as our patients need it—and they do—then it is our medical duty to continue to advance science and medicine, and improve how we perform the procedure so that it is more widely available to future generations of people whose severe disfigurements go beyond the means of conventional surgery.”

REFERENCES

A family tradition:
Fellows describe influence of surgeon parents and other relatives

by
Jeannie Glickson
Some Fellows of the American College of Surgeons (ACS) come from families with three or four generations of surgeons. A number of these family members go back more than 100 years to the founding of the ACS. Their stories, several of which are featured here, are a testament to the fact that the pursuit of surgical excellence often passes from one generation to the next.

**ACS founder**

One family of surgeons that includes an ACS founder is the Richter family of Chicago, IL. Three generations of the family have dedicated their lives to surgical practice. Harry M. Richter III, MD, FACS, Rush University Medical Center, acknowledges the vital role his grandfather, H. M. Richter, MD, FACS, played in 1913 as a College founder and Governor (1913–1916).

“My grandfather was attuned to the need for surgical standards in his time,” said Dr. Richter III, who remembers his grandfather as a tall, lean, imposing figure who was deeply dedicated to his profession and patients. His grandfather had a sterling reputation as a specialist in thyroid procedures and surgical care of infants. “Before there was a College, surgeons were on their own,” Dr. Richter said. “The College founders realized that they needed some behavioral guidelines.”

Dr. Richter’s father, Harry M. Richter, Jr., MD, FACS, a member of the department of surgery, Northwestern University Medical School, and surgeon at Cook County Hospital, was a role model for his son. “What impressed me as a child about my dad’s work at Cook County was that patients would come off the street with medical problems, having not seen a primary care doctor, and they would get treated, whether they had money or not. That has always been the role of Cook County,” he said.

“My dad never directed me to go a certain way,” the younger Dr. Richter said. “He just tried to influence me to make wise, practical choices in life.” He considered other careers in math and science, but found surgery was the best fit. In high school, he accompanied his father to surgical society meetings and spent a couple of summers doing research at Chicago’s former Michael
Reese Hospital, which, at the end of the 20th century, was a major research and teaching hospital. These experiences clearly left an impression on the young man.

“I could not have chosen more meaningful work,” he said. “It is especially rewarding to see young surgeons develop.” The residents he teaches at Rush give Dr. Richter reason for optimism. “The residents are every bit as committed to becoming good surgeons as we were.”

In Mississippi since the Civil War
The Gamble family represents another surgical dynasty and, like the Richter family, a Gamble family member was involved in establishing the College. “There’s been a Gamble practicing surgery in Mississippi since the Civil War,” said retired thoracic surgeon Hugh A. Gamble II, MD, FACS, Greenville, MS.

The Gamble family's surgical tradition began with William Gaston Gamble, MD, who ran a practice from his home in Lee County, MS, until his death in 1920. His son, Hugh Agnew Gamble, born in 1876, became a nationally known surgeon who crossed racial divides in the Jim Crow South to provide high-quality surgical care. In 1915 he founded what would become the multispecialty Gamble Brothers Clinic. An ACS founder and later a Governor, Dr. Gamble provided surgical and gynecological care, and his brother Paul handled urologic cases. For nearly 50 years, they built the reputation of the Gamble name in surgical care.*

“Growing up, I was surrounded by medical talk,” said Dr. Hugh Gamble. “Discussions around our dinner table were always about medicine. My dad [Lyne Starling Gamble, MD] would talk about difficult patients and arguments he was having with the hospital, and my mother was a nurse. Doctors have always had arguments with hospital [administrators]. Sometimes the discussion would be about how state and local government were affecting medicine.”

He recalls accompanying his father to medical society meetings in Mississippi. “The Mississippi State Medical Association has always been a strong organization, and I’ve always been active in it,” he said. He also remembers piling into the car with his three siblings to accompany their father on emergency call.

Dr. Lyne Gamble’s dedication to practice reflected lessons learned from his surgeon father. “My grandfather really liked practicing medicine. He had a strong sense of civic responsibility,” Dr. Hugh Gamble said. “He didn’t drive, and he didn’t sleep much. If the phone rang at 3:00 am, he’d have Lewis, his chauffeur, drive him wherever he needed to go to see a patient.”

Dr. Hugh Gamble enjoyed a thriving practice, as he was the only thoracic surgeon within a 100-mile radius in Mississippi. “As a Gamble, you were expected to be as good as those who preceded you. I rarely went through a week without a patient knowing something about my family history,” which had good and bad consequences. “If they liked your family, they liked you, too,” Dr. Gamble said.

He recalls that in about the ninth grade, he was required to take a foreign language. “I chose Latin because I knew a lot of doctor words were in Latin,” Dr. Gamble said. “I knew from that point forward that that’s what I wanted to do. I never considered anything but becoming a doctor. I would have been miserable doing anything else.”

He recalls, as a boy, walking past his father’s office after school, that there would always be a large group of patients who couldn’t afford to pay for services. “My dad had a cabinet of drug supplies, and he would give away samples to patients,” he said. “My grandfather basically ran a clinic for free. That pure charity was replaced with federal involvement. Now programs like Medicare and Medicaid have had a significant impact on access to care, and there is an endless supply of rules and regulations.”

Defying Jim Crow

Like the Gamble family, the Green family defied the Jim Crow laws of the Deep South. The Green family established a clinic in Ruston, LA, that continues to thrive. Marvin Green, MD, FACS, who became a Fellow of the College in 1935, spent much of his time making house calls to patients of all income levels and racial backgrounds. Dr. Marvin Green eventually realized that a centralized surgical practice resulted in the best patient outcomes. He traveled across the country in search of experts who would relocate their practices in Ruston.

“I grew up hearing stories about my grandfather from all different kinds of people,” said John M. Green, MD, FACS, a general surgeon at Carolinas Medical Center, Charlotte, NC. All of the stories had a similar theme. “A family member had been treated with compassion and skill and held my grandfather in high regard. Many times they had no way to pay and brought him eggs or meat from their farms. Every time I walked into the clinic that bore the family name, I saw his portrait in his [ACS] robe.”

“I grew up in the back hallways of the clinic my grandfather established,” he continued. “At one point, I know he personally paid the nurses to keep the local hospital open. It was always exciting for me to visit my dad at work and see that environment.”
“I grew up hearing stories about my grandfather from all different kinds of people,” said [Dr. John Green]. All of the stories had a similar theme. “A family member had been treated with compassion and skill and held my grandfather in high regard.”

“My grandfather grew up on a farm. His parents were sharecroppers, but he understood that education was important. He didn’t go through a formal residency, but he learned procedures by taking several trips to the Mayo Clinic in [Rochester,] Minnesota.” The younger Dr. Green would spend his vacation days during college in the operating room (OR) with his uncle, Marvin T. Green, Jr., MD, FACS.

“My relatives were my early mentors, and they all truly inspired me. I also looked at my medical school chairman, John C. McDonald, MD, FACS, and my residency chairman, [a Past First-Vice-President of the ACS] R. Phillip Burns, MD, FACS, and so many others along the way, almost like family members.

“Clearly, I had some great role models,” he said. Several members of his family are medical practitioners. His father, James D. Green, MD, is a retired radiologist; his brother Andrew E. Green, MD, is a gynecologic oncologist; and his father’s first cousin, M. Ragan Green, Jr., MD, is an orthopaedic surgeon. “It was not unusual for people to bring us fresh vegetables because my grandfather had operated on one of their relatives,” said Dr. Jim Green. Today he strives to deliver the same type of patient-centered care. “I get the same sense of satisfaction as my mentors did in solving complex problems,” he said.

A family of surgical accomplishment

Like the other surgeons profiled here, ACS Executive Director David B. Hoyt, MD, FACS, grew up in a family defined by surgical accomplishment. His father, Walter A. Hoyt, Jr., MD, FACS, was an esteemed orthopaedist in Akron, OH, who helped establish the musculoskeletal curriculum at Northeastern Ohio Universities Colleges of Medicine and Pharmacy (now the Northeast Ohio Medical University) and founded Summa Health System’s Walter A. Hoyt, Jr. Musculoskeletal Research Laboratory in Akron.

His colleagues described Dr. Walter Hoyt, Jr., as a charismatic man of substance and humor, a surgical mentor, and a jack-of-all-trades. He served as President of the ACS Ohio Chapter (1964–1965).
Dr. Hoyt’s grandfather, Walter A. Hoyt, Sr., MD, FACS, became a Fellow in 1921 and served as director of the orthopaedic departments at Akron City Hospital and Akron Children’s Hospital. Dr. David Hoyt’s father and grandfather were both honored by the American Academy of Orthopaedic Surgeons for their groundbreaking achievements—his father for his work in emergency medical services, and his grandfather for his work with antibiotics.

“In my dad’s days, orthopaedists did it all,” Dr. Hoyt said. “They treated trauma patients. They treated joint problems. They were very involved with their community.

“My father was a mentor by example,” Dr. Hoyt added. Dr. Walter Hoyt, Jr.’s, life was devoted to his profession, and Dr. David Hoyt understood that reality. “He wasn’t able to attend all my school events, but I would see him every evening, and he would help me work on my school projects. I remember entering something in a science fair, and my dad was completely absorbed in the project.

“He was just a kind person who taught me by example,” he said. “He used to say proudly that he was operating on a patient when I was born. He may not have had the time to give me hands-on lessons in life, but he was always there as an example of the kind of person I wanted to become.”

When he was about seven years old, Dr. David Hoyt recalls getting in a verbal scuffle with a neighborhood kid. “Doctors do all their work for free,” he told the other child. “You don’t have to pay for anything they do for you in the hospital.” He learned, of course, that he was incorrect, but his claims reflected his early exposure to the dedication that a physician brings to the profession.

After Dr. David Hoyt graduated from Amherst College, MA, he wanted to write and express himself creatively, so he moved to New York, NY, where he wrote a play. Later he composed a book of poetry. “I was waiting for my life to begin,” he said, “and I decided to pursue meaning through the arts. What I realized in the year that followed was that to be an effective writer, you need to understand life,” he said. Through his father’s example, he knew that he could make a difference in other people’s lives through medicine, which spurred him to take premedical courses. A few months later, he entered medical school at Case Western Reserve University, Cleveland, OH.

He had difficulty choosing a specialty. “I finally decided that surgeons have the most fun,” he said. “It fit my personality, and helping patients was part of the deal. Surgeons have to lead, and they have to think on their feet.” After graduation, Dr. Hoyt headed to California for his residency and practice. “I wanted to start out on my own in a place where nobody knew about my family,” he said. He enjoyed a long and successful career as a trauma surgeon, serving as executive vice-dean of the School of Medicine; chairman, department of surgery; and the John E. Connolly Professor of Surgery at the University of California, Irvine.

Education lays the groundwork
Education provides the foundation for all surgeons. A high school education probably would have been sufficient for a farmer at the turn of the century. But unlike his father, Leonard Wright Edwards, MD, FACS, wanted to be a physician. To raise money for his medical education, Leonard Edwards drove an ice truck. By choosing a medical career, Dr. Edwards began a pattern...
that has endured for three generations of surgeons in the Edwards family.

Dr. Leonard Edwards graduated from Vanderbilt Medical School, Nashville, TN, in 1912. He became a part-time demonstrator in surgical anatomy and an assistant in the department of surgery at the Vanderbilt Medical School. Soon after that, he joined renowned surgeon and Vanderbilt clinical professor, Duncan Eve, MD, FACS, in private surgical practice, and together they founded the Edwards-Eve Clinic in 1938, today known as the Edwards-Eve Clinic Association. A pioneer in vagotomy and antrectomy surgery, Dr. Leonard Edwards established an approved residency training program in surgery at Saint Thomas Hospital in Nashville.

Leonard’s grandson, William Hawkins Edwards, Jr., MD, FACS, a vascular surgeon in Nashville, jokes that he was “preordained” to become a surgeon. His father, William H. Edwards, Sr., MD, FACS, was a busy vascular surgeon, two of his uncles were surgeons, his aunt married a physician, and his mother was a nurse. “I started working as a scrub nurse at the hospital when I was 16, as soon as I got my driver’s license,” said Dr. William Edwards, Jr.

Like his father and grandfather, Dr. William Edwards, Jr., attended medical school at Vanderbilt University, where he sometimes felt pressured to live up to his family’s legacy. His memories of his grandfather are strong, but they are of him as a grandfather, not as a surgeon. “I heard that he had a bad temper, but I never saw that side of him. My grandfather was self-taught in a lot of things,” he said. “He taught me the value of education.

“My grandfather was a railroad doctor, ahead of the game on managed care,” he continued. “Railroads employed a large number of people, and the Edwards [-Eve] Clinic took care of their surgical needs through a process that worked like managed care.”

Although there are some similarities between today’s health care system and practice at the Edwards-Eve Clinic, surgical practice has changed substantially. “We’ve gotten away from physical diagnosis,”

Dr. William Edwards, Jr., said. He shares some of Dr. Hugh Gamble’s concerns regarding the future of surgery. “With diagnostic tests, we have displaced much of that human interaction. When my grandfather was a surgeon, physicians ran hospitals,” he said. “Then professional administrators took control of the hospitals, and many physicians have been sidelined.”

Surgery is a young person’s game, Dr. Edwards’ uncles tell him today. A practice requires tremendous stamina and physical effort, he said, but it is often hard to convince a surgeon that it is time to quit.

In Germany, before WWII

Some surgeons featured here traveled an unobstructed path to their profession. This was not the case for Walter J. Pories, MD, FACS, whose family’s surgical tradition began improbably, in Germany right before the start of World War II. Retired surgeon Dr. Walter Pories—founding chair emeritus, department of surgery; professor of surgery, biochemistry, and kinesiology; and director, Bariatric Surgery Research Group, Brody School of Medicine, East Carolina University, Greenville, NC, and Second Vice-President of the College—escaped Nazi Germany at nine years old in May 1939, five months after Kristallnacht, the “night of broken glass,” November 9–10, 1938, when a wave of violent anti-Jewish pogroms swept throughout Germany. His daughter, Susan Pories, MD, FACS, chief of breast surgery and director of the Hoffman Breast Center, Mount Auburn Hospital, and associate professor of surgery, Harvard Medical School, Cambridge, MA, says her father rarely speaks of his experiences in Germany but does have clear memories of Kristallnacht and the yellow identification badges that German Jews were required to wear.

As a youngster, Dr. Walter Pories spent summers with his aunt and uncle, who shared a medical practice in a small town approximately 21 miles from Dachau, and these experiences exposed him to the physician’s ability to heal. Josef Seidl, MD, was a family practitioner and his wife, Johanna Seidl, MD, was a
pediatrician. Josef Seidl was Catholic, but Johanna was Jewish. Although Johanna converted to Catholicism, the Nazis generally did not recognize such conversions. The couple opened a general medical practice clinic attached to their house, where they delivered babies, made home visits, treated patients of all ages, and managed to stay in Germany for the duration of the war.

“We honestly don’t know how my aunt and uncle and their children survived Nazi Germany,” Dr. Susan Pories said. “Their clinic was across the street from a monastery, and the monks may have protected them.”

Dr. Susan Pories is grateful that her father reinforced the positive aspects of surgical practice. “He started taking me on surgical rounds when I was very young,” she said. As an undergraduate at the University of Vermont, Burlington, Dr. Susan Pories majored in art and English education, then taught and volunteered at a free clinic in Burlington. Aware from a young age of the meaning and purpose that the surgical profession gave her father, however, Dr. Pories never gave up the idea of pursuing a similar goal, and her father always taught her that gender should not be a barrier to pursuing a surgical career. She eventually decided to enter medical school, enrolled at the University of Vermont Medical School, and completed a residency in general surgery at the Medical Center Hospital of Vermont, Burlington. She went on to pursue an oncology fellowship at the New England Deaconess Hospital in Boston, MA, and ultimately focused her practice on breast cancer.

**Four generations of change**

Like Drs. Hoyt and Pories, Stephen Unger, MD, FACS, and Joshua Unger, MD, FACS, considered other options before deciding to pursue a career in surgery. Growing up in the 1960s in Miami Beach, FL, Dr. Stephen Unger considered becoming a hippie. Instead, he followed the lead of his dad and his grandfather and became a surgeon. Dr. Stephen Unger has had a distinguished surgical career for the past 35 years, at Mount Sinai Medical Center, Miami Beach. He has practiced general and vascular surgery and has specialized in advanced laparoscopy and complex dialysis access surgery.

His son, Joshua Unger, MD, FACS, originally opted for a career in computer science and worked for six years at the National Aeronautics and Space Administration’s Goddard Space Flight Center, Greenbelt, MD. “I spent whole days not talking to anybody,” he said. “Then one day I went with a friend to a local hospital, and I got a good feeling there.” He decided to take night courses and apply to medical school.

“My parents never pressured me to become a surgeon or a doctor,” Dr. Joshua Unger said. “But now that I am in practice, my dad and I work like partners. He’ll often ask for my opinion regarding a patient.”

Joshua’s grandfather, the late Harold Unger, MD, FACS, became interested in being a physician from his own father, Jonas Unger, MD, a general practitioner who delivered babies and performed appendectomies in New York, NY, and later moved his practice to Mount Sinai Medical Center.

Dr. Harold Unger was an early adopter of vascular surgery in Miami Beach, having studied for a month in Houston, TX, to learn procedures for treating aneurysms from the late Michael E. DeBakey, MD, FACS. He also was one of the pioneers of immediate breast reconstruction after mastectomy, which at the time was controversial.

Patients often tell Dr. Joshua Unger today that they felt connected to his personable grandfather. “He was
Patients often tell Dr. Joshua Unger today that they felt connected to his personable grandfather. “He was always well-dressed, the perfect gentleman in every interaction. He could connect with anyone from any walk of life,” he said. Dr. Harold Unger always had a joke to tell patients. When Joshua’s father, Stephen Unger, would see a patient first, for example, Harold would step into the office and say to the patient, “I’m covering for my father.” “My grandfather and father had very different personalities, but they were both very professional, very driven, always without being egotistical. Both my father and grandfather instilled in me the idea that your first priority is to take good care of your patients,” Dr. Joshua Unger said.

“My dad is an eternal optimist, just like my grandfather,” Dr. Joshua Unger added. “I am more of a second guesser about medical decisions, and it has been wonderful to have him as a senior partner. He is always available and not bothered if I call to ask for advice at all hours of the day. He has come in to the OR a few times in the middle of the night to help me out with a case.”

“Shameless” in seeking father’s advice
Paul Kunkel Davis, MD, FACS, a cardiac surgeon, Christiana Care Center for Heart & Vascular Health, Newark, DE, often turned to his surgeon father—William S. Davis, MD, FACS, Camp Hill, PA—for counsel. “I was shameless,” he said. “I would call my dad and ask his opinion on a case. He loved getting those calls, and I learned an awful lot from him.”

Dr. Paul Davis has surgical influences in his blood. As a resident, Dr. William Davis joined the Camp Hill, PA, practice of Paul Augustine Kunkel, Jr., MD, FACS, whose daughter he eventually married. The late Dr. William Davis retired from practice at age 70 and “missed it every day of his life until his death 12 years later,” according to Dr. Paul Davis.

“Around age 12, it dawned on me that becoming a surgeon was doable,” said the younger Dr. Davis. “It occurred to me that if I did well in school, I could
“Both my father and grandfather were unflappable people,” [Dr. Davis] added. “I never saw either of them lose their temper or fly off the handle. My dad always said that you are the person you are when the chips are down in the OR.”

Paul Davis has only positive memories of his namesake, Dr. Paul Kunkel. “My grandfather was bigger than life. He was a farmer who went to college at 16. He was a genius of a guy,” he said.

“Both my father and grandfather were unflappable people,” he added. “I never saw either of them lose their temper or fly off the handle. My dad always said that you are the person you are when the chips are down in the OR.”

Both men had a sense of sacred responsibility with respect to patients. “That was the driving force of their lives,” said the younger Dr. Davis. “They took their jobs very seriously. I’d like to think I am carrying on that legacy.”

In many ways, he is. Dr. Paul Davis regularly travels to Nigeria to render cardiac surgical care to the indigenous populations.

Value systems
Each family’s story is unique, but they all reveal the powerful influence one generation of surgeons has on the next. All of the surgeons profiled in this story had the good fortune of growing up in homes with mentors who watched and guided their growth and development on the path to successful surgical careers.

“It’s the example that parents live that sets the stage for the young person trying to find life’s meaning,” Dr. Hoyt said. “I sometimes think that imparting those positive values to our young people is the biggest challenge we face as a society.”

Dr. Paul Davis (right) with his late father, Dr. William Davis, and a portrait (in the background, left) of Dr. Paul Augustine Kunkel.
ACS CoC creates awareness of cancer issues at state and federal levels

by Tara Leystra Ackerman

The American College of Surgeons (ACS) Commission on Cancer (CoC) established an Advocacy Committee in 2013, which is responsible for identifying, evaluating, and recommending positions on legislative and/or regulatory issues that come before the state and/or federal government and that have the potential to affect CoC-accredited cancer programs and cancer patients. The ACS CoC Advocacy Committee meets annually to establish a list of priorities and conducts regular conference calls to discuss ongoing developments.

For the last two years, the ACS CoC Advocacy Committee has hosted briefings on Capitol Hill to promote the CoC and the value of accreditation. Furthermore, in February the Advocacy Committee held its first Lobby Day to promote the CoC and discuss cancer research funding, among other issues.

Policy issues related to cancer care often begin in the state legislatures before any federal action is taken. This pattern is especially true for cancer.

HIGHLIGHTS

- Describes the ACS CoC’s role in advocating for quality cancer care
- Provides an update on state and federal activities regarding the following issues:
  - Raising the age for purchasing cigarettes
  - Creating parity for coverage of oral chemotherapy treatments
  - Regulating the use of tanning beds
  - Screening for colorectal cancer
- Informs readers about how they can advocate for cancer patients
prevention policies, as well as some cancer treatment insurance coverage and access to care issues. In fact, state governments led the way in establishing smoke-free workplaces, raising the legal age to smoke or use tanning beds, regulating e-cigarettes, administering screening and early detection programs, and addressing related health insurance coverage issues. This article focuses on several key cancer issues that state legislatures are addressing this year.

Raising the smoking age
Many cities and a few pioneering states are attempting to raise the legal smoking age to 21 from 18 years old. The movement began in Needham, MA, which in 2005 became the first municipality to increase the minimum age for the purchase of tobacco products to 21. A study showed that after the ordinance’s implementation, the number of Needham youths who smoked declined more sharply than in surrounding communities.1 According to the Centers for Disease Control and Prevention, nearly nine out of 10 cigarette smokers first tried smoking by the time they were 18, and preventing tobacco use among youth is critical to reducing the number of people who become addicted overall.2 Cutting the number of smokers is vital to improving the nation’s public health, as tobacco use is a leading cause of cancer and death from cancer. More than 100 cities have since followed Needham’s example, including New York, NY, which increased its legal smoking age to 21 in 2013.3

Last year Hawaii became the first state to increase its smoking age to 21. The New Jersey legislature passed a bill that called for raising the smoking age to 21 in January of this year, but Gov. Chris Christie (R) pocket vetoed it by taking no action on the legislation. In March, both the California Senate and Assembly had passed a bill (S.B. 7) that would raise the smoking age to 21 and address other tobacco-control related issues. As of press time, it is awaiting action by Gov. Jerry Brown (D). Massachusetts, New York, Oregon, Rhode Island, Utah, Vermont, Washington, and the District of Columbia also considered bills to increase the smoking age to 21 in 2015, but none of them moved to the next stage of the legislative process.4 Pennsylvania, Tennessee, and Utah all have bills active in their 2016 legislative sessions.

A bill also was introduced in the U.S. Senate by Sen. Brian Schatz (D-HI) to raise the legal smoking age to 21 throughout the nation. The Tobacco to 21 Act (S. 2100) prohibits the sale or distribution of tobacco products to individuals under the age of 21. The bill is unlikely to advance in 2016.

Parity for oral chemotherapy
Access to care is another priority issue for the CoC, including improving the availability of new chemotherapies that are administered orally instead of intravenously. Traditional intravenous (IV) anti-cancer medications have been covered health care benefits under most health insurance plans, including Medicare and Medicaid. Cancer patients may only need to make a copayment, or they may incur no cost at all for this treatment. However, many new anti-cancer medications are taken orally, and are covered under a health plan’s pharmacy benefit. These drugs can be expensive, and often health plans require that patients pay coinsurance, which is a percentage of the overall cost of the prescription drug. This payment can be financially burdensome for some cancer patients, and, consequently, many of these patients are unable to fill their prescriptions or complete the entire regimen.5

Legislation was introduced in the states to address this problem by requiring health plans to provide equal coverage for a patient’s out-of-pocket costs for oral and IV therapies. This legislation does not mandate coverage of oral chemotherapy, but it does require health plans to cover treatment equally, meaning patients’ out-of-pocket costs must be the same, regardless of how the therapy is administered. A total of 40 states and the District of Columbia have passed this type of legislation. In 2015, Mississippi, New Hampshire,
North Dakota, South Dakota, West Virginia, and Wyoming passed legislation that provides parity for copayments for intravenous and oral chemotherapy. Similar bills are under consideration this year in the following states: Alabama, Alaska, Michigan, North Carolina, Pennsylvania, and Tennessee. The states that have yet to take action are Arkansas, Idaho, Montana, and South Carolina.

Federal legislation that addresses equal coverage for oral and IV therapies also has been introduced. The Cancer Drug Coverage Parity Act would require health insurance plans that cover traditional IV or injectable chemotherapy to provide comparable coverage for orally administered anti-cancer prescription medications. This bipartisan legislation was introduced in the U.S. House of Representatives by Reps. Leonard Lance (R-NJ) and Brian Higgins (D-NY) as H.R. 2739 and in the Senate by Sens. Mark Kirk (R-IL) and Al Franken (D-MN) as S. 1566. The ACS CoC has voiced support for the legislation because it ensures that a patient’s treatment plan is based on the physician’s recommendation, not on the costs associated with an outdated policy.

Tanning bed regulations
In the last few years, states have increased regulations on tanning devices, including banning their use by individuals younger than 18 years old. Use of tanning devices by minors is banned in 13 states: California, Delaware, Hawaii, Illinois, Louisiana, Minnesota, Nevada, New Hampshire, North Carolina, Oregon, Texas, Vermont, and Washington. In addition, 42 states regulate the use of tanning devices in some manner. In 2016, the College will work with a coalition in Kansas to advance legislation (H.B. 2369) that would ban the use of tanning beds by individuals under the age of 18.

Although at present no federal legislation bans the use of tanning devices by minors, the U.S. Food and Drug Administration did propose a rule on December 22, 2015, that would restrict the use of these devices to individuals 18 years of age and older.

Colorectal cancer screening coverage
The Affordable Care Act mandates coverage of colorectal cancer screenings, including colonoscopies, sigmoidoscopies, and fecal occult blood testing, without any cost sharing. The extent of this coverage isn’t always clear and has created confusion in a number of instances. For example, if someone gets a positive result on a fecal occult blood test, a follow-up colonoscopy is required. However, it may be unclear whether the colonoscopy is covered as part of the original screening, or is considered a separate diagnostic test.

In the last year, at least six state legislatures have considered legislation attempting to clarify this distinction and address other gaps in colorectal cancer screening. For example, an Oregon bill (H.B. 2560) was signed into law in 2015, which requires health care insurers to cover the cost of a colonoscopy for individuals who are 50 years of age or older and have had a positive fecal test result. The law also requires health benefit plans to cover the cost of a colonoscopy for individuals ages 50 and older and who have a positive fecal immunochemical test result. Other state legislatures that are considering bills aimed at increasing colorectal cancer screenings include Florida, Hawaii, Kentucky, Massachusetts, and New York.

Activity related to colorectal cancer screening also is taking place at the federal level. When the Affordable Care Act was first passed, there was confusion regarding polyp detection and removal during a colonoscopy screening and whether it was part of the screening test or a separate therapeutic procedure. Some health care insurers treated it as the latter and sent bills to patients for some or all of the procedure’s costs. In 2013, the Obama Administration clarified that polyp removal is part of the screening process and should be covered without cost sharing. However, this directive did not address Medicare coverage. The Removing
Barriers to Colorectal Cancer Screening Act (H.R. 1220/S. 624) would address this gap. The ACS CoC has previously supported this legislation to ensure that Medicare beneficiaries have access to the full benefits of colonoscopies without bearing responsibility for cost sharing.

**Promoting CoC accreditation**

One important goal of the ACS CoC Advocacy Committee is to promote CoC accreditation at both the state and federal levels. Florida Gov. Rick Scott (R) in 2013 approved legislation creating the Cancer Center of Excellence Award to recognize hospitals, treatment centers, and other providers in the state that demonstrate excellence in offering patient-centered, coordinated care to patients receiving cancer treatment and therapy. To be considered for the award, the provider must have CoC accreditation. The state Surgeon General appoints a team of independent evaluators to determine award eligibility. Last year, four cancer centers were the first to earn the Cancer Centers of Excellence designation. This award is an example of how a state can promote CoC accreditation.

At the federal level, in late 2015, Reps. Lynn Jenkins (R-KS) and Richard Neal (D-MA) sponsored H.R. 487, a nonbinding resolution that recognizes the importance of CoC accreditation to ensure patient access to high-quality, comprehensive cancer care. Visit www.surgeonsvoice.org to learn more about this resolution and to ask your representative to sign on.

If you are interested in getting more involved in advocating for the CoC in your state, contact your CoC State Chair (information available at facs.org/quality-programs/cancer/clp/statechresource/statecontact). To learn more about getting involved in state advocacy, contact ACS State Affairs staff at state_affairs@facs.org. To learn more about the ACS CoC Advocacy Committee, contact Nina Miller, MSSW OSW-C, Cancer Initiatives Manager, at nmiller@facs.org.

**REFERENCES**


Although the creation of a paperless medical record was suggested as early as 1991 in an Institute of Medicine report, the first real progress toward the creation of an EHR came in April 2004, when President George W. Bush issued an executive order that gave the Office of the National Coordinator for Health Information Technology (ONC) the task of implementing EHR nationwide within 10 years. At the time, many health policy experts believed that health information technology had the potential to do the following:

- Improve quality of care
- Reduce medical errors
- Lower administrative costs
- Provide new support for health care professionals
- Improve security and privacy of medical records
- Provide patients with greater access to and control of their personal health information
- Connect clinicians by building an interoperable health information infrastructure so that records could follow the patient

In 2009, Congress passed the Health Information Technology for Economic and Clinical Health (HITECH) Act, which provided financial incentives to eligible professionals (EPs) and hospitals...
through the Medicare and Medicaid programs that adopted and showed meaningful use of certified EHRs.4

Survey responses
The 2015 ACS Governors Survey asked a series of questions about the use of EHR in both the office and the hospital setting. Of the respondents, 78 percent reported using an office EHR, and 89 percent said they use a hospital EHR (see Figures 1 and 2, this page).

Despite the federal incentives for implementing an office EHR system and Medicare reimbursement penalties that took effect in 2015 for EPs who did not participate in the Medicare EHR Incentive Program, 22 percent of the Governors reported that they do not use an office EHR system.

Governors were asked how confident they were that the information in their office and hospital EHR system was current, complete, and accurate. For the office EHR, 70 percent of the respondents were either adequately confident (27 percent) or somewhat confident (43 percent) in the quality of data from their office EHR. The remaining 30 percent were either not confident at all about the quality of data (25 percent), or felt that the data were rarely complete, accurate, or even available (5 percent) (see Figure 3, page 31).

Likewise, when asked about the hospital EHR, 70 percent of the respondents stated that they were either adequately confident (29 percent) or somewhat confident (41 percent) in the quality of hospital EHR data. The remaining 30 percent either lack any confidence in the data (25 percent) or stated that the data were rarely complete, accurate, or even available (5 percent) (see Figure 4, page 31).

Governors were asked how often they exited the office or hospital EHR and searched through multiple data sources to obtain all of the information they needed. With respect to the office EHR, 61 percent of the respondents said that they rarely or never needed to exit the EHR for more data. The remaining 39 percent stated that they needed to exit the EHR for more data frequently or very frequently (see Figure 5, page 32).

For the hospital EHR, 67 percent of respondents stated that they rarely (55 percent) or never (12 percent) needed to exit the hospital EHR to get data from other sources, whereas 33 percent stated that they either frequently or very frequently needed to exit the hospital EHR (see Figure 6, page 32).

Governors were next asked how the use of the EHR in their office and hospital affected their overall workflow and efficiency. With respect to the office EHR, 67 percent of the respondents said they experienced either a decrease in efficiency (36 percent), a major disruption of previous workflow (23 percent), or a severe disruption of workflow in their office (8 percent). In contrast, 21 percent of respondents reported that their overall workflow and efficiency in the office had significantly improved, and 12 percent said they experienced no change (see Figure 7, page 33).

For the hospital EHR, 54 percent of the respondents stated that their overall workflow and clinical efficiency in the hospital had decreased either slightly (33 percent) or significantly (21 percent). In contrast, 46 percent reported that their overall workflow and clinical efficiency in the hospital had either improved slightly (23 percent), improved significantly (14 percent), or had not changed (9 percent) (see Figure 8, page 34). It appears that the hospital EHR is less disruptive to workflow and efficiency than the office EHR.

Rising levels of dissatisfaction
Results from the 2015 ACS Governors Survey clearly show that Governors have many concerns regarding the effects EHRs have had on clinical practice. In a study sponsored by the American Medical Association,
Results from the 2015 ACS Governors Survey clearly show that Governors have many concerns regarding the effects EHRs have had on clinical practice.

A RAND Health report found that EHRs had an important impact on physician professional satisfaction. This report listed nine effects that led to reduced professional satisfaction (see Table I, page 32).

Evidence in the literature suggests that physician dissatisfaction with EHR is increasing. A survey conducted by the American College of Physicians and American EHR Partners showed that dissatisfaction with ease of use of the EHR increased to 37 percent in 2012 from 23 percent in 2010. In that same time period, the percentage of clinicians who would not recommend their EHR to a colleague increased from 24 percent to 39 percent. This survey also showed that surgical specialists were the least satisfied group of physician EHR users.

According to a 2014 Medical Economics article, nearly 20 percent of EPs have dropped out of the meaningful use program. In 2015, the Centers for Medicare & Medicaid Services (CMS) penalized 256,000 physicians for failing to show meaningful use in 2013.

Concerns also have been raised with respect to the limited real-time clinical analytical capabilities of current EHR systems. Health care networks that have sought to analyze large amounts of complex data regarding patient care have reported that private EHR vendors have attempted to control the flow of clinical information by blocking access to clinical information for analytics so that they can monetize the use of data housed in their products.

Not all of the literature reports on EHRs are negative, however. In the RAND Health report cited earlier, almost all of the physician respondents expressed optimism about EHR development in the future. The RAND Health report also showed that EHR had

FIGURE 3. CONFIDENCE IN OFFICE EHR DATA QUALITY

| Data is rarely complete, accurate, or even available | 5% |
| Adequately confident | 27% |
| Somewhat confident | 43% |
| Not confident at all | 25% |

FIGURE 4. CONFIDENCE IN HOSPITAL EHR DATA QUALITY

| Data is rarely complete, accurate, or even available | 5% |
| Adequately confident | 29% |
| Somewhat confident | 41% |
| Not confident at all | 25% |
Several positive effects on professional satisfaction. More specifically, physicians noted that EHR can facilitate better access to patient data and may contribute to quality of care by providing information that may be used in the development of clinical guidelines and by allowing providers to track patient markers of disease control over time. Physicians also described enhanced communication through the medical record by allowing access to other health care professionals’ notes and eliminating the problems associated with illegible handwriting.

The College intervenes

The ACS has long been aware of the many issues that practicing surgeons face in their efforts to use EHR. The EHR Incentive Program page on the ACS website contains a wealth of information that is intended to help surgeons address challenges regarding EHRs. Also available on the website are links to an EHR Incentive Program Reporting Options Timeline, a Basic Starter Guide, a Guide for Vendor Selection, and Contracting Advice for negotiating with EHR vendors. Several ACS Bulletin articles on the EHR Incentive Program are also available for download on this site, as well as links to federal regulations regarding EHR use.

Furthermore, the ACS has partnered with AmericanEHR Partners, which works to assist physicians in the effective use of EHRs. Through this partnership, ACS Fellows can obtain information on EHR vendor ratings and request proposals from vendors.

The ACS also is working with other physician organizations to voice surgeons’ concerns about health information technology and the EHR to the federal government. The ACS and multiple other physician organizations sent a letter to CMS in May.

### TABLE 1.

**EHRs AND REDUCED PROFESSIONAL SATISFACTION**

Issues that surgeons noted regarding EHR included the following:

- Time-consuming data entry
- User interfaces that do not match clinical workflow
- Interference with face-to-face care
- Insufficient health information exchange
- Information overload
- Mismatch between meaningful use criteria and clinical practice
- Effects on practice finances
- Need to perform lower-skilled work
- Template-based notes degrade the quality of clinical documentation
REFERENCES


continued on next page
CHIP (Children’s Health Insurance Program) Reauthorization Act. A January 19 clarification on The CMS Blog stated that although the EHR incentive programs were designed to encourage the adoption of new technology and measure the benefits for patients, CMS recognizes that the existing program may place too much of a burden on physicians and pull physicians’ time away from patient care. This blog post stated that future Medicare payments will be linked to getting better results for patients, providing better care, distributing health care dollars more wisely, and keeping people healthy. New regulations will be proposed later this year. These revised rules will be guided by the principles of rewarding providers for the outcomes that technology helps them to achieve with their patients, promoting innovation and the development of new apps and analytic tools so that data can be securely accessed and directed, and prioritizing interoperability through the implementation of national standards.

Conclusion
The results of the 2015 ACS Governors Survey reveal the many concerns that the Governors, as practicing surgeons, have about the EHR. These results serve to reinforce the position the ACS has taken for many years, with the goal of improving the EHR system so that it can function as a tool to enhance and improve the care of surgical patients.

REFERENCES (CONTINUED)

The College recognizes that a successful surgical career should not preclude a surgeon’s choice to be a parent. Surgeons who choose to have children (whether through the pregnancy of the surgeon or the surgeon’s partner, a surrogate, or adoption) have made an equivalent commitment and investment in their surgical careers as those individuals who choose not to have children. Choosing to become a parent does not detract from one’s full professional commitment as a surgeon. As a profession, surgery should be supportive of healthy pregnancy outcomes and should not impose punitive repercussions on those surgeons who choose to have children.

Parental leave terms should be explicitly included in all employment contracts. The following guidelines provide a framework for a parental leave policy:

- The surgeon will inform appropriate team members of the pregnancy or anticipated adoption in a timely fashion to allow for accommodation of anticipated absence from professional duties. The team has a responsibility to support the medical needs of the surgeon and to keep health care information confidential. The surgeon will work together with the team to create a schedule that is flexible and equitable for the surgeon taking leave and all others who will be affected by the absence. Surgeons should not be expected to make up for call missed during leave.

- The Family Medical Leave Act (FMLA) of 1993 allows employees to take up to 12 weeks of unpaid leave for certain reasons, such as the birth of the child, to care for a newly adopted child, or placement of the child with the individual for adoption, presuming the surgeon is employed by an organization meeting the criteria of the law and the surgeon meets the eligibility criteria for FMLA and has FMLA time available. The ACS supports maternity leave of no less than six weeks (vaginal delivery)/eight weeks (cesarean section) and paternity leave of not less than six weeks.

Payment for parental leave should be negotiated between the surgeon and the employer. If a surgical practice or employing
Surgeons who choose to have children (whether through the pregnancy of the surgeon or the surgeon’s partner, a surrogate, or adoption) have made as equivalent of a commitment and investment in their surgical careers as those individuals who choose not to have children. Choosing to become a parent does not detract from one’s full professional commitment as a surgeon.

organization is unable to provide paid parental leave, the surgeon should not be responsible for costs to the practice during the period of leave.

The ACS encourages institutions and practices that are exempt from the FMLA law to voluntarily allow new parents to take unpaid leave consistent with what is provided by the FMLA, if requested. In addition, the ACS encourages an individualized assessment of requests for reasonable accommodations of pregnancy-related conditions during pregnancy in accordance with applicable federal and state laws.

• To encourage a positive return to practice, surgeons should not be required to make up call coverage for the period of absence. Upon return from leave, surgeons who intend to breastfeed should be allowed flexibility to support expressing breast milk. Nursing mother break time provisions in the Patient Protection and Affordable Care Act of 2010, which amended Section 7 of the Fair Labor Standards Act, require covered employers to provide eligible employees with reasonable break time in a private place other than a bathroom to express breast milk for one year following the birth of a child. Parental leave should not be a factor when making decisions regarding benefits, promotion, or continued employment.

BIBLIOGRAPHY


The rural general surgeon delivers a range of services, including trauma, critical care, obstetrics, gynecology, orthopaedic, vascular, urology, and head and neck procedures, in small hospitals. Given the range of procedures performed in this setting and the advances in surgery and surgical technology, rural surgeons need efficient and targeted continuing medical education (CME) that matches their broad scope of practice. Furthermore, rural surgeons have relatively limited opportunities to interact with other surgeons and to participate in CME activities. Barriers to these activities include the need to travel long distances and the difficulties of leaving a practice with no clinical coverage during the surgeon’s absence. Responding to the need for specialized CME opportunities, the College introduced the first rural surgeons’ skills course in 2011. The Nora Institute Advanced Skills Course for Rural Surgeons has since been presented at the annual Clinical Congress of the American College of Surgeons (ACS).

The Nora Institute Advanced Skills Course for Rural Surgeons provides a multidisciplinary curriculum that is customized to meet the unique learning needs of rural surgeons. Course participants can hone their endoscopic and laparoscopic skills and learn new surgical procedures, such as facial reconstruction, breast ultrasound, and the management of a partially amputated finger. In addition, the curriculum covers the management of urologic, gynecologic, and vascular emergencies. At present, 10 modules are rotated annually (see Table 1, page 38). Participants are provided with Web-based learning materials to review before attending the in-person session in order to maximize the time spent in hands-on, mentored skills practice. Content experts contribute to and teach each course module.

**Origins of the course**
The inspiration for the rural surgeons skills course is rooted in the vision of the late Paul F. Nora, MD, FACS. Dr. Nora generously committed time and finances to the College to establish a program to further the College’s efforts to promote patient safety.
This dedication resulted in the establishment of what is now known as the ACS Nora Institute for Surgical Patient Safety.

In considering how to expand the College's existing efforts in the area of patient safety, Dr. Nora supported outreach to rural surgeons. Ruth Shea, Dr. Nora's long-time assistant and a former ACS employee, suggested contacting Tyler G. Hughes, MD, FACS, who had authored a Bulletin article on rural surgical practice.* In early 2009, I called Dr. Hughes, then an ACS Governor and general surgeon from McPherson, KS, and asked him how the College could better support rural surgeons. Dr. Hughes invited me to Cooperstown, NY, to attend a rural surgery symposium led by David C. Borgstrom, MD, FACS, who at the time led the Mithoefer Center for Rural Surgery, Mary Imogene Bassett Hospital, Cooperstown, and who at present is a general surgeon at West Virginia University in Morgantown. It was at this symposium, through numerous conversations with rural surgeons, that the idea for a skills course emerged.

The Nora Institute Advanced Skills Course for Rural Surgeons was developed by a team of rural and academic surgeons, as well as individuals with expertise in adult education.

Initial planning for the course involved numerous one-on-one and group discussions with rural surgeons in an effort to develop suggestions for the course content. A needs assessment questionnaire was designed based on these discussions as well as a review of the literature and rural surgeon case logs.† Results from this needs assessment guided the content development. Once the content was determined, we worked with subject experts to develop training models and assessment tools.

**Value of the course**

In the course of their careers, surgeons may need to learn new skills or retool current practices. The development of new technology and improved

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### TABLE 1. THE NORA INSTITUTE ADVANCED SKILLS COURSE FOR RURAL SURGEONS CURRICULUM MODULES

<table>
<thead>
<tr>
<th>MODULES</th>
<th>SKILLS COVERED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leadership and communication</td>
<td>Emotional intelligence—organizing and communicating effectively with team members</td>
</tr>
<tr>
<td>Emergency urology</td>
<td>Cystoscopy and ureteral stent insertion, management of testicular torsion, suprapubic tube insertion, ureteral repair</td>
</tr>
<tr>
<td>Emergency gynecology</td>
<td>Laparoscopic management of ovarian torsion and ectopic pregnancy</td>
</tr>
<tr>
<td>Facial plastic surgery</td>
<td>Lesion excision, local flap reconstruction, eyelid laceration repair, lip laceration repair</td>
</tr>
<tr>
<td>Ultrasound</td>
<td>Breast ultrasound and ultrasound for central line insertion</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>Conscious sedation, management of difficult airways</td>
</tr>
<tr>
<td>Hand trauma</td>
<td>Repair of fingertip amputation, extensor tendon repair</td>
</tr>
<tr>
<td>Laparoscopic common duct exploration</td>
<td>Cholangiogram, transcystic and transcholedochal exploration</td>
</tr>
<tr>
<td>Advanced endoscopy</td>
<td>Endomucosal resection of polyps, foreign body removal, stent placement, hemostasis techniques</td>
</tr>
<tr>
<td>Vascular surgery</td>
<td>Placement of temporary shunt after traumatic injury, management of acute arterial occlusion, management of venous disease</td>
</tr>
</tbody>
</table>

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quality of care strategies necessitate keeping our technical skills up-to-date. Furthermore, some surgeons may want to broaden their scope of practice, which requires refreshing old skills or attaining new ones. While some knowledge may be learned from independent study, technical skills are best acquired through hands-on, mentored training using cadaver, porcine, and simulated models.

Past participants have reported improved confidence and patient care after attending a course, examples of which can be seen in the following comments:‡

• “Not only did I gain a couple of useful techniques—especially ultrasound for central line placement and the trick with the nail matrix—but, more importantly, I had knowledgeable people watch how I was doing things and either affirm that what I was doing was correct or make helpful suggestions [for improvement]. I have been in solo practice most of my career with no other surgeons on staff. It is always great to have a proctor look over your shoulder and make useful suggestions. I wish I had had this course available to me 34 years ago when I started my practice. Thank you.”

• “I reconstructed a huge facial lac/scalping injury from the eyelid across the forehead to the back of the scalp which turned out beautifully!”

• “I had a patient with a neglected avulsion of the tip. I used the technique of ‘dyeing’ the matrix to be certain I removed it all. I found this very helpful, as the anatomy was distorted. Yet with this technique, I was able to identify and remove all of the matrix and got an excellent functional result. Thanks!”

Looking forward
The key limitation to the implementation of new skills is primarily the practice patterns unique to the local community.

For example, if another urologist or orthopaedic surgeon is in town, these cases will get referred. Additionally, after the ultrasound course, several surgeons reported pushback from radiology departments when using diagnostic breast ultrasound or ultrasound for central line placement.

With this feedback in mind, the College has begun offering the Nora Institute Advanced Skills Course for Rural Surgeons at the regional level to increase accessibility. In 2015, the ACS hosted the first regional skills course in conjunction with the North Dakota Chapter and South Dakota Chapter joint annual meeting. Future courses are planned for Utah, New Mexico, and Alabama.

The ACS Nora Institute for Surgical Patient Safety looks forward to making this program available and accessible to surgeons throughout the rural U.S. ♦

How successful is NST in increasing breast-conserving surgery rates in TNBC patients?

by David W. Ollila, MD, FACS; Mehra Golshan, MD, FACS; and Judy C. Boughey, MD, FACS

Historically, neoadjuvant systemic therapy (NST) has been mainly used to convert breast cancer from inoperable to operable; however, today NST also is incorporated into the treatment of patients who initially present with operable disease. NST can allow some patients with stage II-III breast cancer who initially present with disease extent necessitating mastectomy to possibly undergo breast-conserving therapy (BCT) by down-staging the volume of disease in the breast. This neoadjuvant approach is particularly useful in patients where systemic therapy is clearly indicated, such as triple-negative breast cancer (TNBC) and Human Epidermal Growth Factor Receptor (HER) 2-positive disease.

Study on effect of NST
Although NST has been studied extensively, comprehensive data on the impact of NST on converting BCT-ineligible patients to BCT-eligible is lacking. To quantify this conversion rate, a prospective surgical study was incorporated into Cancer and Leukemia Group B 40603 (CALGB, now a part of the Alliance for Clinical Trials in Oncology), a randomized phase II-III trial that tested the addition of carboplatin and bevacizumab to a standard neoadjuvant regimen (paclitaxel followed by doxorubicin and cyclophosphamide) in TNBC. The primary clinical endpoint was pathological complete response (pCR), defined as the absence of residual invasive disease in the breast, and the primary surgical endpoint was breast preservation rates.

Specifically, this study required that the treating breast surgeon assess and document the patients’ eligibility for BCT based on physical exam, native breast size, and breast imaging studies both at initial presentation before the start of NST and after the completion of drug therapy. The surgeon also was asked to document the reason for non-candidacy for breast conservation at both time points.

A total of 404 TNBC patients, treated from 2009 to 2012, had pre- and post-NST surgical assessments and surgical procedure outcomes. Before NST, 219 (54 percent) patients were considered eligible for BCT; of these patients, 197 (90 percent) remained eligible, with BCT attempted in 138 (70 percent) and successful in 130 (94 percent). Of the 185 (46 percent) patients who were considered ineligible for BCT pre-NST, 78 (42 percent) were considered eligible for BCT after treatment. Of these, BCT was attempted in 53 (68 percent) and was successful in 48 (91 percent).

Overall, there was a significant increase in the incidence of surgeon-determined BCT eligibility from 54 percent before NST to 68 percent after NST (p < 0.001). BCT was attempted in 69 percent of eligible patients and was successful in 93 percent. Final surgical management was BCT in 191 (47 percent) patients and mastectomy in 213 (53 percent) patients, including 13 patients in whom BCT was unsuccessful. The rate of pCR did not differ significantly according to breast conservation candidacy.
Although NST has been studied extensively, comprehensive data on the impact of NST on converting BCT-ineligible patients to BCT-eligible is lacking.

Findings

By including this prospective surgical sub-study in this large, randomized NST trial, we identified that a substantial number of patients with TNBC deemed ineligible for BCT at presentation by the treating surgeon could be successfully converted to BCT-eligible (42 percent) with NST. For those patients who attempted BCT, the likelihood of success was 93 percent. Before NST, the breast surgeon and/or radiologic factors most commonly cited as the reasons a patient was BCT-ineligible were a tumor being deemed too large and/or concern of a probable poor cosmetic outcome. However, because most TNBC downsize with NST, multi-centricity became the predominant factor for non-candidacy after NST.

Our 47 percent BCT rate needs to be viewed in the context of three other large trials on NST: Neo-ALTTO, women with HER2-positive disease, 44 percent BCT rate; CALGB 40601, women with HER2-positive disease, 48 percent BCT rate; and GeparSixto, women with HER2-positive disease and TNBC, nearly 75 percent BCT rate.\(^7\)\(^-\)\(^10\)

Despite the high rate of BCT in the GeparSixto trial, the addition of carboplatin, which increased the pCR, did not lead to an increase in BCT in that arm of the trial. Intuitively, higher pCR rates should lead to higher BCT rates, but, interestingly, this outcome has not always been observed in modern trials. In an era when drug therapies have produced remarkably high pCR rates for TNBC, it is surprising that BCT rates are lower than in the past when drug therapy was less robust and pCR rates were much lower.

In CALGB 40603, many BCT-eligible patients, regardless of whether they were always candidates for BCT or converted to BCT candidates with NST, ultimately did not seek breast conservation. Instead, they opted for mastectomy regardless of

REFERENCES


continued on next page
Breast surgical oncologists need to appropriately convey to patients the risks of locoregional recurrence or second primary cancers and discuss likely cosmetic outcomes so patients can make informed decisions regarding local therapy.

Suggestions for the future
Breast surgical oncologists need to appropriately convey to patients the risks of locoregional recurrence or second primary cancers and discuss likely cosmetic outcomes so patients can make informed decisions regarding local therapy. In addition, breast imaging needs to improve to accurately determine treatment response to NST so that interested patients can be offered BCT, if appropriate.

Despite NST successfully converting 42 percent of patients from BCT-ineligible to BCT-eligible and overall high rates of pCR, most NST patients still underwent mastectomy—many without even attempting BCT. Future NST trials should be prospectively designed to address patient, surgeon, and radiologic-specific factors that may influence offering and/or successful completion of BCT.14

If the main proven benefit of NST is to increase BCT rates, our results are disappointing and warrant an effort among surgical oncologists and medical oncologists to encourage decision making based on modern-day response to therapy. ♦

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Dr. Rudolph Matas: Learned trailblazer, father of vascular surgery

by Craig A. Miller, MD, FACS

Rudolph Matas, MD, FACS (1860–1957), was one of the towering figures of 19th- and 20th-century American surgery, and the ninth President of the American College of Surgeons (ACS). His long life and extraordinary career—inextricably linked with Tulane University, New Orleans, LA—were marked by innumerable surgical innovations and scholarly accomplishments. By all accounts, Dr. Matas, who was fluent in six languages, was also among the most erudite individuals in the history of modern medicine.

Dr. Matas was born in Bonnet Carre, LA, in 1860. His parents were Spanish immigrants, and his father was a physician. During his childhood, the family lived in many locales in the U.S. and abroad, but Dr. Matas returned to New Orleans in 1877 to study medicine at the University of Louisiana (the forerunner of Tulane University).1 After graduating in 1880 at age 19, Dr. Matas became an intern at New Orleans’ Charity Hospital. He was named demonstrator in anatomy at the medical school, as well as editor of the New Orleans Medical and Surgical Journal at age 23. He published his first significant paper, showing that the cecum and appendix are intraperitoneal structures, the following year.2

On May 6, 1888, Dr. Matas performed the first successful endoaneurysmorraphy on a traumatic brachial artery aneurysm.3 This episode is widely regarded as the birth of modern vascular surgery.

In 1895, Dr. Matas became chief of surgery at Tulane, a post he retained until 1927. His contributions to the advancement of surgical science were myriad: the development of intravenous fluid therapy, spinal as well as locoregional anesthesia, and positive pressure ventilation, to name just a few.4 He authored more than 600 scientific articles.

Dr. Matas was one of the founding members of the ACS in 1913 and among the first members of the Board of Regents. He was elected to serve as the ACS President in 1926.

Unfortunately, Dr. Matas’ personal life was not marked by the conspicuous favor that attended his professional career. Although his marriage to Adrienne was happy, their only child was stillborn. In mid-career, Dr. Matas lost his right eye as a result of gonococcal conjunctivitis contracted while draining a tubo-ovarian abscess.5 These events, along with Adrienne’s death from pneumonia in 1918, cast long shadows over the professor’s life.

By all accounts, Dr. Matas, who was fluent in six languages, was also among the most erudite individuals in the history of modern medicine.
life. Nevertheless, he retained a fundamentally positive, intellectually curious outlook.

His reading was legendary, and Dr. Matas’ home was said to resemble a library. He also was a renowned cinephile, advocating film as a means of surgical training as early as 1912.⁵

One of the famous episodes in Dr. Matas’ life was the “secret operation” performed by his close friend William S. Halsted, MD, FACS. This event took place at Dr. Halsted’s home in Baltimore, MD, in the fall of 1903. Neither man ever divulged this procedure during his life, nor even the nature of it in their private correspondence. It was only after Dr. Matas’ death that he was noted at autopsy to have undergone a right orchiectomy.⁶

Rudolph Matas died September 23, 1957, at age 97. He left his estate to the Tulane University School of Medicine. ♦

REFERENCES
For surgeons, the highly refined skills you require to carry out your professional responsibilities lower the injury or illness threshold that could prevent you from performing your specialty.

According to the Council for Disability’s Long-Term Disability Claims Review, the following were the leading causes of new disability claims that are also a threat to a surgeon:5

- Approximately 90 percent of disabilities are caused by illnesses rather than accidents.

- One in eight Americans will be disabled for five years or more during their working careers.

- More than 37 million Americans are classified as disabled, and more than 50 percent of Americans with disabilities are in their working years—ages 18 to 64.

- Only 26 percent of Americans have disability insurance.

An assessment of current and expected financial needs can help determine the amount and type of life insurance policy necessary to protect an individual’s family and estate. In the event of a tragedy, life insurance proceeds can do the following:

- Pay off outstanding debt, including credit cards and mortgages
- Allow your family to maintain the standard of living to which they are accustomed
- Finance future needs, such as your children’s education
- Protect a spouse’s retirement plan
- Pay off medical tuition/student loans

Disability income insurance

Disability income insurance is critical for today’s surgeon. Because the ability to earn a living is perhaps an individual’s greatest asset, it is important to protect yourself and your family in the event you develop a disability that prevents you from working.

Professionals typically don’t hesitate to insure their homes, automobiles, and other valuable possessions, but they may overlook insuring their income. Statistics reveal the following:2,3

- More than 37 million Americans are classified as disabled, and more than 50 percent of Americans with disabilities are in their working years—ages 18 to 64.
- One in eight Americans will be disabled for five years or more during their working careers.
- As a surgeon, the highly refined skills you require to carry out your professional responsibilities lower the injury or illness threshold that could prevent you from performing your specialty.
- Approximately 90 percent of disabilities are caused by illnesses rather than accidents.

An assessment of current and expected financial needs can help determine the amount and type of life insurance policy necessary to protect an individual’s family and estate. In the event of a tragedy, life insurance proceeds can do the following:

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- Allow your family to maintain the standard of living to which they are accustomed
- Finance future needs, such as your children’s education
- Protect a spouse’s retirement plan
- Pay off medical tuition/student loans

Life insurance

Life insurance protects the financial security of your family and your estate. It is a simple solution to a difficult question: How will my family and estate manage financially when I die? Consider the following facts:4

- More than two-thirds of Americans are more concerned about saving for retirement than dying prematurely and creating financial strain.
- As household income increases, consideration of life insurance decreases.
- Only three in 10 Americans feel they have sufficient coverage.
- The number one reason people cite for not buying life insurance is perceived cost.

S
ometimes people question the value of investing in life and disability insurance, but these forms of insurance are vital to any surgeon who is concerned about protecting their family’s future.

by Bob Winkleblack
Although many options for acquiring life and disability insurance are available, the ACS has sponsored programs to address a surgeon’s unique need for these types of plans.

- Musculoskeletal/connective tissue disorders (28.6 percent)*
- Cancer (15.1 percent)
- Injuries and poisoning (10.3 percent)
- Mental disorders (8.3 percent)
- Cardiovascular/circulatory disorders (8.7 percent)

A long-term disability plan can help an individual maintain his or her current lifestyle and help protect personal assets by replacing a portion of your income.

It is recommended that high-wage earners conduct a needs assessment to determine whether they have adequate coverage. This suggestion applies both to surgeons who are in private practice and who are health care systems employees.

Although many options for acquiring life and disability insurance are available, the American College of Surgeons (ACS) has sponsored programs to address a surgeon’s unique need for these types of plans. The ACS encourages Fellows to look into these programs and to consider their options with regard to educational and personal needs. Visit acs-insurance.com or call the ACS Insurance Program at 800-433-1672 for more information.

*This category includes claims caused by neck and back pain; joint, muscle and tendon disorders; foot, ankle and hand disorders, and so on.

REFERENCES

In the January issue of The Joint Commission Journal on Quality and Patient Safety (JQPS), M. Michael Shabot, MD, FACS, FCCM, FACMI, system chief medical officer, Memorial Hermann Health System (MHHS), Houston, TX, and Mark R. Chassin, MD, MPP, MPH, president and chief executive officer, The Joint Commission, describe how MHHS used the Joint Commission Center for Transforming Healthcare’s Targeted Solutions Tool (TST) to improve hand hygiene compliance. This initiative resulted in sustained reductions in health care-associated infections (HAIs).*

The TST is an application that guides health care institutions through a step-by-step process to accurately measure performance, identify barriers, and identify proven solutions that are customized to address specific roadblocks to high reliability.

**MHHS project**
MHHS comprises 12 hospitals, 200 ambulatory care centers, 24,000 staff members, and 5,000 physicians. According to the article, in 2006 MHHS started down the road to becoming a high reliability organization (HRO)—defined as an organization that, despite the potential for high risk given the type of procedures performed at these facilities, maintains high levels of quality and safety over long periods of time with few adverse events. The overall goal is to achieve zero harm for patients. In 2007, MHHS started Robust Process Improvement projects to reduce HAI rates, specifically improving compliance with hand hygiene standards.

MHHS and seven other health care institutions voluntarily participated in the Joint Commission Center for Transforming Healthcare’s inaugural TST pilot test in 2009 on the hand hygiene issue. Together, the organizations identified effective and reliable methods to record hand hygiene compliance data, find root causes for noncompliance, and determine solutions to address those issues. Following this pilot, the participating institutions and the center created the TST.

Four MHHS hospitals participated in various stages of that initial project—all of which achieved significant improvement in hand hygiene compliance in the process. MHHS’ The Woodlands Hospital, for example, increased compliance from 27 percent to 80 percent in the test phase.

After seeing the results from the initial project, MHHS implemented the TST in all 12 of its hospitals—approximately 3,225 total beds—in September 2010. According to the JQPS article, MHHS implemented the TST in 150 inpatient units from October 2010.


by Carlos A. Pellegrini, MD, FACS, FRCSI(Hon), FRCS(Hon), FRCSEd(Hon)
The TST project, if carried out properly, will improve and sustain an institution’s hand hygiene compliance, as well as reduce health care-associated infections.

2010 through December 2014. Based on 31,600 observations, the results were as follows:

• From October 2010 through May 2011, the hand hygiene compliance baseline rate averaged 58.1 percent.

• In the improvement phase—June 2011 through November 2012—compliance averaged 84.4 percent.

• In the first 13 months of the control phase—spread out from December 2012 through December 2014—compliance averaged 94.7 percent. In the final 12 months, compliance averaged 95.6 percent.

Drs. Shabot and Chassin concluded that MHHS “substantially improved hand hygiene compliance,” and the health system was able to sustain those results for 25 months after implementation.* In addition, adult intensive care unit rates of central line-associated bloodstream infections and ventilator-associated pneumonia decreased by 49 percent and 45 percent, respectively.

Other TST projects
The TST to improve hand hygiene compliance projects have varied in duration from six to 12 weeks. A team of three to seven people is recommended for the project, and support from management is necessary for its successful implementation. The project team may need to spend approximately four hours a week collecting and inputting compliance data, attending meetings, or implementing solutions.

The TST project, if carried out properly, will improve and sustain an institution’s hand hygiene compliance, as well as reduce health care-associated infections. To learn more about the TST, visit www.centerfortransforminghealthcare.org/tst_hh.aspx.

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

In 1957, Byron Smith, MD, and William F. Regan, MD, coined the term blowout fracture to describe the mechanism of injury resulting from the impact of a blunt object hitting the orbital soft tissues of a cadaver. Specifically, the resultant increase in hydraulic pressure caused the thin internal walls of the orbit to fracture, and the displaced soft tissues became incarcerated, producing enophthalmos along with restricted mobility.

Causes and diagnosis
Two mechanisms are known to cause a blowout fracture. One is the hydraulic pressure described previously, which is considered an orbital hydrostatic force created when a force on the globe in an anterior to posterior direction results in expansion in its equatorial diameter. This elastic force jackhammers the orbital floor, blowing the bone out into the sinus. The orbital floor is the shortest and one of the thinnest of the four walls that comprise the orbital cavity. A second mechanism is a blow to the orbital rim or zygoma that leads to a bone-to-bone transmission of energy known as the mechanical buckling model.

The diagnosis of a blowout fracture for the two decades since its identification was based upon plain radiographs and tomography. Treatment recommendations varied widely from early surgical intervention for all fractures to the opposite extreme of prolonged observation. Surgery was then reserved for late enophthalmos or persistent diplopia. With the emergence of computed tomography scanning in the 1980s and 1990s, this debate narrowed and resulted in an approach where large fractures with a high likelihood of enophthalmos were operated on within the first two weeks.

At least one emergent situation requires intervention: a fracture that results in an oculocardiac reflex. This reflex can show up in any fracture and is truly an emergency.

Looking up and die
by Richard J. Fantus, MD, FACS, and Robert J. Fantus

At least one emergent situation requires intervention: a fracture that results in an oculocardiac reflex. This reflex can show up in any fracture and is truly an emergency.

In 1908, both Giuseppe Dagnini in Bologna, Italy, and later that year Bernhard Aschner in Vienna, Austria, independently reported the cardiac depressor reflex that may result in nausea, significant bradycardia, a junctional rhythm, asystole, and death. This reflex has an afferent limb via the
trigeminal nerve and an efferent limb via the vagus nerve. The triggering stimulus is traction on the extraocular muscles. When the inferior rectus muscle is entrapped in the orbital floor after a blowout fracture, diplopia results. The natural response to overcoming diplopia is attempting to look up with the entrapped eye. This upward gaze tugs on the extraocular muscle and may elicit this reflex.

**Frequency**
To examine the occurrence of orbital floor blowout fractures in the National Trauma Data Bank® (NTDB) research dataset admissions year 2014, medical records were searched using the International Classification of Diseases, Ninth Revision, Clinical Modification diagnoses codes. Specifically searched were records that contained the diagnosis codes of 802.6 (closed fracture of orbital floor: blow-out) or 802.7 (open fracture of orbital floor: blow-out). A total of 23,478 records were found, 19,816 of which contained a discharge status, including 14,520 patients discharged to home, 2,652 to acute care/rehab, and 1,784 sent to skilled nursing facilities; 860 died. Of these patients, 69.6 percent were male, on average 45.4 years of age, had an average hospital length of stay of 6.6 days, had an intensive care unit length of stay of 6.6 days, had an average injury severity score of 15.5, and were on the ventilator for an average of seven days (see Figure 1, this page). The top three mechanisms accounting for almost 90 percent of the injuries were the blunt mechanism of motor-vehicle related, 36.1 percent; fall, 28.2 percent; and struck by, against, 22.7 percent (see Figure 2, page 51).

**Advice for avoiding blowout fractures**
One of the hazards of playing baseball is being hit by a foul ball. No one knows this better than Juan Encarnacion, outfielder for the St. Louis Cardinals. In 2007, he was waiting to pinch-
hit in the on-deck circle when he was struck by a foul ball. He suffered a devastating orbital fracture while his globe remained intact. Spectators, too, are at risk of being struck by foul balls. It is important to keep your head up and watch out for foul balls. However, if one does get hit in the eye and sustains a blowout fracture, it is advisable to avoid the temptation of an upward gaze to correct the resultant diplopia. If not, one could look up and die as a result of the oculocardiac reflex.

Throughout the year, we will be highlighting these data through brief monthly reports published in the Bulletin. The NTDB Annual Report 2015 is available on the ACS Web site as a PDF file at facs.org/quality-programs/trauma/ntdb. In addition, information is available on our website about how to obtain NTDB data for more detailed study. If you are interested in submitting your trauma center’s data, contact Melanie L. Neal, Manager, NTDB, at mneal@facs.org.

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

REFERENCES
**NEWS**

In memoriam:

Dr. John Connolly, pioneering cardiothoracic surgeon

by Peter H. Connolly, MD; James G. Chandler, MD, FACS; and David B. Hoyt, MD, FACS

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**John Earle “Jack” Connolly, MD, FACS**

Past-Second Vice-President and Vice-Chair of the Board of Regents of the American College of Surgeons (ACS), passed away peacefully surrounded by his family on January 20 at 92 years old. A pioneering cardiothoracic surgeon, Dr. Connolly was the founding chairman, department of surgery, University of California, Irvine (UC Irvine).

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**Outstanding mentors**

Jack was born May 21, 1923, in Omaha, NE, where his father, Earle Connolly, MD, was a surgeon on the faculty of Creighton University’s School of Medicine. The elder Dr. Connolly and Jack’s mother, Gertrude, created an environment that encouraged scholastic excellence. Dr. Earle Connolly often took Jack along on weekend rounds to share his passion for academic surgery. These parental influences were evident as Dr. Jack Connolly went on to graduate with honors from Harvard College, Cambridge, MA, in 1945 and Harvard Medical School, Boston, in 1948.

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Dr. Connolly then left New England for the fast-paced life of post-World War II California to begin training in surgery at the Stanford University Hospital, San Francisco, where Emile Holman, MD, FACS, was chief of surgery. Dr. Holman, the last resident to train under William S. Halsted, MD, FACS, was an expert in arteriovenous fistula physiology and management. Dr. Connolly’s residency at Stanford included a penultimate year as a surgical registrar on Sir James Patterson Ross’ professorial unit at St. Bartholomew’s Hospital in London, U.K.

After completing a final year as chief resident at Stanford, Jack returned to the East Coast in 1955 for a two-year thoracic and cardiovascular surgery residency at Columbia Presbyterian Medical Center, New York, NY. At that time, the emphasis of the program was substantially more thoracic than cardiac, with George H. Humphreys II, MD, FACS, and Robert H. Wylie, Jr., MD, FACS, at the medical center and J. Maxwell Chamberlain, MD, FACS, at Roosevelt and Bellevue hospitals.

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**Trailblazing career**

By the time Dr. Connolly returned to Stanford in 1957 as an instructor in surgery, Frank L.A. Gerbode, MD, FACS, FRCS, had performed the first open heart operation on the West Coast in 1954 and had a well-established cardiac team. Norman E. Shumway, MD, FACS, had just come to Stanford directly from training at the University of Minnesota, Minneapolis, with Richard L. Varco, MD, FACS, and C. Walton Lillehei, MD, FACS, who were in the vanguard of this rapidly developing field.

Jack decided to focus his efforts on clinical research and was awarded funding as a Markle Scholar from 1957 to 1962. The return on this investment included 37 reports in peer-reviewed publications, ranging from “Direct vision surgery of acquired aortic and mitral valvular stenosis under hypothermia” in *Surgery* to “Intestinal adhesions—present status of prevention and treatment” in *California Medicine*.

Most importantly, however,
Dr. Connolly emerged from this experience as a quintessential gentleman surgeon and educator, and well-prepared to accept important responsibilities.

In 1962, California voters approved a proposition to merge doctor of osteopathic medicine (DO) and doctor of medicine licensing, which would both allow existing DOs to become MDs and California Osteopathic Colleges to grant doctor of medicine degrees. The merger resulted in the renaming of the College of Osteopathic Physicians and Surgeons in Los Angeles, which traced its roots to the 19th century, as the California College of Medicine. The school retained its mixed faculty of ex-DOs and a few conventional MDs when it was subsequently acquired by UC Irvine and moved to the Irvine campus.

Stanford Medical School dean Loren R. “Yank” Chandler, MD, FACS, had resigned in 1953 after holding the position for 20 years to become a practicing pediatric surgeon on the Stanford faculty but could not avoid becoming involved in the issues surrounding the granting of MDs to former DOs. Dr. Chandler was particularly perturbed by the situation at Irvine, which he viewed as a dangerous precedent. When he learned that UC Irvine was interested in Dr. Connolly as a candidate for chair of surgery, Dr. Chandler visited dean Warren L. Bostick, MD, FACS, to urge him to allow Jack complete freedom in appointing or reappointing faculty, a request that Dr. Bostick granted.

Dr. Connolly eagerly accepted the invitation in 1965 to be the founding chair of what would become, essentially, a new department of surgery. He recruited or accepted all of the new department’s original physicians and anesthesiologists, as well as the heads of seven divisions. The university wavered about building a more modern hospital on campus until 1976, when it purchased the Orange County Medical Center, located approximately 12 miles from the main campus. It is now the UC Irvine Medical Center, which radically expanded under the guidance of Jack and two deans to become a center of excellence.

Jack relinquished his chairmanship of the department of surgery in 1978 after serving in that position for 13 years but retained his professorship in thoracic and cardiovascular surgery. Dr. Connolly never actually retired and remained at UC Irvine as its last original faculty member, teaching medical students and residents for nearly half a century.

For a time, he worried that he’d have to retire at age 70. “But then the government changed the retirement age and that saved me,” he would say, smiling broadly. “I really like what I do—I like the atmosphere. As long as they think I’m contributing, I want to keep doing exactly what I’m doing now.”

**National and international recognition**

Jack’s commitment to surgery has been recognized both at home and abroad. A Fellow of the College since 1958, he was an ACS Governor (1957–1960); a Regent.

In addition, he was president of the American chapter of the International Cardiovascular Society (1976–1977) and a member of the James IV Association of Surgeons. The John E. Connolly Surgical Society, honoring Jack’s dedication to surgical education and fostering mentorship and camaraderie among his former surgical residents, was established in 1975, and members continue to dine together at the annual ACS Clinical Congress.

Dr. Connolly’s career took him all over the world with numerous honors and visiting professorships. He was perhaps most proud of his honorary fellowships in the Royal College of Surgeons of England, Ireland, and Edinburgh, and his honorary memberships in the Japan Surgical Society and the Vascular Surgical Society of Great Britain and Ireland. He celebrated a major career landmark on June 27, 2012, when the John E. Connolly Endowed Chair in Surgery, now occupied by Michael J. Stamos, MD, FACS, became fully funded.

**A family tradition**

Dr. Connolly enjoyed taking some of his family along with him on many of his invited international lectures. He also was an enthusiastic golfer and member of several clubs, including Cypress Point Golf Club, San Francisco Golf Club, Big Canyon Country Club, the Bohemian Club, the Pacific Union Club, and the Harvard Club.

Jack Connolly and Virginia “Ginny” Hartman were married in 1967 and had three children: Peter Hart Connolly, MD, was born in 1974; John Earle Connolly, Jr., in 1976; and Sarah Elizabeth Connolly in 1980. History repeated itself when Dr. Peter Connolly graduated from the UC Irvine School of Medicine in 2004 to train in general surgery at the Columbia Presbyterian Medical Center and then in vascular surgery at the New York-Presbyterian Hospital/Weill Cornell Medical Center, where he is now an assistant professor on the vascular surgery service.

Dr. Jack Connolly also is survived by five grandchildren, raising the possibility of yet another generation of Connolly surgeons. ♦
Modernizing the AMA Code of Medical Ethics

by John H. Armstrong, MD, FACS, and Jon H. Sutton, MBA

At its June meeting, the American Medical Association (AMA) House of Delegates (HOD) will revisit an issue that has been at the forefront of the organization’s activities for two years—updating, or modernizing, the organization’s Code of Medical Ethics. The AMA Council on Ethical and Judicial Affairs began this arduous task in 2014. The HOD was involved throughout the process, holding open forums and discussions at reference committee hearings. The complexity of this task, as well as the serious nature of the project, resulted in thoughtful recommendations from delegates and the specialty societies, including the American College of Surgeons (ACS) Committee on Ethics.

**Background**

First adopted in 1847, the AMA Code of Medical Ethics has been revised on several occasions: first in 1903 and then in 1957, 1980, and 2001. The pace of change in medicine and surgery—particularly with respect to advances in technology—has made more frequent updates necessary. Telemedicine, for example, is constantly evolving, and the profession must keep up with the ethical dilemmas that arise from this type of innovation.

The Code of Medical Ethics plays an important role in the disciplinary actions of state medical boards. In its Essentials of a State Medical and Osteopathic Practice Act, the Federation of State Medical Boards recommends that boards “be authorized to take disciplinary action for unprofessional or dishonorable conduct, including...engaging in conduct calculated to, or having the effect of, bringing the medical profession into disrepute, including but not limited to, violation of any provision of a national code of ethics acknowledged by the Board.”* In this case, nearly all state boards see the AMA Code of Medical Ethics as the national code, making it critical that revisions be made in a serious and thoughtful manner with input from all interested parties.

**ACS delegation**

The June AMA HOD Annual Meeting will provide another opportunity for the HOD to discuss the modernization of the code, along with many other issues. The College’s


**ACS DELEGATION AT THE AMA HOD**

John H. Armstrong, MD, FACS, Delegation Chair; acute care surgery, Tallahassee, FL

Brian Gavitt, MD, ACS Resident and Fellow Section delegate

Jacob Moalem, MD, FACS, ACS Young Fellows Association and ACS Young Physician Section Delegate; general surgery, Rochester, NY

Leigh Neumayer, MD, FACS, general surgery, Tucson, AZ, ACS Regent

Naveen Sangji, MD, General surgery resident, Boston, MA

Patricia L. Turner, MD, FACS, Chair-Elect, Council on Medical Education; general surgery, Chicago, IL, Director, ACS Division of Member Services, Chicago, IL
...[N]early all state boards see the AMA Code of Medical Ethics as the national code, making it critical that revisions be made in a serious and thoughtful manner with input from all interested parties.

delegation to the HOD, under the guidance and direction of the ACS Committee on Ethics, will represent the ACS during discussion of the most current draft of the code.

The surgeons who serve as delegates for the ACS commit considerable time and energy to representing the positions and policies of the College: A list of the ACS delegates appears in the sidebar on page 55.

It is not always easy to predict what issues will come before the HOD. At the November 2015 meeting, for example, in addition to modernization of the AMA Code of Medical Ethics, the HOD discussed funding for graduate medical education, a potential ban on direct-to-consumer advertising by pharmaceutical and device manufacturers, alternative pathways to board recertification, and pharmaceutical costs.

In June, the ACS delegation will represent the College on all of the issues “with skill and fidelity.” Questions regarding the HOD may be directed to jsutton@facs.org.

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27 cancer care facilities receive CoC Outstanding Achievement Award

The Commission on Cancer (CoC) of the American College of Surgeons (ACS) has granted its second installment of 2015 Outstanding Achievement Awards (OAs) to a select group of 27 accredited cancer programs throughout the U.S. Award criteria were based on qualitative and quantitative surveys conducted during the second half of 2015.

The award is an effort to increase awareness about quality care choices among cancer patients and their loved ones. In addition, the award does the following:

- Recognizes cancer programs that achieve excellence in providing quality care to cancer patients
- Motivates other cancer programs to work toward improving their level of care
- Facilitates dialogue between award recipients and health care professionals at other cancer facilities for the purpose of sharing best practices
- Encourages honorees to serve as resources on quality care to other cancer programs

Review a list of these cancer programs on the ACS website at facs.org/quality-programs/cancer/accredited/about/outstanding/2015-part-2.

The 27 award-winning cancer care programs represent approximately 12 percent of programs surveyed by the CoC from July 1 to December 31. New programs undergoing their initial survey and National Cancer Institute-designated programs are ineligible for the OAA.

“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, CoC Chair. “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. Through this recognition program, I’d like to think we’re playing a vital role in helping them make informed decisions on their cancer care.”

♦
Brooklyn-Long Island Chapter/Nassau Surgical Society host Annual Clinic Day
On December 2, 2015, the Brooklyn-Long Island Chapter of the American College of Surgeons (ACS) and the Nassau Surgical Society hosted their combined Annual Clinic Day in Uniondale, Long Island, NY, which attracted more than 400 attendees. The meeting featured an educational program highlighting topics of interest in 10 surgical specialties.

The luncheon speakers included Katie Oehmen, ACS Professional Association-SurgeonsPAC [Political Action Committee] Associate, Division of Advocacy and Health Policy, Washington, DC; and Deborah Roberts, an ABC News correspondent. For the first time, the event included a Resident Jeopardy competition with an award to the top team. A Resident Abstract Poster Presentation featured the top 10 posters receiving special awards.

The joint efforts of both the Nassau Surgical Society and the
ACS WELCOMES NEW DOMESTIC CHAPTER SERVICES MANAGER

The ACS Division of Member Services is pleased to announce that Jennifer Connelly, FACHE, CAE, has been hired to serve as Manager, Domestic Chapter Services. Ms. Connelly joined the College in January from the American College of Healthcare Executives, where she served as a regional director for chapter services. She has more than 10 years of experience in association management and has worked throughout her career to build and maintain strong member relationships and achieve strategic goals to increase member engagement at the national and local levels. Ms. Connelly’s role will include providing support and resources for all domestic chapters of the ACS. Ms. Connelly can be reached at jconnelly@facs.org or 312-202-5737.

Donna Tieberg now will focus her efforts on supporting and expanding the international chapters and can be reached at dtieberg@facs.org or 312-202-5361.

VIRGINIA CHAPTER HUMANITARIAN SURGICAL RESIDENT TRAVEL SCHOLARS

The Virginia Chapter of the ACS (VA-ACS) recently announced the recipients of the VA-ACS Humanitarian Surgical Resident Travel Scholarship Program. Now in its eighth year, the program was established to offset travel expenses for surgical residents in Virginia who are interested in participating in humanitarian missions to provide surgical care in underdeveloped countries.

The 2016 recipients include the following:

- **Ben Rubinstein, MD**, Eastern Virginia Medical School, Norfolk, will travel to Honduras in October to provide office examinations and surgical services at the Hospital Loma de Luz, Colon, which serves as a medical hub for approximately 70,000 rural Hondurans. The hospital is an outreach hospital on the north coast of Honduras that is staffed by Christian missionaries who seek to improve not only the health but the overall quality of life of the residents by providing community outreach, employment opportunities, and counseling services.

- **Brittany Weber, MD**, and **Clara Olcott, MD**, both of Eastern Virginia Medical School, traveled to the Philippines in January for 10 days as part of the Ifugao Medical and Surgical Mission. Ifugao is a rural province in the northern, mountainous Luzon region of the Philippines. Landlocked because of its rugged terrain, this region offers limited medical access for its residents. The mission involved the provision of otolaryngology surgery, plastic surgery, obstetrics/gynecology, dental, and anesthesia services.

- **Collier Pace, MD**, department of surgery, Virginia Commonwealth University, traveled to the Hue Central Hospital and Hue University Hospital, Vietnam, in March. It was his second trip to Vietnam as part of a team that
Ecuador Chapter: The Council and members of the ACS Ecuador Chapter hosted its annual assembly at the Pharmaceutical Technology Laboratory in Guayaquil, December 4, 2015.

demonstrated advanced surgical techniques developed in U.S. operating rooms in a region of the world that is severely lacking in modern technology and training. In addition, the team provided a spectrum of both plastic and reconstructive and orthopaedic surgery procedures.

**Florida Chapter hosts first Surgical Coalition Legislative Day**

The Florida Chapter of the ACS hosted its first legislative day February 4 in Tallahassee, led by a coalition representing the full spectrum of surgical subspecialties. Chris Nuland, Florida Chapter lobbyist, started the program with an update on legislative issues relevant to surgery. This presentation was followed by a coalition discussion that gave participating societies an opportunity to discuss specific legislative issues within their specialty.

Attendees then went to the Capitol Building to meet with their elected officials and begin their legislative visits. The surgical coalition met with multiple representatives. While the primary issue was balance billing, coalition members had the opportunity to discuss additional surgical and specialty-specific issues.

The goal was to demonstrate a unified front on these issues and to promote the idea that surgeons can be a valuable resource to legislators.

In addition, Lucy Gee, Director, Division of Medical Quality Assurance, Florida Department of Health, updated meeting attendees on topics under discussion in the legislature, including the following:

- Office-based surgery
- Medical errors
- Crackdown on pain clinics operating as so-called pill mills
- Medicaid expansion
- Exploratory discussions regarding videotaping of operations

At lunch, Tara Leystra Ackerman, MPH, State Affairs Associate, ACS Division of Advocacy and Health Policy, gave an update on state affairs and legislative developments in other states.

A total of 18 people, including six specialty society representatives, participated in the day’s events, which were made possible in part through the use of facilities offered by the Florida Medical Association.

**Fellows in Trinidad and Tobago form new chapter**

At its February meeting in Chicago, IL, the ACS Board of Regents unanimously approved the establishment of the Trinidad and Tobago Chapter—the 109th chapter of the College. With the addition of Trinidad and Tobago, the College now has 42 international chapters. The newly elected officers of the new chapter are as follows: Dilip Dan, MB, BS, FACS, President; Steve Budhooram, MB, BS, FACS, FRCS, Vice-President; Jimmy Ramdass, MB, BS, FACS,
Ecuador Chapter holds annual meeting in Guayaquil
The Ecuador Chapter of the ACS hosted its annual assembly at the Pharmaceutical Technology Laboratory in Guayaquil December 4, 2015. Chapter President Enrique Guzmán Cottallat, MD, FACS, reported on the activities of the Committee on Trauma in Ecuador and spoke of sponsorships given to different institutions and scientific societies in the country, such as the Ecuadorian Society for Burns and Universidad San Francisco de Quito.

The ACS Governor for Ecuador, Cesar Gastón Cabezas-Tamayo, MD, FACS, provided details about the chapter’s participation in the First Meeting of ACS Governors of Region XIV and the 59th Annual Congress of the Chilean Chapter of the ACS, which took place earlier in the year in Viña del Mar. The central topic for the regional meeting was Surgery Techniques: Standards for Today’s Surgeon. The meeting also included a special session for ACS Governors, with Governors from Argentina, Bolivia, Brazil, Chile, Ecuador, Peru, and Uruguay in attendance. Esteban Foianini, MD, FACS, Vice-Chair of the Governors Chapter Activities Workgroup and Region XIV Chief for the Workgroup, led the special session.

Save the date for Speed Networking Session at Clinical Congress
The ACS Governors of the Chapter Activities Domestic and International Workgroups will once again host a fun, fast-paced learning and social Speed Networking Session at Clinical Congress 2016, Tuesday, October 18, 3:00–5:00 pm. Join chapter officers, executive staff, and ACS Governors for this unique opportunity to accelerate your learning experience through concise roundtable talks on topics important to domestic and international chapters. Bring plenty of business cards to network with chapter leaders from around the world.

For more information, contact Ms. Connelly at jconnelly@facs.org or 312-202-5737, or Ms. Tieberg at dtieberg@facs.org or 312-202-5361.

FRCS, Secretary/Treasurer; Patrick Harnarayan, MB, BS, FACS, FRCS, Councilor; Dale Hassranah, MB, BS, FACS, FRCS, Councilor; Jitendra Shah, MB, BS, FACS, FRCS, Councilor; Vijay Narayansingh, MB, BS, FACS, FRCS, ACS Governor.
All military surgeons, as well as medical students, residents, and fellows at military medical centers, are invited to submit their research for presentation at the Second Annual Excelsior Surgical Society Meeting, sponsored by the Military Health System Strategic Partnership American College of Surgeons (MHSSPACS) and the Excelsior Surgical Society. The date for the Excelsior Surgical Society meeting is Sunday, October 16, in conjunction with the ACS Clinical Congress 2016, October 16–20 in Washington, DC. The meeting will serve as a scholarly forum with a variety of abstract presentations showcasing the best surgical research being done in the U.S. military. Those authors chosen to present will share their research with some of the most senior military surgical leaders, both past and present.

**Submission information**

Following are requirements for submitting abstracts for consideration:

- All general surgery and non-general surgery surgical subspecialties will be considered.
- Oral and video presentations are welcome; case studies will not be accepted.
- The deadline for submissions is 5:00 pm (Central), Friday, **May 13**.
- Accepted authors are encouraged to submit full manuscripts to the *Journal of the American College of Surgeons*.
- Format: Introduction, methods, results, and conclusion.
- Times New Roman, 12 point.
- 250-maximum word limit, one table limit (included in word count).
- Research may be completed or in progress but not previously presented or published.
- Abstracts should be submitted online to Garrett Kirk at gkirk@facs.org.
- Authors also should provide the following information upon submission:
  - Name, including rank
  - Branch of service
  - Military status: active duty/reservist/retired/prior service
  - Station: military treatment facility or hospital
  - Contact info: e-mail, phone number, and address
  - Training level: resident, medical student, fellow, or staff
  - Program director, if applicable
- Questions about research criteria should be directed to Robert Lim, MD, FACS, at robert.b.lim.mil@mail.mil or Gordon Wisbach, MD, FACS, at gordon.g.wisbach.mil@mail.mil. All other questions should be sent to Mr. Kirk at gkirk@facs.org.

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MHSSPACS and Excelsior Surgical Society issue call for abstracts
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In 2015, I was fortunate to be awarded the American College of Surgeons (ACS) Murray F. Brennan, MD, FACS, International Guest Scholarship. As the recipient of this award, I attended the ACS Clinical Congress 2015, October 4−8, in Chicago, IL, and then traveled to a number of renowned institutions of my choosing.

Although this was an amazing opportunity, the thought of organizing such a complex trip was daunting. However, with the advice of the ever-patient Kate Early, ACS International Liaison, and my assigned mentor, Quyen Chu, MD, the scholarship began to take shape.

As an oncoplastic breast surgeon, I selected each institution for its particular area of research or expertise. Visits to these institutions would help clarify situations we found challenging in our weekly multidisciplinary tumor board meetings and allow me to fine-tune my operating techniques. In surgery, decision making is a key aspect of successful outcomes, and I thought that by spending one week in a number of institutions I would get a feel for how similar patients are managed in different centers.

Chicago
The first stop on my trip was the Windy City for the ACS Clinical Congress. It was the first U.S. clinical meeting I had attended, and I had never experienced anything on this scale. McCormick Place is a vast conference hall, and the number of participants far exceeded attendance at the Royal College of Surgeons annual meeting.

Convocation on Sunday, October 4, gave me a sense of what was to come. As I viewed the flags on stage, I was struck by how we are united across the globe by a common purpose. Incoming ACS President J. David Richardson, MD, FACS, was unable to attend, but his message was clear. We practice in challenging times, and the future is in our hands. My philosophy is that it is better to do than to be done to, and this speech resonated with me. Health and politics often are entwined, and we must take ownership of our profession for the benefit of our patients.
The international theme continued in the Opening Ceremony on Monday morning. After the ACS leadership was introduced, distinguished visitors were acknowledged. At work, we often grumble that we don’t have the latest kit or enough staff, but during the Martin Memorial Lecture, Paul E. Farmer, MD, PhD, Kolokotrones University Professor of Global Health and Social Medicine, Harvard Medical School, Boston, MA, reminded us that many people in the world lack access to lifesaving essentials, such as clean syringes, drinking water, and health care services. Many of us make sacrifices to care for our patients, but few of us risk our lives to do so.

The choice of educational sessions was huge, and I was pleased to have the opportunity to attend sessions devoted to lifestyle concerns—topics usually addressed only in the social program at U.K. meetings.

It is rare that we get to meet our heroes—surgeons with vision who have shaped our daily practices—and hear them speak. Everywhere I turned at this Clinical Congress, however, I saw heroes of mine. The I.S. Ravdin Lecture in the Basic and Surgical Sciences, Radical Mastectomy to Radical Conservation: Revolutionary, by Melvin J. Silverstein, MD, FACS, medical director, Hoag Breast Center, Newport Beach, CA, offered material that will stay with me for years.

I also had a new challenge in Chicago when I was invited to write about my experience for the Clinical Congress News, the convention daily. This process was a useful and fun way to reflect on the start of the scholarship, and the finished article seemed to be warmly received by the readers.

The highlight of the Clinical Congress was having the opportunity to meet my fellow International Guest Scholars. After informally meeting at the Opening Ceremony, we attended a number of sessions together and were formally introduced at the International Relations Committee meeting and were presented with our certificates at the Scholars and Travelers Luncheon. It was fascinating to attend the College’s International Scholars and Travelers session and learn more about everyone’s specialty interests. We also had ample opportunity to discuss surgical practice in our different countries at the Scholar’s Luncheon and the Governors Dinner. I anticipate that the friendships and professional connections that I formed at these events will last for many years to come.

The Mayo Clinic

The most rapidly evolving area of breast surgery at present is the management of the axilla. Judy C. Boughey, MD, FACS, professor and vice-chair of research, department of surgery, Mayo Clinical, Rochester, MN, and chair, ACS Clinical Research and Program Education Committee, Massachussetts General Hospital

The first post-Clinical Congress visit was to Massachusetts General Hospital (MGH), Boston, MA, where Amy S. Colwell, MD, FACS, quality director, division of plastic surgery, was my host. Many plastic surgeons do acellular dermal matrix reconstructions, and several go directly to implant, but I had heard Dr. Colwell speak at a previous clinical meeting and was impressed with the large number of patients she had treated who experienced few complications. Many of my patients express a preference for having a one-stage reconstruction, and I am interested in expanding the range of patients to whom I could offer this option.

The team at MGH could not have been more welcoming. It is odd for a busy surgeon to be uprooted and placed in a strange environment, but the residents at MGH went out of their way to ensure I was escorted around, that my many questions were answered, and that I could get the most from my visit. Dr. Colwell asked me a number of questions about my practice so that she could advise me on how to develop using her techniques. At this point, I wished I could have popped home for a few weeks to try my new techniques before continuing my trip!

Health and politics often are entwined, and we must take ownership of our profession for the benefit of our patients.
was the author of the Z1071 trial, which studied the management of the positive axilla in patients who then had neoadjuvant chemotherapy. This treatment plan is still a source of controversy in the U.K., and I wanted to see firsthand how the Mayo Clinic managed these patients.

Dr. Boughey initially trained in the U.K. and thus had insight into the key differences between the two health care systems and cultures. I had a fantastic week with the multidisciplinary team at the Mayo Clinic and came away with a clear understanding of how to manage these patients. As in many of the centers I visited, I saw cutting-edge imaging and radiotherapy technology and learned about innovative research and trials not yet available to patients in the U.K.

**MD Anderson Cancer Center**

My sponsor at the University of Texas MD Anderson Cancer Center, Houston, was Steve Kronowitz, MD, FACS, a plastic surgeon. After I had arranged my placement he let me know he had left his position as a professor at MD Anderson to go into private practice. This afforded me an opportunity to visit MD Anderson as well as experience a different side of practice in the U.S. I have an interest in health care systems and I spent a morning with Dr. Kronowitz learning about his new practice and talking about the different models of care. My reason for visiting MD Anderson was to learn about their techniques with radiotherapy and implants. Dr. Kronowitz and the team at MD Anderson clarified how they safely deliver these services to patients.

I was fortunate also to see some lymphoedema surgery—still a developing practice in the U.K., and my new sponsor Mark Clemens, MD, FACS, assistant professor, department of plastic surgery, had just lectured in the U.K. on Breast Implant Associated Anaplastic Large Cell Lymphoma—a condition that we are just starting to study. Dr. Clemens provided me with the most up-to-date guidelines on managing this rare but important condition.

**Georgetown University Hospital**

I had wanted to visit Scott L. Spear, MD, FACS, past-chief of plastic surgery, Georgetown University Hospital, Washington, DC, since I was a junior oncoplastic trainee, so this opportunity to observe his practice was not to be missed. Dr. Spear is now in private practice but kindly arranged for me also to be hosted by Troy Pittman, MD, assistant professor of surgery, Georgetown University School of Medicine, and a plastic surgeon at MedStar Georgetown University Hospital.

I was able to visit Dr. Spear at his practice and even had the privilege of being featured in

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I was able to visit Dr. Spear at his practice and even had the privilege of being featured in
his blog. It was fantastic to have time to learn from someone who was so instrumental in shaping our specialty. He was incredibly patient and answered most of my questions about the techniques he has developed through the years by providing me with one of his papers. One of my interests is revision reconstruction, and I picked up several novel techniques from Dr. Spear and his team that I can use for my patients in the U.K. Team members at Georgetown were also extremely welcoming, and it was fascinating to see them use one of their four hyperbaric chambers for their post-reconstruction patients if they had anxiety about the skin flaps. The team was studying this approach, but, unfortunately, I cannot see this becoming an option in the U.K. anytime soon.

Memorial Sloan Kettering Cancer Center

The trial that the majority of plastic surgeons would probably agree has changed breast surgery most in the last five years is the Z0011 trial. This study has received a reasonable amount of criticism but nonetheless has been widely adopted. I wanted to see how it was applied to patients at the medical center that conducted the trial—Memorial Sloan Kettering Cancer Center (MSKCC), New York, NY.

My host there was Hiram "Chip" Cody III, MD, FACS, attending surgeon on the breast service, department of surgery, MSKCC, and professor of clinical surgery, Weill Cornell Medical College, New York. Dr. Cody is a fount of knowledge about all matters related to breast surgery, and many of my questions were answered, "Ah, we wrote a paper about that."

Dr. Cody also arranged for me to meet with Monica Morrow, MD, FACS, chief of breast surgery at MSKCC. Dr. Morrow was extremely generous with her time and knowledge in helping me grapple with the key differences between management of breast cancer in the U.K. and the U.S. My role as chief of the breast service in the U.K. is quite different from Dr. Morrow’s, but she was more than willing to give me some pointers on managing my team.

While at MSKCC I also had the pleasure of being able to thank Dr. Murray himself for affording me this opportunity.

Moffitt Cancer Center

The last stop on my trip was the H. Lee Moffitt Cancer Center and Research Institute, Tampa, FL. My hosts were a fellow Brit, Bryan McIver, MD, PhD, program leader, head and neck, and endocrine oncology; and Nazanin Khakpour, MD, FACS, a surgical oncologist specializing in breast cancer at Moffitt’s Center for Women’s Oncology. Since this was my last stop on the scholarship, the team here went out of their way to accommodate any areas of my practice that hadn’t been covered at the other centers. I spent a week in their new breast unit and talked with the administrators who had helped design the building and organize the move. I also spent
time with other members of the team, including the genetics counselors, nurse practitioners, and breast radiologists.

**Back in the U.K.**
I am keen to spread knowledge about everything I learned on my trip. I have already spoken at a national meeting and given several talks locally. In February of this year, I spoke at a European Multidisciplinary Breast Cancer Collaborative meeting held in Paris. At the meeting, I addressed our trainees at the Royal College of Surgeons Oncoplastic Course on management of the axilla in the U.S.

With my team, I am drafting a plan to incorporate my new ideas and learning into our daily practice for the benefit of our patients.

I cannot thank everyone enough for making this trip possible. Special thanks go to Ms. Early and Dr. Chu for their help in organizing the trip, to all my hosts and their teams for their generosity and patience, to my team back in the U.K. for allowing me to leave them for a few months, and to Dr. Brennan and the International Scholarship Committee for this award. This has been an amazing experience for me and will benefit our patients enormously.

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**Apply now for the 2016 Claude H. Organ, Jr., MD, FACS, Traveling Fellowship**

The American College of Surgeons (ACS) is now accepting applications for the 2016 Claude H. Organ, Jr., MD, FACS, Traveling Fellowship. The deadline for all application materials is **June 1**.

The family and friends of the late Dr. Organ established an endowment through the ACS Foundation to provide funding for this fellowship, which is awarded annually to an outstanding young surgeon from the Society of Black Academic Surgeons, the Association of Women Surgeons, or the Surgical Section of the National Medical Association. The fellowship, in the amount of $5,000, enables a U.S. or Canadian Fellow or Associate Fellow younger than age 45 who is a member of one of these societies to attend an educational meeting or participate in an extended visit to an institution of his or her choice, tailored to his or her research interests.

Past awardees have used their fellowships to develop their careers in creative ways. The most recent fellow, Kathie-Ann Joseph, MD, MPH, FACS, associate professor of surgery, New York University School of Medicine, and chief of surgery, Bellevue Hospital Center, New York, NY, is researching how health care systems work in a major metropolitan area, with a focus on the ways that large hospitals systems manage care for underserved women.

The full requirements for the Claude H. Organ, Jr., MD, FACS, Traveling Fellowship are posted at facs.org/member-services/scholarships/special/organ. The 2016 awardee will be informed of the College’s decision by August 2016. Questions and application materials should be submitted to the attention of Kate Early, ACS Scholarships Administrator, at kearly@facs.org.
### APRIL

**Egypt Chapter**  
April 21–22  
Cairo, Egypt  
Contact: Mohey Elbanna, mohey.elbanna@yahoo.com

**North Dakota Chapter & South Dakota Chapter**  
April 22–23  
Watertown, SD  
Contact: Terry Marks, tmarks@sdsma.org

**Indiana Chapter**  
April 22–24  
French Lick, IN  
Contact: Tom Dixon, TDixon@ismanet.org, www.infacs.org

**Northern California Chapter**  
April 29–30  
Berkeley, CA  
Contact: Christina McDevitt, nccacs@att.net, www.nccacs.org

**Metropolitan Washington, DC Chapter & Virginia Chapter**  
April 30  
Washington, DC  
Contact: Norma Smalls, drnormasmalls@gmail.com, www.dcacs.org, www.virginiaacs.org

**Jordan Chapter**  
May 5–8  
Amman, Jordan  
Contact: Osama Hamed, ohamed@ccf.org, www.acs-jordan.org

**Ohio Chapter**  
May 6–7  
Columbus, OH  
Contact: Walter Sun Cha, chaw@ccf.org, www.ohiofacs.org

**Florida Chapter**  
May 7  
Tampa, FL  
Contact: Nicole Woodsmall, nwoodsmall@floridafacs.org

**Chile Chapter**  
May 8–11  
Viña del Mar, Chile  
Contact: Patricio Burdiles, pburdiles@acschile.cl, www.acschile.cl

**Turkey Chapter**  
May 11–13  
Istanbul, Turkey  
Contact: Mehmet Ali Haberal, rectorate@baskent.edu.tr

**West Virginia Chapter**  
May 12–14  
White Sulphur Springs, WV  
Contact: Sharon Bartholomew, wvacs@labs.net

**Metropolitan Philadelphia Chapter**  
May 16  
Philadelphia, PA  
Contact: Lauren Newmaster, mpcacs@pamedsoc.org, metrophilasurgeons.org

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### MAY

**Minnesota Surgical Society**  
May 5–7  
Minneapolis, MN  
Contact: Janna Pecquet, janna@mnscs.org, www.mnsurgicalsociety.org

**Illinois Chapter**  
May 18–20  
Springfield, IL  
Contact: Luann White, lwhite26@gmail.com, www.ilacs.org

**Michigan Chapter**  
May 18–20  
Mackinac Island, MI  
Contact: Carrie Steffen, carrie@steffenmanagement.com, www.michiganacs.org

**Maine Chapter**  
May 20–22  
Portland, ME  
Contact: Jennifer Starkey, jennifer@executive-office.org, www.mainefacs.org

**Vermont Chapter**  
May 26  
Stowe, VT  
Contact: Kenneth Hans Sartorelli, Kennith.Sartorelli@vtmednet.org

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### FUTURE CLINICAL CONGRESSES

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

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

- **2018**  
  October 21–25  
  Boston, MA