Do what’s right for the patient

Franklin H. Martin and the American College of Surgeons
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The American College of Surgeons (ACS) experienced another successful year in 2016 and launched a range of initiatives that we believe will make surgery safer for patients and the profession more hospitable for all individuals who are drawn to health care careers. Details about these programs are outlined in the Executive Director’s annual report on page 46, but I would like to use this column to point out a few high points here.

Advocacy and Health Policy
The ACS is playing a leading role in ensuring that the Medicare Access and CHIP (Children’s Health Insurance Program) Reauthorization Act (MACRA) is implemented in a way that encourages the provision of safe, quality, reliable care. Implementation of the new payment system developed under MACRA is discussed in the Medicare Physician Fee Schedule final rule that the Centers for Medicare & Medicaid Services issued in mid-October. This plan calls for the establishment of a Quality Payment Program (QPP), which will center initially on a Merit-based Incentive Payment System (MIPS), with eventual expansion to include Alternative Payment Models (APMs). The November “Looking forward” column provides a comprehensive summary of MIPS and its four components: Quality, Resource Use, Advancing Care Information, and Clinical Practice Improvement Activities.

The College urges all Fellows to prepare for the transition to MIPS and is offering a range of resources and services to help them succeed in 2017 and beyond at facs.org/advocacy/qpp.

To assist in the development of APMs, the ACS is collaborating with Brandeis University, Waltham, MA, and the Center for Surgery and Public Health at the Brigham and Women’s Hospital, Boston, MA, and has formed a task force to advise our staff. The project has continued to evolve, but, at press time, we expected to have a proposal to submit to the relevant government agencies in December.

Quality
The ACS is dedicated to making surgery safer across the continuum of care—from the initial patient consult through the patient’s full recovery—and across all specialties and patient demographics.

To ensure that all patients are in optimal condition to undergo surgical care, the ACS will be leading a national Strong for Surgery initiative. Under the Strong for Surgery model, health care providers use a series of checklists and tools to assess four modifiable areas to ensure the patient’s readiness for operative care: nutrition, blood sugar control, smoking cessation, and medication use.

The College is committed to ensuring patient safety throughout the perioperative period and has issued a number of statements regarding surgeons’ responsibilities throughout this stage of care. In response to concerns about surgeons performing concurrent operations, the College updated its Statements on Principles to include, among other directives, the following admonishment: “A primary attending surgeon’s involvement in concurrent or simultaneous surgeries on two different patients in two different rooms is inappropriate.”

In addition, the College responded to a number of requests that the ACS issue a position statement addressing surgical attire. The statement, which endorses the use of either the bouffant hat or the surgical skull cap and makes a number of recommendation about the wearing of scrubs in and out of the operating room, has been published online and in the October Bulletin.

To improve care after an operation has been completed, the College intends to promote and expand at the national level the enhanced recovery after surgery (ERAS) programs in place at Kaiser Permanente hospitals. With the tagline, “Get up, get moving, get better,” ERAS calls for the development of a detailed plan for each patient, including specific pre- and postoperative instructions for pain control, diet, exercise, and other factors that affect recovery.

Furthermore, the ACS has developed programs to address the unique needs of pediatric and geri-
The ACS is dedicated to making surgery safer across the continuum of care—from the initial patient consult through the patient’s full recovery—and across all specialties and patient demographics.

Education

Every year, Clinical Congress attendees tell me that this event just gets better and better. This year’s conference in Washington, DC, comprised 24 Tracks, 128 Panel Sessions, 18 Didactic Courses, 14 Skills Courses, 45 Meet-the-Expert Luncheons, and 18 Town Hall Meetings. Three Special Sessions were offered on Firearm Injury Prevention, ACS Strong for Surgery, and Global Engagement and were well-received.

Another mainstay in the College’s educational programming repertoire is the Surgical Education and Self-Assessment Program (SESAP®). At this year’s Clinical Congress, we unveiled SESAP 16, which features a variety of apps for handheld devices, and is available in Web and print versions. Additional SESAP products include the SESAP Sampler—a Web-based resource consisting of monthly modules designed to enhance surgical decision making through ongoing self-assessment and review of surgical content—and SESAP Audio Companion.

Importantly, the College is working to ensure that surgeons experience a smooth transition from one phase of their career to the next. A key initiative aimed at achieving this objective is the growing Transition to Practice Program. And to make certain that surgeons are well prepared to perform advanced procedures, the Committee on Emerging Surgical Technology and Education continues to identify and track innovations, evaluating their surgical potential and promoting their safe and effective adoption. In addition, the ACS Accredited Education Institutes continue to promote patient safety through the use of simulation to develop new education and technologies, identify best practices, and promote research and collaboration among our institutes.

Member Services

This year’s Initiate class was the largest ever, with a total of 1,823 new members. I would argue that growing interest in ACS Fellowship demonstrates that surgeons recognize that the College is responsive to

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This year’s Initiate class was the largest ever, with a total of 1,823 new members. I would argue that growing interest in ACS Fellowship demonstrates that surgeons recognize that the College is responsive to their needs and concerns in an ever-changing health care environment.

Likewise, the Journal of the American College of Surgeons (JACS) launched a redesigned home page at journalacs.org. The layout is more user-friendly, allowing readers to find content quickly, and includes more surgical videos and images, as well as a complete list of the JACS Continuing Medical Education articles for the month.

Similarly, the College’s electronic newsletters underwent a makeover, ensuring that they all have a consistent look and feel and are easily viewed on a computer, tablet, or smartphone.

The College’s social media presence also continues to grow. For details about the growth of the online ACS Communities, see the article on page 87. Furthermore, we continue to see upward participation trajectories on our Facebook, Twitter, and LinkedIn pages.

Looking forward to 2017
As these few examples demonstrate, the College continues to move forward to bring surgeons and their colleagues the tools, resources, and educational opportunities they need to succeed in practice and provide optimal care to their patients. As always, we welcome your suggestions regarding how we can best serve you in the future. Thank you for your ongoing support, and here’s to another transformative year. ♦

Integrated Communications
The Division of Integrated Communications played a pertinent role in launching Bleedingcontrol.org and continuously strives to bring news and information to the membership in formats that are compatible with the needs of today’s busy surgeons.

Efforts are under way to transition Bulletin readers from the print version to online only beginning January 1, 2017. Each month, members receive an e-mail alerting them when the new issue is available and information about how to access the Bulletin website, read an interactive version of the magazine, or download the app.

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

DEC 2016 BULLETIN American College of Surgeons
Presidential Address:

Do what’s right for the patient

Franklin H. Martin and the American College of Surgeons

by Courtney M. Townsend, Jr., MD, FACS
Do what’s right for the patient. This proclamation is the bedrock of the American College of Surgeons (ACS). It is our lodestar and the cardinal principle of the original Oath of 1913 and of the Fellowship Pledge that Initiates make today.

Our calling, our mission, our passion are education and quality. These two objectives have been the watchwords of our College since the beginning. They are today and will be tomorrow.

Development and great progress in American surgery have come from surgeons—not imposed from without—who recognized the shortcomings of the present and set out to correct them for the future.

In this address, I would like to tell you the story of the College—the who, what, why, and how of the organization’s evolution:

• Who: Individual surgeons recognizing a pressing need for change.

• What: Improved education to ensure quality.

• Why: Surgical education and training were characterized by a lack of standards.

• How would this be done?

An organization would eventually be formed that would have as requirements for membership standards for surgical competence and character of the applicants, affirmed by their peers. The organization would advance the science of surgery and the competent practice of its art and eliminate the incompetent and occasional operator—to do what’s right for the patient.

Within 25 years of its founding, the College established standards for educating surgeons, standards for hospitals, and standards for graduate training for general surgery and the surgical specialties. These accomplishments did not happen simultaneously but sequentially. As one set of standards was set, it became evident that another would be required—to do what’s right for the patient.

Dr. Martin’s vision

Who was Franklin H. Martin, MD, FACS—and why did he decide to take on these challenges?

To fully understand Dr. Martin’s vision, we must examine the state of medical education in the late 19th and early 20th century. It was deplorable. Abraham Flexner issued a report in 1910 titled Medical Education in the United States and Canada.1 The Flexner Report, as it is commonly referred to, noted 155 existing medical schools and placed each of them in one of three divisions.1,2 Group I included 22 schools that required two or more years of college work for entrance; Group II comprised 50 schools that demanded actual graduation from a four-year high school or its “supposed equivalent”; and Group III was composed of 83 schools that asked “little or nothing more than the rudiments or the recollection of a common school education.”

State Boards of Medical Examiners were no help. A total of 82 different boards were operating in 49 states and territories; all required only a written examination. A graduate of a medical school who passed a state board examination and received a medical license could enter practice the same day—without any formal postgraduate training or restrictions on scope of practice. Internship was not required for licensure until 1914.3 Those individuals who wanted to become a surgeon would apprentice themselves to an established surgeon upon whose skill and knowledge their education depended. Furthermore, it required that the senior surgeon remain current. This relationship often lasted years. No standards were in place for medical education, for postgraduate training, or for hospitals.

Now a bit more about Franklin Martin and what drove him. He was born in 1857 in Ixonia, WI. He was raised and went to school in a rural setting and he worked in various manual labor jobs as a teenager. In his autobiography, Dr. Martin wrote that in 1876, “on a blistering day in August” as he was working in the fields, he saw the local doctor, nicely dressed, drive by in his buggy. At that moment, he decided he would “be a doctor.”

Dr. Martin found an apprenticeship; entered Chicago Medical College, IL, in 1877; graduated in March
1880; obtained a two-year internship at Mercy Hospital; and opened his practice in Chicago. He wrote, “In those good old days, surgeons developed and were not made to order...one learned his surgery by seeking out emergency cases...those more interested in gynecological surgery literally learned it by operating on our patients.” After one year of practice, he performed his first abdominal operation, a bilateral oophorectomy “in a large west room of an apartment,” which led to the death of the patient on his third post-op day. He wrote, “There was little consolation in the fact that I had done the best I know. What was it that I did not know?”

He obtained an appointment to Women’s Hospital of Chicago in 1887 and developed a successful practice in gynecologic surgery. Driven to improve graduate education, Dr. Martin and others established the Postgraduate Medical School and Hospital in 1889. In 1905, he founded Surgery, Gynecology & Obstetrics (SG&O), which he said was edited by “practical men of authority in their respective specialties.” This publication, which later became the Journal of the American College of Surgeons, was an overnight success.

In 1903, a group of prominent surgeons founded a travel club, The Society of Clinical Surgery. Members would go to each other’s clinics and observe surgical technique demonstrations. Although Dr. Martin was not a member of this club, he saw the value of this concept, and in 1910 he had the thought, “Why not make a demonstration?” In an editorial published in SG&O, he wrote of his plan “…to invite to a clinical meeting every man in the United States and Canada who is particularly interested in surgery, to observe the principal clinics in one of the large medical centers.” He called this program the Clinical Congress of Surgeons of North America (CCSNA), and the first meeting took place in Chicago, November 7–10, 1910. It was an overwhelming success. The CCSNA was the first organized program devoted to postgraduate medical education.

In 1912, on the train traveling to the third annual CCSNA, Martin wrote that he realized “there must be a change.” By the time he arrived, he had a written plan proposing a College of Surgeons of the United States and Canada. The five-point plan for the College, which he presented to the assembled physicians, and would involve the following:

• A standard of professional, ethical, and moral requirements for every authorized graduate who practices general surgery or any of its specialties as in the Royal Colleges
• A supplementary degree for operating surgeons
• Special letters to indicate Fellowship in the College
• A published list of members
• The appointment of a committee of twelve with full power to proceed with the plans

Martin proposed “…this largest organization of surgeons on the American continent” would assume “…the responsibility and the authority of standardizing surgery.”

Articles of Incorporation for the American College of Surgeons were issued by the State of Illinois on November 25, 1912. In May 1913, an organizing committee met and prepared a charter and bylaws to be proposed at the first meeting in November 1913.
Article II of the Bylaws stated, “The object of the College shall be to elevate the standard of surgery, to establish a standard of competency and character for practitioners of surgery, to provide a method of granting fellowships in the organization, and to educate the public and the profession to understand that the practice of surgery calls for special training, and that the surgeon elected to fellowship in this College has had such training and is properly qualified to practice surgery.”

John M. T. Finney, MD, FACS, the first ACS President, stated in his Presidential Address to the Fellows, “The American College of Surgeons...stands only for the good of humanity and the uplift of professional standards of morality and education. If it does not fulfill its special mission...it is your own fault.”

The American College of Surgeons was the first professional organization to take upon itself the responsibility to set standards for education and training of medical graduates and to educate the public and profession as to who was qualified to practice surgery. Of the founding 17 Regents, five had college degrees, all had taken one- or two-year internships, and two had additional hospital experience. Seven had spent some time in Europe. Only one—Canadian Walter Chipman, MD, FACS—had both undergraduate and medical degrees, several years of hospital graduate training, and then certification, all acquired in the U.K. The founders were most concerned that this new organization serve to “elevate the standards of surgery,” to do what’s right for the patient. At the organizing meeting in May 1913, Albert J. Ochsner, MD, FACS, said, “The young...who come into the profession...will have made good not only technically and scientifically but morally.”

In November 1913, the Regents formally adopted the name American College of Surgeons and the initials FACS to denote membership. The Clinical Congress of Surgeons of North America became the Clinical Congress of the American College of Surgeons in 1917.

**Requirements for Fellowship**

Each applicant was required to report the complete records of 50 consecutive major operations as surgeon and 50 abstracts of major operations in which they were surgeon or first assistant; but a problem became apparent. Hospital records were found to be incomplete or nonexistent, so that many could not complete the application. At the Regents’ meeting in 1915, Charles H. Mayo,

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**THE OATH, 1913:**

...“to place the welfare of my patients above all else.”

...“I pledge myself not to stoop to secret money trades with consultants.”

**FELLOWSHIP PLEDGE, 2016:**

“I pledge to place the welfare and rights of my patients above all else.”

“I will take no part in...improper financial dealings that induce referrals.”
Dr. Finney, MD, FACS, said, “In this entire country there is not even a minimum of hospital standards.” The Committee on Hospital Standards was established with Ernest Amory Codman, MD, FACS, as chair. In 1916, ACS Director John Bowman, MD, FACS, reported at the annual meeting of the Fellows that the problems with incomplete hospital records and facilities would be addressed with the proposed hospital survey process and said, “This work is not merely something, which we may do; it is something which we must do. It is our business to know what real training in surgery means.” He went on to describe the distribution of a “series of pamphlets…to set out the essentials which make hospitals the right sort of institution for the care of the sick…written so simply that the man who moves his lips when he reads can understand.”

The Minimum Standards published
In 1918−1919, College staff visited 692 general hospitals of 100 or more beds. The plan was to report the results of the surveys with names of the hospitals at the 1919 Annual Meeting. When the Regents learned that only 89 of 692 hospitals met the Minimum Standards, the report was not delivered; the data were burned. The object of the standards was to help hospitals meet them. In his Presidential Address that year, William J. Mayo, MD, FACS, said, “…the College will demand special training…it is our duty to see that these facilities are developed.” By 1920, more than 400 hospitals met the standards. George D. Stewart, MD, FACS, in his 1928 Presidential Address, reported that the American Automobile Association published a yearbook that contained a list of all the hospitals in America approved by the American College of Surgeons. Hospitals prominently displayed the certificate of approval.

By 1950, the hospital verification program consumed so many resources of the College that an independent body, now known as The Joint Commission, was created in 1952 to take up this work.

Surgical training
Hospitals were the training ground of surgeons. With the hospital standards in place, it was time to establish standards for graduate training programs. Malcolm T. MacEachern, MD, FACS, ACS Associate Director, led this effort. In 1936, the Regents required that applicants for Fellowship who received a medical degree after 1938 must have three years of hospital service, and two years in a hospital approved by the College. The next year the requirement that the medical school be approved by the College was added. A comprehensive survey of graduate training in surgery by College staff in 1937−1938 concluded that there was “no basic standard of uniformity in the methods of graduate training.” In 1938, the criteria for training and a manual for hospitals that sought approval for their training programs were established. The standards focused on the hospital and the resident and prescribed regular inspection of the hospitals. The College established the first Residency Review Committee, as it is now known, in the U.S.

The importance of the standards for hospitals and standards for surgical training cannot be emphasized enough. These programs, instituted by an organization of volunteers, fundamentally and profoundly changed how medicine was practiced and physicians were trained in the U.S. Patients were no longer operated
on in the home. Surgeon training was standardized. If the College had ceased to exist at this point, it would have more than fulfilled the expectations of Drs. Martin and Finney and of the other founders—but that did not happen.

The College has continued to be dedicated to inspiring quality, to maintaining the highest standards, and to ensuring better outcomes. Medical knowledge and technology are continuously and rapidly expanding. The College has kept pace by developing educational and training resources to prepare surgeons to enter practice and for practicing surgeons to adapt. There have been many quality and educational programs (they are inextricably linked) carried out by the College since its founding. I would like to focus on three programs—the Commission on Cancer (CoC), the Committee on Trauma (COT), and the Committee on Emerging Surgical Technology and Education (CESTE)—as examples of how the Fellows continue to recognize opportunities for improvement, seize them, and establish standards to ensure quality.

### Commission on Cancer

The ACS Committee on Treatment of Malignant Diseases with Radium and X Ray was established in 1922. In keeping with the quality efforts of the hospital approvals program, the “Minimum Standard for Cancer Clinics in General Hospitals” was issued in 1930. The primary purpose of this body was to ensure that patients would receive quality cancer care in their community hospitals. In 1953, the committee issued a manual titled *A Standardized Method for Reporting Cancer End Results*. The influence of Dr. Codman...
was never-ending. Recognizing the multidisciplinary nature of optimal cancer treatment, other organizations joined the College to create the Commission on Cancer. The cancer hospital accreditation program now covers 70 percent of incident cancers, with more than 1,500 participating hospitals. The National Accreditation Program for Breast Centers, initiated in 2008, has 650 accredited centers. The accreditation process for all of the College programs is used not only for initial survey to verify achievement of program standards, but also for reverification. The National Cancer Database contains more than 30 million cancer cases.

Committee on Trauma
The American Surgical Association formed a committee to evaluate the results of treatment of simple fractures of the femur in 1890. At the annual meeting in 1921, a report was issued that recommended the use of a standard fracture report form, which was recognized by the College. In 1922, the Regents established the Committee on Treatment of Fractures with Charles Scudder, MD, FACS, as Chair. The original organizational structure, with area chairs and local chairs, emphasized the grassroots participation of Fellows and continues to the present. A Manual on Treatment of Fractures was issued in 1931, and the COT was formed in 1939. An updated manual, Resources for Optimal Care of the Injured Patient, first issued in 1976, is now in its sixth edition.
That same year, an airplane crash involving James K. Styner, MD, FACS, and his family occurred in rural Nebraska. No appropriate facilities or standardized approaches for evaluation and management of severely injured patients were available in the area. In a widely read editorial, Dr. Styner noted that folks were probably tired of hearing him criticize the treatment he received prior to transport to Lincoln. He enlisted the participation of several other surgeons in developing a trauma training course for physicians in Nebraska. Paul Collicott, MD, FACS, at the time a practicing surgeon in Nebraska as well, participated and took the lead in developing the course called Advanced Trauma Life Support® (ATLS®)—modeled on Advanced Cardiac Life Support (ACLS), also developed by a group led by a Fellow in Lincoln. ATLS was approved by the COT in 1979 and by the Board of Regents in 1980. In 1980, 41 courses trained 460 students. In 2015, 3,113 courses trained more than 48,000 students. Since the first course, more than 1.5 million students have participated in more than 75,000 courses. ATLS now ranks as the College’s most widely known and successful educational and quality program. Successful completion of ATLS is required for American Board of Surgery certification. ATLS and other courses of the College are used not only for initial training, but also for periodic retraining to maintain knowledge and skills.

The trauma center verification program began in 1987. At present, more than 450 programs have COT accreditations, and 29 have both adult and pediatric center accreditation.

Another current Fellow and ACS Regent, Lenworth M. Jacobs, Jr., MD, MPH, FACS, recognized the dearth of experience surgeons had in managing penetrating trauma and led a group in developing a course in Advanced Trauma Operative Management, ATOM, which the College adopted in 2008. Furthermore, in response to the tragedy at Sandy Hook Elementary School in Newtown, CT, he formed the Hartford Consensus™ to improve the nation’s ability to respond to mass casualty incidents.
Committee on Emerging Surgical Technology and Education

The laparoscopic surgical revolution began June 22, 1988. On that day in Marietta, GA, J. Barry McKernan, MD, FACS, assisted by William Saye, MD, a gynecologist, performed the first laparoscopic cholecystectomy in North America. By September of that year, Eddie J. Reddick, MD, FACS, and Douglas O. Olsen, MD, FACS, in Nashville, TN, reported their case on the national news and the next year at the Clinical Congress they had a booth with a continuous loop video of the procedure; surgeons flocked to see it. Practicing surgeons began to attend courses—usually over a weekend—that were often commercial ventures, were for the most part observational, and lacked hands-on experience. Attendees would return home, have the hospital order the equipment, and begin to operate on patients. It was “see one, do one, and teach one.” The learning curve for laparoscopic cholecystectomy was steep; complications soared.

The College recognized that the courses were informal exercises that were irregular in quality and focused only on techniques. There was no standardized curriculum and no documentation of skills acquisition. In 1992, the Regents established CESTE with Jim Carrico, MD, FACS, as chair. The committee’s charges were as follows: develop a system and a process to evaluate/reevaluate new technology; develop standards for teaching and assessment of skills; recommend standards for credentialing surgeons in new technology; and initiate outcomes research. Two of the most important education and quality programs of the late 20th century, the Accredited Education Institutes (AEI) and the Division of Research and Optimal Patient Care (DROPC) sprang from CESTE.

In 2001, Ajit K. Sachdeva, MD, FACS, FRCSC, an internationally recognized scholar and early champion of surgical simulation, was recruited to lead the Division of Education in developing new, innovative programs. In 2005, the Regents adopted the AEIs, which provide standardized education and training to adopt new technology or a new procedure, and
are useful for all stages of a surgeon’s career from residency to retooling as surgical practice evolves.

In 2004, R. Scott Jones, MD, FACS, 82nd President of the ACS, became founding Director of DROPC and assumed responsibility for bringing the Veterans Affairs (VA) National Surgical Quality Improvement Project to the College. More than 750 non-VA hospitals now participate in this most important, risk-adjusted outcomes measurement program aimed at quality improvement.

Loyal Davis, MD, FACS, 43rd President of the ACS, wrote, “No other medical organization, voluntarily entered into by its Fellows, has exerted such a profound influence on the discipline and art of surgery in the United States.”

The future belongs to you

So, that is the who, why, what, and how.

Now where do we go? That is up to you.

Surgeons have been responsible for the development and progress of surgery since the early 20th century. The 21st century belongs to you. Our College is the largest organization of surgeons in the world. I want to encourage you to participate in all the activities of the College—for your benefit, and for the benefit of your patients. Participate at the local, state, and national levels and establish personal relationships with leaders at all levels. Be an advocate for our education and quality programs, join the online ACS Communities and your state chapters, and serve as a Governor. Attend the annual Leadership & Advocacy Summit, in Washington, DC. Most importantly, attend the annual Clinical Congress to keep abreast of the latest developments in our profession and to network with other Fellows.

This is your College. It will be what you make it. I am confident that there are those among you who will become leaders to continue the evolution and progress of the College, to inspire quality, to maintain the highest standards, and to ensure better outcomes.

Remember these words by Emily Dickinson: “Surgeons must be very careful when they take the knife! Underneath their fine incisions stirs the culprit—life!” Welcome to the American College of Surgeons.

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Surgery in the U.S. is undergoing a paradigm shift, with safety, quality, and patient-centered care now driving care delivery processes and payment. As a result of the passage of the Medicare Access and CHIP (Children’s Health Insurance Program) Reauthorization Act, major changes are being proposed as part of a new Quality Payment Program (QPP), which will be implemented in 2017 by the Centers for Medicare & Medicaid Services (CMS) with the goal of aligning payment with high-quality care.  

At the same time, the population is rapidly aging, placing significant stress on the health care system. Older adults comprise a growing portion of the surgical population and affect all health care settings, including large and small hospitals, urban and rural locales, and university and community facilities. According to the U.S. Census Bureau, the proportion of adults ages 65 years and older is projected to grow from 15 percent in 2015 to 24 percent of the population in 2060. This rapidly growing segment of the population constitutes a large part of the medical and surgical care provided in the U.S. Patients older than age 65 account for approximately 38 percent of hospital discharges in 2010, according to data from the National Hospital Discharge Survey. A total of 51.4 million procedures were performed across the U.S. in 2010, with 19.2 million of those operations performed on patients ages 65 and older. The aging of the population will lead to a significant increase in the demand for surgical services, and surgeons must

**HIGHLIGHTS**

- Points to the aging U.S. population and efforts to align Medicare payment with quality of care as key reasons for an increased emphasis on improving geriatric surgical care
- Describes the College’s ongoing efforts to improve quality of care for the surgical patient
- Outlines the development and status of the ACS quality improvement activities specific to geriatric patients, led under the aegis of the Coalition for Quality in Geriatric Surgery
- Offers insights into the future direction of the College’s activities in this area

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Improving quality in geriatric surgery:

**A blueprint from the American College of Surgeons**

by Marcia M. Russell, MD, FACS; Julia R. Berian, MD, MS; Ronnie A. Rosenthal, MD, MS, FACS; and Clifford Y. Ko, MD, MS, MSHS, FACS, FASCRS
Although the role of the surgeon is usually focused on the technical activities in the operating room, the complex needs of an elderly surgical population require a broader perspective.

New model for surgical care
Although the role of the surgeon is usually focused on the technical activities in the operating room, the complex needs of an elderly surgical population require a broader perspective. Increased attention to preoperative risk assessment, explicit communication with the patient and family regarding goals of care as well as anticipated functional outcomes, and an emphasis on postoperative rehabilitation must be as much a part of the job as the execution of the technical aspects of surgery. In addition, due to advances in surgical technique, anesthesia, and postoperative care, surgical procedures are safer and in-hospital mortality rates are low. For older adults, the new focus on patient safety and quality no longer revolves solely around surgical morbidity and mortality; patient-centered issues have now gained importance, including quality of life, maintenance of independence, and return to preoperative level of functioning. A patient’s personal health care goals become increasingly important for older, complex patients who may lack the physiologic reserves of younger adults and often prioritize quality over quantity of life when making health care decisions.

The combination of these forces created demand for the development of a new model for surgical care of older adults to ensure the provision of efficient and optimal care for this vulnerable population. The National Academy of Medicine defines health care quality as the delivery of safe, effective, patient-centered, timely, efficient, and equitable care. It is clear that care for the elderly surgical patient must fulfill each of these domains. The paradigm shift in surgery will affect not only how the health care system provides care for elderly surgical patients, but also how surgeons are trained. The American College of Surgeons (ACS) has been a leader in surgical quality improvement and surgeon education through its quality programs in specialties such as trauma, cancer, and bariatrics. The time has come to take on the same role for geriatric surgery.

ACS leadership in surgical quality
Throughout its more than 100-year history, the ACS has been dedicated to promoting high-quality care. The College now has extensive experience in the development and verification of quality improvement (QI) programs across various multidisciplinary surgical conditions or populations, including trauma, cancer, and bariatric surgery. These programs are based on four principles:

- Set the standards, individualized by patient and supported by research
- Provide the right infrastructure, including staffing composition and equipment
- Measure the outcomes using the right data
- Verify that the standards, the infrastructure, and the data are meeting expectations

At present, more than 3,000 hospitals are accredited through one or more ACS Quality Programs.

Building on the strength of the College’s Quality Programs, the ACS partnered with the John A. Hartford Foundation to develop a geriatric surgery QI program based on these same principles. The Coalition for Quality in Geriatric Surgery (CQGS) Project is
a four-year initiative to define the processes, resources, and infrastructures necessary to provide optimal care of the older adult surgical patient. The project aims to guide improvement for all hospitals, regardless of size, location, or teaching status. The CQGS comprises a nine-member core development team, including surgeons, nurses, and geriatricians with expertise in geriatric surgery, ACS staff, and research scholars. The CQGS is supported by a diverse group of more than 50 stakeholder organizations. The seven overarching goals of the CQGS Project are as follows:

• Set the standards
• Engage key stakeholders
• Develop measures that matter
• Develop the verification process to ensure delivery of high-quality care
• Educate patients and providers
• Pilot the program
• Launch the Geriatric Surgery Quality Campaign

The evidence and expert-based standards will provide a framework that will be scalable and generalizable to all facilities that perform surgical care for older adults. The standards will ultimately form the foundation for the development of age-appropriate and patient-centered outcome measures, as well as the verification program, which will not only audit adherence to the standards, but will define the processes for assuring continuous quality improvement and patient safety.

Improving quality of care for older adults
The health care community has developed many tools to support the evaluation and improvement of care of the geriatric surgical patient. Examples include guidelines, quality indicators, National Quality Forum-endorsed quality measures on elderly surgery outcomes, and products developed from the ACS National Surgical Quality Improvement Program (ACS NSQIP®), including the Surgical Risk Calculator (see related article, page 29); a data registry with geriatric-specific variables such as postoperative delirium and functional status at hospital discharge; and consortia/collaboratives on geriatric surgery. The next logical step is to assemble these tools together into a feasible and generalizable set of standards that will provide a multi-layered approach to the optimal care of the older surgical patient.

The issues surrounding quality of care for the elderly patient differ from those affecting younger patients. First, the degree of comorbid disease burden is higher in elderly patients, requiring closer attention to preoperative optimization of cardiovascular, pulmonary, renal, and endocrine status.

Second, the assessment of geriatric syndromes, including cognitive impairment, malnutrition, and risk of falls or pressure ulcer development, should be considered a standard part of the routine preoperative evaluation. Assessment of baseline cognitive, nutritional, and functional status will not only guide the perioperative care of the elderly patient, but may affect the patient-provider discussions regarding aggressiveness of surgical intervention as well as provide a baseline level for comparison of these measures upon discharge from the hospital.

Third, the quality of care for elderly surgical patients is more complex due to diminished physiologic reserves, which affects the ability to withstand perioperative stress. Therefore, prevention of perioperative morbidity (delirium, infection, deep venous thrombosis, myocardial ischemia, and so on) becomes the emphasis for this vulnerable population.

Finally, patient-provider discussions become increasingly important to define the goals of surgical intervention as well as the extent of life-sustaining interventions in the event of untoward postoperative complications. The goals of care may range from a
decision not to pursue surgical intervention, to pal-
liation of malignant bowel obstruction, to curative
colorectal cancer resection.

Traditional outcomes measures in surgery include
morbidity and mortality; however, additional out-
comes measures are appropriate in the elderly
population given the emphasis on quality of life
rather than on prolongation of life. The typical defi-
nition of postoperative morbidity must be expanded
to include postoperative events more commonly seen
in the elderly population, including episodes of post-
operative delirium, in-hospital falls, development of
a pressure ulcer, and maintenance versus decline of
functional or cognitive status. A primary outcome of
interest after surgical intervention in the elderly pop-
ulation should be the ability to return to the previous
living environment, as well as the level of function
before surgery, which may require looking beyond
the traditional end point of 30 days after surgery.
Therefore, the location of discharge after surgery (for
example, home versus skilled nursing facility), the
functional status as measured by activities of daily
living, and ambulation become important outcomes
for the elderly patient undergoing surgery.

What have we done so far?
The discipline of geriatrics is becoming an important
part of the care on the surgical ward, which has implica-
tions for how to train, teach, and restructure the surgical
unit for both surgeons as well as other health care professionals.

Internal medicine has made changes in the accredit-
ation process of residency programs to ensure
that the emphasis on quality of care also is translated
into quality of training. In this regard, many potential
tools are available to effect policy changes within the
field of surgery and improve the care for elderly surgical
patients.

It is important to embrace the shift toward inter-
disciplinary care of surgical patients. In the traditional
surgical model, the surgeon rounds on their patients
twice a day while the nursing staff is primarily trained
to manage the technical aspects of the patient’s post-
operative recovery. A new model may be required for
elderly surgical care, more in line with a team approach
and integration of providers, including surgeons, anes-
thesiologists, geriatricians, general internists, medical
specialists, and rehabilitation specialists, as well as
nursing, physical/occupational therapists, speech
pathologists, nutritionists, and care transition profes-
sionals (such as social work, case management, and
discharge planning personnel). The team approach
is central to the success of this model because the
elderly surgical patient often brings an amalgam of
both medical and surgical comorbidities, in addition
to a range of capabilities with respect to cognition,
ambulation, psychosocial needs, and degree of inde-
pendent self-care. No single provider can maintain the
optimal care needed for an elderly patient undergoing
a major surgical procedure because the cross-cutting
issues of nutrition, cognition, rehabilitation, manage-
ment of comorbid disease burden, and postoperative
surgical care require coordination among multiple
health care providers. Furthermore, multidisciplinary
care for older adults is critical across the phases of care
from the preoperative assessment, to postoperative
recovery, to discharge from the hospital.

A second tool that may be used to address the unique
issues of elderly surgical care is best practice guidelines.
In 2012, the ACS and the American Geriatrics Society
(AGS) entered a partnership with the John A. Hartford
Foundation to synthesize the available evidence on pre-
operative care for elderly patients. This collaboration
resulted in the development of the Optimal Preoper-
ative Assessment of the Geriatric Surgical Patient: A
Best Practices Guideline from the American College
of Surgeons National Surgical Quality Improvement
Program and the American Geriatrics Society.”15 This
protocol provides a clear framework for conducting
preoperative evaluation of geriatric surgical patients,
emphasizing the importance of cognitive assessment,
depression and substance abuse screening, cardiac and
pulmonary evaluation, documentation of functional
status and history of falls, evaluation of nutrition status
and polypharmacy, and inquiry into the patient’s understanding of treatment goals and expectations.\textsuperscript{15}

A follow-up set of guidelines detailing best practices for care in the perioperative period (including immediate pre-, intra-, and postoperative phases) was released in 2016.\textsuperscript{16} Recommendations range from a purposeful reconsideration of treatment preferences, to modification of perioperative anesthetic medications, to pain management and delirium prevention postoperatively, to the importance of clear discharge instructions and communication with the primary physician during the transition from the hospital to home.

In addition, the John A. Hartford Foundation has supported the development of the AGS clinical practice guideline for postoperative delirium in older adults.\textsuperscript{18} This guideline meets the rigorous standards set forth by the Institute of Medicine (now the National Academy of Medicine) Committee on Standards for Developing Trustworthy Clinical Practice Guidelines.\textsuperscript{19} Its report provides recommended pharmacologic and non-pharmacologic interventions that should be implemented perioperatively both for the prevention and, if needed, treatment of postoperative delirium in older adults.

**ACS NSQIP Geriatric Surgery Pilot Project**

Special attention must be paid to geriatric-specific risk factors and outcomes. The ACS NSQIP Geriatric Surgery Pilot Project, launched in 2014, includes 26 hospitals that are collecting data on four important patient-centered domains: cognition, decision making, mobility, and function.\textsuperscript{20} Within each domain, the pilot collects data on both preoperative and postoperative variables. For example, cognition variables include whether a patient has preoperative cognitive impairment or experiences an episode of postoperative delirium. Similarly, the mobility domain includes information about a history of falls and whether a new mobility aid is required at the time of discharge. Examining changes in mobility, functional status, and discharge destination (home versus facility), the Geriatric Surgery Pilot data may be used to improve understanding of patient-centered outcomes. Loss of independence, defined as decline in mobility or function or the need for new assistance in the post-discharge living situation, occurred among almost half of older adults postoperatively and was significantly associated with not only readmission, but also death after discharge.\textsuperscript{6} The ACS NSQIP Geriatric Surgery Pilot has now collected geriatric-specific data on more than 25,000 older adults. As these data points become easier to collect, awareness and responsiveness to geriatric-surgery issues will continue to improve. It is clear that quality of care cannot be limited to the immediate hospitalization. The pilot has recently expanded its use of longer-term outcomes and has begun collecting 30-day outcomes of functional status and living location. Future work will aim to incorporate patient-reported outcomes into the ACS NSQIP clinical data.

### TABLE 1. SUGGESTED STRATEGIES TO IMPROVE SURGICAL CARE OF OLDER ADULTS

<table>
<thead>
<tr>
<th>Steps for improved surgical care of older adults</th>
<th>Action items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elicit patient goals</td>
<td>Ask separately about the patient’s overall health goals and the patient’s goals specific to the procedure</td>
</tr>
<tr>
<td>Perform geriatric risk assessment preoperatively</td>
<td>Examples: Administer the “mini-cog” to assess cognition.\textsuperscript{21} This exam includes three steps: (1) provide three words for recall, (2) clock drawing, (3) ask patient to recall the three words from step 1. Timed up-and-go test to assess ambulation; includes the time required for patient to stand from a chair, walk three meters or 10 feet, then return to chair and sit down.\textsuperscript{22,23}</td>
</tr>
<tr>
<td>Educate health care professionals about geriatric-specific issues</td>
<td>Visit facets.org/geriatrics to access the Pre- and Peri-Operative Guidelines for Optimal Management of the Geriatric Surgical Patient and to learn more about the CQGS Project</td>
</tr>
<tr>
<td>Increase communication across disciplines and phases of care</td>
<td>Engage multidisciplinary care at your hospital: Discuss high-risk older adults at a preoperative conference or enact postoperative multidisciplinary team rounds</td>
</tr>
</tbody>
</table>
registry, which will provide more detailed and granular information to improve surgical decision making and align the care provided with patient goals.

Bringing together all of this groundwork, the CQGS Project seeks to improve the quality of surgical care for older adults, regardless of the hospital’s size, location, or teaching status. The CQGS has engaged more than 50 stakeholder organizations, including groups representing the various surgical disciplines, anesthesia, geriatrics, nursing, social work, pharmacy, patient advocacy, emergency medicine, physical therapy, community resources, advocacy and regulatory organizations, and, perhaps most importantly, patients and families.

Two formal stakeholder meetings occurred in the first year of the project. The goal of the first meeting was to map out the gaps in surgical care against the ideal future state of surgical care for older adults. These goals are represented in Table 1, page 26, and have been used to develop recommendations to immediately improve care. In addition, based on the input from the first stakeholder meeting, extensive literature searches, in-person field visits to hospitals across the nation, and targeted input from key stakeholders, 308 preliminary standards were drafted.

At the second stakeholder meeting, these preliminary standards were discussed and rated by the stakeholders for both validity and feasibility using a modification of the RAND/University of California, Los Angeles, Appropriateness Method. The analysis of stakeholder ratings is under way to produce the final set of standards defining the optimal care of the older adult surgical patient across the preoperative, intraoperative, postoperative, and transition to home phases of care.

The near future
As the CQGS Project continues to evolve, the standards will be finalized and attention will turn toward measurement. The project will soon begin development of an online registry that will allow hospital staff from across the country to enter data, view comparisons, and learn from best practices.

REFERENCES
The project will soon begin development of a data registry that can track important data elements and outcomes as defined by the standards. The project aims to develop measures that matter to older adults, which may include longer-term outcomes like a return to previous level of functioning.

of a data registry that can track important data elements and outcomes as defined by the standards. The project aims to develop measures that matter to older adults, which may include longer-term outcomes like a return to previous level of functioning. Drawing on the experience of the ACS NSQIP Geriatric Surgery Pilot Project, we will begin to refine patient-centered outcomes in important domains, including cognition, function, mobility, and decision making.

As the payment system shifts in the coming years, many payors, including CMS, will attempt to better align compensation with quality of care. The CQGS Project will provide a streamlined set of standards for processes of care, and a system for data collection and measurement of outcomes that are not only important to providers but also to the patients whom we serve. Furthermore, external peer verification will provide public assurance of the quality of care for older surgical patients. With the newly proposed QPP, the current project has the potential to contribute meaningful quality metrics for surgeons who care for older adults.

Conclusion

The expanding and aging U.S. population has created a growing demand for high-quality care in geriatric surgery. As the population continues to age, the number of elderly patients requiring surgical intervention will continue to increase. Surgeons, geriatricians, internists, and other health care providers need to become more familiar with the complex interdisciplinary issues unique to the growing elderly patient population. It is the vision of the ACS, in partnership with the John A. Hartford Foundation, that the CQGS project will lead the effort to improve care for every older surgical patient. ♦

REFERENCES (CONTINUED)

The American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP®) Surgical Risk Calculator was developed in 2013 as a decision support tool to “provide accurate, patient-specific risk information to guide both surgeon decision making and informed consent.”1-3 Since the introduction of the ACS NSQIP Surgical Risk Calculator, several studies have been published validating its use for a range of surgical procedures.4-7 Little has been published, however, about how this important tool may also be used for surgical education in addition to quality improvement in clinical practice.

This article describes our experience with incorporating the ACS NSQIP Surgical Risk Calculator (see Figure 1, page 30) into weekly morbidity and mortality (M&M) conferences at the department of surgery, New York Presbyterian Hospital Weill Cornell Medicine, NY.

What we did
Each week, the chair of quality improvement in our department selects cases for presentation at the M&M conference. The decision regarding which cases will be presented is based on several criteria, including perceived educational value, opportunities to improve patient care, and whether the cases highlight systems-related or multidisciplinary issues that may arise in our institution. Beginning in June 2014, all residents were asked to include the ACS NSQIP Surgical Risk Calculator in each M&M case presentation. We conducted a retrospective chart review from June 2014 to December 2015 to determine the implementation of the risk calculator in our M&M conferences.

What we found
We reviewed 124 M&M cases during the 18-month study period. Of those cases, 13 (11 percent) cases did not include use of the ACS NSQIP Surgical Risk Calculator. A total of seven of those 13 procedures had Current Procedural Terminology (CPT) codes that could not be accurately captured...
using the risk calculator. Three additional cases (2 percent) used the calculator for the wrong procedure. After excluding these 16 M&M presentations, 108 (87 percent) cases were deemed appropriate for analysis.

The median age of patients discussed in these M&M presentations was 59 years old. A total of 73 cases (68 percent) were elective while 35 cases were classified as urgent/emergent (32 percent). Of the 90 M&M cases (83 percent) that involved intra-abdominal operations, 58 (64 percent) were open procedures, and the remaining 32 (36 percent) were laparoscopic or endoscopic cases. Residents used the “surgeon adjustment” function in 21 (19 percent) cases to estimate that their patients were actually at higher risk than the calculator had determined independently.

The ACS NSQIP Surgical Risk Calculator estimated that 61 patients were at “above average” risk (56 percent) for the primary complication they developed. In contrast, 29 patients (27 percent) were estimated to be at “below average” risk, and the remaining 18 (17 percent) were estimated to be at “average” risk (see Figure 2, page 31). Of the 29 patients who were at “below average” risk, the most common complications were return to operating room (10 patients, or 34 percent) and venous thromboembolism (seven patients, or 24 percent). Eight of the “below average” cases involved procedures that had CPT codes that could not be accurately captured using the ACS NSQIP Surgical Risk Calculator, including single incision laparoscopy (2), robotics (2), and laparoscopic conversion to open (4).

What it means
To our knowledge, this is the first article to describe the use of the ACS NSQIP Surgical Risk Calculator during weekly M&M conference as a tool for educating surgery residents on risk assessment and quality improvement. Our findings confirm that it is feasible to have surgery residents incorporate the risk calculator in M&M presentations and that the ACS NSQIP Surgical Risk Calculator may serve as an important tool for educating surgery residents about the importance of risk assessment and quality improvement. This innovative approach to M&M arguably touches on all six of the Accreditation Council for Graduate Medical Education (ACGME) core competencies of resident education: patient care and technical skills, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. An important next step of this study is to measure the effect on resident education of using the risk calculator during M&M presentation.
Another important finding of the study is related to the fact that most of these M&M cases were considered to have an “above average” risk for the complication ultimately developed by the patient. Several “below average” cases, as well as those M&M cases that did not involve the ACS NSQIP Surgical Risk Calculator, were for procedures that did not have CPT codes that could be accurately captured using the risk calculator. Future studies should focus on validating this tool’s ability to estimate the risk of complications for particular circumstances, including laparoscopic conversion to open, single-incision laparoscopic surgery, and robotic surgery.

Another possible next step for future research is to use the ACS NSQIP Surgical Risk Calculator as part of M&M case selection. Whereas our study found the highest proportion of M&M cases was composed of above-average risk complications, perhaps the risk calculator should be used to identify below-average risk cases for M&M presentation. These below-average risk cases may indicate postoperative complications that are worth discussing to highlight areas for quality improvement.

It should be noted that our study had several limitations. First, it involved a retrospective chart review, and selection of cases for M&M presentation was subjective, leading to a potentially biased cohort. Furthermore, the study was not designed to validate the ACS NSQIP Surgical Risk Calculator or detect any statistically significant differences in complication rates. This was not a stated objective of our study, however, because our primary goal was to provide a qualitative description of our experience using the risk calculator.

Nevertheless, our study demonstrates the feasibility of using the ACS NSQIP Surgical Risk Calculator as part of surgical education during M&M presentations. Future studies are needed to determine the effect of this important tool on uptake of the ACGME core competencies.

Editors’ note
This topic was presented as a poster and oral presentation at the 2016 ACS NSQIP Annual Conference Monday, July 18, in San Diego, CA.
The 2017 Inpatient Prospective Payment System: What it means for surgery

by Molly Peltzman, MA

The Centers for Medicare & Medicaid Services (CMS) released the Inpatient Prospective Payment System (IPPS) final rule August 2. The final rule establishes fiscal year (FY) 2017 (October 1, 2016, through September 30, 2017) policies for Medicare payments to hospitals for inpatient stays. Under the IPPS final rule, the payment rate update to general acute care hospitals is 0.95 percent for FY 2017. The rule also updates payments for inpatient services provided by certain IPPS-exempt providers, such as cancer centers and children’s hospitals and religious nonmedical health care institutions. The American College of Surgeons (ACS) submitted comments to CMS on the proposed IPPS rule released in April, which CMS took into consideration when drafting the final regulation.

Because the IPPS rule outlines coverage criteria for Medicare Part A inpatient hospital claims, and a large proportion of surgical care is provided in the inpatient setting, this rule is likely to affect many surgical practices. The IPPS rule contains hospital pay-for-performance and pay-for-reporting programs that require the reporting of quality metrics, many of which measure surgical outcomes. For example, hospitals that fail to participate successfully in the Hospital Inpatient Quality Reporting (IQR) program or are not meaningful users of electronic health records (EHRs) are ineligible for the full percentage increase. CMS finalized a few changes to the measures used in these programs. This article describes some of the future measure changes that CMS finalized.

Changes to the IQR program

The Hospital IQR program is a pay-for-reporting program that requires hospitals to report specific quality measures to CMS. Successful participation is determined based on whether hospitals report the Hospital IQR measures—not how hospitals performed on those measures. Pay-for-reporting programs differ from pay-for-performance programs in that pay-for-performance programs determine reimbursement on a hospital’s performance with respect to specified measures. The IQR program provides an opportunity to further analyze and understand the usability of measures and their effects before they are incorporated into pay-for-performance programs, such as the hospital Value-Based Purchasing (VBP) program. Under the hospital IQR program, hospitals must meet the requirements for reporting specific quality information to receive the full market basket update for that year.

In the rule, CMS has finalized both the removal and adoption of surgical measures from the IQR program for FY 2019. CMS finalized the removal of the surgical measure Participation in a Systematic Clinical Database Registry for General Surgery because it is purely
Because the IPPS rule outlines coverage criteria for Medicare Part A inpatient hospital claims, and a large proportion of surgical care is provided in the inpatient setting, this rule is likely to affect many surgical practices.

structural and does not provide information on patient outcomes, given that hospitals only state whether they participate in registries. Additionally, CMS has added two surgery-related measures to the IQR program for FY 2019 and subsequent years. The first is a clinical episode-based payment measure, Cholecystectomy and Common Duct Exploration Clinical Episode-Based Payment, which was added because of the high costs and substantial variation associated with these services, according to the final rule. The second is an outcome measure Excess Days in Acute Care after Hospitalization for Pneumonia that was added because of concerns that readmissions are costly, expose patients to additional risks, interfere with work and family care, and impose significant burden on caregivers. CMS also supports limiting the measure to inpatient utilization because a lack of restrictions may make the measure susceptible to gaming, or manipulating reporting, that could distort a provider’s performance.

Changes to the VBP
The hospital VBP program is a pay-for-performance program and part of CMS’ effort to link payment and value to improve the quality of care provided in an inpatient hospital setting. Under the hospital VBP program, CMS calculates a hospital’s incentive payment based on performance on specified measures that were reported on for the IQR.

In the IPPS final rule, CMS made changes to the measures included in this program for FY 2018, one of which is relevant to surgical care. CMS finalized a reporting change for the patient safety indicator-90 (PSI-90): Patient Safety for Selected Indicators composite measure to accommodate the 10th revision of the International Classification of Diseases (ICD-10) transition. The PSI-90 measure steward, the Agency for Healthcare Research and Quality, is reviewing any potential issues related to ICD-10 conversion of coded operating room procedures; while that effort is being completed, CMS will only use ICD-9 codes. The new performance period for PSI-90 will measure 15 months instead of the previously adopted 24 months. The shortened performance period will apply only in the FY 2018 program year.

In addition, CMS has adopted new measures for FY 2021 that include risk-standardized payment associated with a 30-day episode of care for acute myocardial infarction (AMI) and risk-standardized payment associated with a 30-day episode of care for heart failure (HF). Both AMI and HF are high-volume conditions, and evidence of variation in hospital payments shows variation in payment for patients with these conditions among hospitals. CMS supports the position that these measures cover topics of critical importance to quality improvement in the inpatient hospital setting and that it is appropriate to offer strong incentives for hospitals to provide high-value and efficient care.

Changes to the HAC Reduction Program
Since October 1, 2014, the Affordable Care Act has required that CMS establish an incentive for hospitals to reduce the incidence of hospital-acquired conditions (HACs) and improve patient safety by imposing financial penalties on hospitals with high instances of the HACs specified under this program. A 1 percent payment reduction applies to a hospital with poor performance whose ranking is in the top 25 percent of all applicable hospitals relative to the national average. The HAC Reduction Program adjustment is applied after adjustments are made under the hospital VBP program and the Readmissions Reduction Program.
The HAC Reduction Program is separate from, and an adjunct to, the HAC program, which withholds payments to hospitals for select conditions not present upon a patient’s admission to the hospital.

The HAC Reduction Program also requires hospitals to report PSI-90. Several changes were made to PSI-90, including:

- Addition of PSI-9 (perioperative hemorrhage or hematoma rate), PSI-10 (physiologic and metabolic derangement rate), and PSI-11 (postoperative respiratory failure rate)
- Removal of PSI-7 (central venous catheter-related bloodstream infection rate)
- Specification changes to PSI-12 (perioperative pulmonary embolism) and PSI-15 (accidental puncture or laceration rate)
- Weighting of individual measures based on both volume of the adverse event and harm associated with adverse event

PSI-9, PSI-10, and PSI-11 were added to the composite to better capture the range of PSI events. PSI-7 was removed due to concerns that the measure overlapped with another similar measure that addresses the same condition (central line infections) within the HAC Reduction Program. Changes were made to the specifications of PSI-12 and PSI-15 to help identify events that are more statistically significant. Additionally, PSI-90 was reweighted so that the measures were not based solely on volume, but also on the level of excess clinical harm and outcome severity.

The ACS supports CMS’ decision to remove PSI-7 and the reweighting of PSI-90. The new weighting mechanism, along with the addition of indicators and the removal of PSI-7, more equally distributes the component weights compared to earlier versions. The revised weighting approach offers a better measure of adverse events that patients experience in U.S. hospitals, supporting performance comparisons based on a hospital’s ability to safeguard patients from these incidents.

The FY 2017 IPPS final rule can be accessed at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2017-IPPS-Final-Rule-Home-Page.html. Background information and IPPS resources are available on the ACS website at facs.org/advocacy/regulatory/medicare-a-b#ipps. If you have questions regarding IPPS, contact Molly Peltzman, Quality Associate, ACS Division of Advocacy and Health Policy, at mpeltzman@facs.org.
STATE LEGISLATIVE WRAP-UP

2016 state legislative year in review and a look ahead

by Amy E. Liepert, MD, FACS, and Tara Leystra Ackerman, MPH

Health care-related issues received significant attention in state legislatures in 2016. Opioid abuse was a particularly hot topic, with hundreds of pieces of legislation related to this issue introduced across the country. In addition, states continued to grapple with the effects of the Affordable Care Act and the new insurance marketplace, including heightened concern regarding narrow insurance networks and surprise billings for patients who receive care from out-of-network providers. A number of other issues that affect surgery were addressed in state legislatures as well, including trauma system development and funding, injury prevention, cancer prevention and treatment, scope of practice, and medical liability. This article summarizes these issues and provides insight into the issues that state legislatures will likely address in 2017.

Opioid abuse
The opioid abuse epidemic, which affects communities across the U.S., continues to escalate. According to the U.S. Drug Enforcement Agency, drug overdose is now the leading cause of injury death in the U.S., ahead of motor vehicle- and firearm-related deaths. More than half of drug-related deaths are linked to opioids—both prescription pain killers and heroin.

So far, the main policy solutions adopted by the states include increasing access to naloxone; providing Good Samaritan protection to individuals who call in overdoses; creating prescription drug monitoring programs (PDMPs) that allow and, in many cases, require prescribing physicians and pharmacists to check the PDMP when initially writing/dispensing a prescription for opioids and other scheduled drugs, and at regular intervals thereafter; and requiring physicians to become better educated about opioid prescribing.

In 2016, states began limiting the length of opioid prescriptions. Connecticut, Maine, Massachusetts, New York, and Rhode Island passed laws limiting initial prescriptions to seven days. Vermont passed a law that requires the state health department to set an opioid prescribing limit through the regulatory process in consultation with the Vermont Medical Society. These state laws closely follow recommendations from the Centers for Disease Control and Prevention, which, in March, released voluntary guidelines suggesting that initial prescriptions for acute pain be limited to three days and stating that there does not appear to be any need to prescribe opioids for more than seven days.

PDMPs are being used to track opioid prescriptions in some manner in all states except for Missouri (legislation attempting to create one in that state failed this year). More than 30 states require prescribers to check the PDMP if certain conditions are met, although these conditions vary by state. State policymakers continue to work on the functionality of these programs, with at least 29 states passing PDMP-related legislation this year. For example, according to the National Conference of State Legislatures, Alaska, California,
With no sign of the opioid epidemic abating, the ACS anticipates states will continue to legislate on the opioid abuse issue in 2017, including continuing medical education-related policy, PDMP use, and policy regarding opioid medication dosage.

Maryland, Massachusetts, Minnesota, Mississippi, New Hampshire, Utah, Vermont, Virginia, and Wisconsin passed laws initiating or changing requirements for when prescribing providers or pharmacists should check the PDMP. Although some health care providers may believe these requirements are onerous, these mandates have proven useful both in lowering the amount of opioids being prescribed and in identifying individuals who are addicted or are at risk of addiction.3

With no sign of the opioid epidemic abating, the American College of Surgeons (ACS) anticipates states will continue to pass legislation on opioid abuse issue in 2017, including continuing medical education-related policy, PDMP use, and policy regarding opioid medication prescription restrictions.

Health insurance networks
State legislative activity around narrow insurance networks and surprise billing increased in 2016. As reported in the July issue of the Bulletin in the article “Health care networks: Surprise billings for surgical patients,” increased attention has been given to the development of narrow networks, high-deductible plans, and surprise billings.4 State legislatures have been particularly concerned about out-of-network physicians and the impact of balanced billing on patients. To address this concern, states passed laws this year to improve transparency, cost estimates, and patient disclosures.4

Georgia adopted S.B. 302, and Minnesota passed H.F. 3142—bills that require carriers to pay in-network rates when their provider directory is inaccurate. Florida passed legislation, H.B. 221, which requires hospitals to post contracted carrier information on their websites, and to notify patients that they may receive services from practitioners who bill separately and are out-of-network providers. Florida also passed H.B. 1175, which requires health care facility websites to include an estimated average of payments received from all private payors for specific bundles of services. S.B. 425 went into effect in Texas, which requires freestanding emergency care facilities to prominently display information stating that the facility and/or physicians providing care at the facility may not be in the patient’s network, and patients could receive bills from physicians separate from the facility.

Some states are capping or limiting charges for out-of-network care. California Gov. Jerry Brown (D) signed A.B. 72 in September, limiting out-of-network payments to providers at in-network hospitals at 125 percent of Medicare or the average contracted rate determined by health insurance data adjusted to the specific geographic region, whichever is greater. California also adopted A.B. 1305 earlier in the session. This bill applies annual out-of-pocket caps on covered benefits inclusive of out-of-network emergency care received up to the point of patient stabilization. In Florida, H.B. 221 will require carriers to cover emergency care delivered at in-network hospitals for in-network rates and to cover nonemergency care at in-network rates when the facility is in-network and the beneficiary could not or was unable to choose a participating provider at the facility. This same law established a process for resolving billing disputes between carriers and providers, which includes time limits for responding to a settlement offer before it automatically goes into effect. Texas also lowered the amount at which a beneficiary can request mediation of a settlement from $1,000 to $500.

Balance billing, surprise billing, and increasingly narrow networks will likely continue to be a problem for patients, and the ACS anticipates that more state legislatures will address these issues in 2017.

Trauma and injury prevention
The ACS reviewed nearly 150 state bills aimed at changing injury prevention statutes in the last year, although less than a third were signed into law. These bills addressed issues ranging from motorcycle helmet
requirements, to youth concussion prevention, to all-terrain vehicle use.

One issue that receives attention from state legislatures annually is youth concussion prevention. Most states already have passed some iteration of mandated guidance regarding how public schools should treat a student athlete who may be suffering from a concussion, but these laws often do not touch on private schools or non-school-related sporting events. Notably, some states are now expanding youth concussion prevention protocols to include other venues. Delaware, Hawaii, Illinois, and New Mexico all acted on this issue in 2016.

Another hot topic in recent years is universal helmet mandates. Only 19 states have a universal motorcycle helmet mandate, and Georgia, Louisiana, Mississippi, Nebraska, New York, Tennessee, and West Virginia all saw legislative attempts to repeal these laws. In Tennessee, the bill was heard by committees in both the House and Senate but failed to advance to the floor of each chamber for full legislative consideration. Both the ACS and the Tennessee Chapter actively opposed the legislation. None of the other bills received any votes, but efforts to repeal the remaining universal helmet laws will surely return in these states in 2017.

States still are working to make their roads safer by eliminating distracted driving practices. Most states, with the exception of Arizona, Missouri, Montana, and Texas, ban texting by all drivers. In Texas, drivers younger than age 18 are banned from texting while driving. Furthermore, 14 states ban handheld cell phone use, and 38 states ban cell phone use by young drivers. Unfortunately, these efforts have done little to lessen the occurrence of distracted driving, and state level policymakers continue to grapple with this issue. Policymakers in 14 states (California, Florida, Indiana, Kansas, Massachusetts, Michigan, Missouri, New Mexico, Ohio, Oklahoma, South Carolina, Vermont, Washington, and Wisconsin) worked on legislative efforts in 2016 to toughen or implement distracted driving laws. California’s bill, A.B. 1785, was the only one to advance out of the legislature. Signed into law in late September, this bill updates the state’s distracted driving law to ban drivers from holding their phones in their hands; phones must instead be mounted to the dashboard.

Alabama, Kansas, and Louisiana all considered legislation to raise the fines for not wearing a seat belt in 2016; Louisiana was the only state to adopt it. In addition, Maryland, Missouri, New York, and Vermont all had legislation introduced to change not wearing a seat belt from a secondary offense to a primary one, but none of the bills advanced.

Trauma system development and funding is another active area in state legislatures. This year, Ohio is considering legislation to institute significant updates to its trauma system. Ohio is one state with a full-year state legislature, and at press time, H.B. 261 had not advanced. The Ohio Chapter of the ACS has played an active role in this trauma system update effort. As for funding, in states that are having budget issues, such as Alaska and New Mexico, funding for trauma systems is being reduced or eliminated altogether. In 2017, the ACS expects to see significant funding efforts in Kentucky and Montana, and a significant effort to stop the repeal of the Driver Responsibility Program in Texas, which provides funding for its trauma and emergency medical service system.

Cancer
The ACS monitors state legislation related to cancer prevention, including tanning bed regulation, access to and coverage of appropriate screenings, changes to the legal smoking age, tobacco tax increases, and e-cigarette regulation. In addition, the College monitors access issues, specifically access disparities for oral and intravenous chemotherapies.

In 2016, Arizona, Florida, Iowa, Kansas, Kentucky, Massachusetts, Mississippi, Oklahoma, South Dakota, Virginia, and Wisconsin all considered banning individuals younger than the age of 18 from using
a tanning device, although Kansas and Massachusetts were the only states to pass legislation. The Kansas Chapter, led by Chapter President Joshua Mammen, MD, FACS, was integral to building the support necessary to get the bill passed.

Alaska and Pennsylvania joined 40 other states in enacting provisions ensuring equal access to oral and intravenous chemotherapies. Similar bills were considered in Alabama and North Carolina. Alabama, Arkansas, Idaho, Montana, North Carolina, and South Carolina are the only states that have yet to adopt this provision.

Bills were introduced in California, Kentucky, Mississippi, and New York to improve access to and coverage of colorectal cancer screenings. A.B. 1763 in California passed both the Assembly and Senate, but Governor Brown vetoed it at the end of session.

In early 2016, California became the second state to restrict the sale of tobacco products to individuals ages 21 and older. New Jersey still is considering legislation that would raise the legal age for purchasing tobacco products to 21, even though Gov. Chris Christie (R) vetoed similar legislation in January.

One of the areas of significant state legislative action every year impacting health care is nonphysician scope of practice. There are hundreds of bills introduced in state legislatures annually that attempt to change (usually increase) the scope of practice of various health care professionals.

**Scope of practice**

One of the areas of significant state legislative action every year impacting health care is nonphysician scope of practice. Hundreds of bills are introduced in state legislatures annually that attempt to change (usually increase) the scope of practice of various health care professionals. The ACS takes an active interest in a segment of these bills, mainly focusing on optometric scope expansion, nurse anesthetists’ scope expansion, and efforts to expand the use of lasers and other surgical devices into nonmedical fields.

This year, the ACS actively opposed efforts in California and Illinois to expand the scope of practice of optometry. In California, S.B. 622 would have allowed optometrists to perform scalpel eye lid surgery, injections, and laser surgery with insufficient education and training. The ACS wrote to committee leadership and activated its grassroots action center to oppose this bill. In Illinois, S. 2899 would have allowed optometrists to perform certain surgical procedures and administer injectable medications. The ACS worked with the state medical society and other specialty societies to oppose this bill. The other scope of practice bill the ACS worked actively to oppose was H.B. 548 in Ohio. This bill would have allowed certified registered nurse anesthetists to issue and administer medications both before and after operations. It would also allow them to delegate certain tasks to other providers without consulting a physician. The ACS worked with the Ohio Chapter to oppose this effort as well.

Scope of practice battles are not going away in the foreseeable future, and the ACS expects similar battles in California and Illinois on optometric scope of practice expansion next year, and most likely in many other states.

**Videotaping of surgery**

In the last two years, Wisconsin and Indiana lawmakers have sought to mandate that surgeons provide their patients with the option of having their operations video-recorded and for these recordings to be discoverable in medical liability lawsuits. In Wisconsin, a bill would have mandated that patients have the option of having all operative and dental procedures performed under general anesthesia to be recorded in color. This bill, A.B. 255, would require that each entrance to the room be covered so that all incoming and departing staff are date and time stamped. Additionally it would require that all setup and preparatory time be recorded. All patients undergoing nonemergency procedures would be offered this option. Health care facilities would be responsible for installing and maintaining the recording devices and for providing one copy of the recording to the patient and for maintaining one in the patient’s medical record.
Audio-visual technology can be harnessed in productive and professional ways to improve the quality of surgical care delivered to patients. Highly specific and professional review of technical surgical skills leads to improved individual technical performance and is under scientific study for use in coaching programs, much in the same way professional athletes use video review to improve their performance. Video also is used to evaluate team-based communication and to improve team skills in high-stress settings, such as trauma and code situations, both within and outside of the operating room. However, introducing the potential of legal discovery and punishment may hinder these activities in health care. Because of these potential negative side effects, the ACS will study video recording further, as these bills are likely to resurface in Indiana and Wisconsin, as well as other states.

**Getting involved**

Many important legislative efforts that affect surgical care are debated in the state legislatures every year. Fellows can have a real impact on the legislation lawmakers consider, as well as on the outcome of many of these efforts. The College strongly encourages Fellows to get involved in ACS chapter legislative advocacy efforts and to work directly with the State Affairs staff in the ACS Division of Advocacy and Health Policy to support quality patient care-related legislative priorities. For more information, e-mail State_Affairs@facs.org, or call at 202-672-1522. ♦

**REFERENCES**

Women’s role in otolaryngologic medicine

by Remy Friedman, BS; Christina H. Fang, MD; Mays Zubair, MD; and Evelyne Kalyoussef, MD, FACS

HIGHLIGHTS

• Illustrates the contributions of women otolaryngologists throughout the history of surgery
• Describes advances women otolaryngologists have made in the last 200 years
• Emphasizes the need for greater gender equity in surgery
Otolaryngology may be among the oldest surgical specialties, and many of its practitioners have been revered for thousands of years. However, surgeons and other physicians may be unaware of the contributions women have made to this specialty.

**Brief history of otolaryngology**

Otolaryngology has an extensive history that spans nearly five millennia; in fact, the world’s first known physician, Sekhet’enanch, may be considered a rhinologist. As the “[healer of] the king’s nostrils,” he is believed to have served as personal physician to Pharaoh Sahura in approximately 3500 BC. Indeed, detailed otolaryngological knowledge shared by generations of ancient Egyptian physicians has been unearthed, specifically in the Edwin Smith papyrus dating to approximately 1600 BC and in the Ebers papyrus, a document littered with surgical cases written in hieroglyphics in approximately 1500 BC.

Further roots of otolaryngology have been uncovered in the well-known Grecian schools of the fourth and fifth centuries BC, where Hippocrates outlined multiple otologic etiologies and treatments. Centuries later, noted Arab physicians such as Abu al-Qasim Khalaf ibn “Abbas al-Zahrawi” (known in the West as Albucasis) performed and detailed multiple otolaryngological techniques, including tracheotomy, tonsillectomy, and nasal polyp removal.

Moshe ben Maimon, also known as Moses Maimonides, a Jewish scholar and physician in the 12th century AD, wrote extensively on proper management of various pathologies that affect the ear, nose, and throat, ranging from peritonsillar abscesses, to vertigo and beyond. Advancements in otolaryngology continued throughout the Renaissance, in the late 1300s through the scientific revolution in Europe between the 16th and 18th centuries, and into the modern era with novel ideas proposed by individuals such as Heinrich Adolf Rinne, Robert Barany, Manuel Garcia, Graeme Clark, and others whose influence has proven to be invaluable to the field. Nonetheless, discussions of the history of otolaryngology often glaringly overlook the contributions of many woman physicians who, alongside their male counterparts, have helped to shape the specialty. This article summarizes the contributions of a handful of influential women otolaryngologists who have served as pioneers in the field.

**Women as specialty physicians**

Multiple medical schools in ancient Egypt and Greece, including, perhaps, the most famous institution at Heliopolis on the northeast edge of modern-day Cairo, trained women students as early as 1500 BC. Although medical historians acknowledge that specialty physicians practiced medicine during this era, evidence speaking to the degree of specialization of the two most
The greatest advancement of women in otolaryngology has occurred within the last 200 years. The development of multiple medical schools for women...in the mid-19th century provided opportunities for women to continue to breach the boundaries of the medical profession.

Prominent women physicians of ancient Egypt, Pesehet and Tawe, has yet to be discovered. Similarly, while research suggests that Antiochis—a famous and well-respected woman physician in Tlos, Greece, in the first century AD—was accomplished in areas pertaining to rhinology, particularly nasal hemorrhage, no proof has emerged documenting medical or surgical treatment provided by Antiochis in the field of otolaryngology. Regardless of whether these women performed otolaryngologic procedures, their involvement in the medical profession paved the way for future women physicians and surgeons.

Despite the increasing role of women physicians during the first century, the rise of the Catholic Church, beginning in the middle of the first millennium AD, significantly challenged women seeking to practice medicine. Patriarchy dominated the sciences, and medical education for women was outlawed throughout Europe. Moreover, the lack of a formal educational system and the increasing illiteracy among women in the Middle Ages precluded self-tutelage from the wide array of surgical and medical texts that existed in this era. Interestingly, medieval literature often fails to assign women who practiced medicine the title of physician (fisica) or surgeon (cirurgica). Multiple census data derived via household taxes from the late 13th through 15th centuries AD reveal that across Europe, fewer than 2 percent of medical professionals were women.

Notably, some women superseded all of these obstacles to become well-known, highly proficient surgeons. For example, Cleopatra Metrodora, a Greek physician, perfected her practice in obstetrics and gynecology before branching out into other medical specialties and performing novel facial reconstructions, likely in the seventh century AD.

Later, a clandestine Frau von Tesingen contributed various medicinal treatments for auricular pathologies to a German text published in the 13th century. Further contributions were made by Benvinguda Mallnovell of Spain, who used herbal preparations to treat diseases affecting the throat in both pediatric and adult populations.

Although important rays of light in otolaryngologic medical history, these few examples likely represent a small portion of women’s contributions to this specialty during this era. It is important to note that treatment of otolaryngologic disease by women medical practitioners during medieval times likely has been overlooked due to a lack of documentation.

Pioneers in the field

The greatest advancement of women in otolaryngology has occurred within the last 200 years. The development of multiple medical schools for women such as The Women’s Medical College of New York and the Woman’s Medical College of Pennsylvania (WMCP), Philadelphia, later renamed The Medical College of Pennsylvania, in the mid-19th century provided opportunities for women to continue to breach the boundaries of the medical profession. The WMCP, for example, offered lectures in otology, laryngology, and rhinology during third-year coursework, providing women with the background necessary to enter otolaryngology.

Margaret F. Butler, MD, a graduate of the WMCP program in 1894, was appointed chief of the nose and throat department of the WMCP in 1906. Many female physicians of her time chose to specialize in women’s health, but Dr. Butler was adamant about pursuing otolaryngology, not solely to satisfy her own interests but also to form a path for future female surgeons to follow. She stated, “While I enjoy obstetrics and gynecology, I feel a woman is needed in nose and throat work, and I have decided to work in that field.” In accordance with this sentiment, Dr. Butler spent many hours in the operating room performing multiple procedures, including biopsy and removal of malignancy of the paranasal sinuses, tonsillectomy, and middle turbinate resection. With a knack for innovation, she went on to design multiple instruments used in otolaryngologic operations, such as the Butler tonsil snare and a nasal septum splint used following submucosal resection of the turbinates.

Dr. Butler proved influential in guiding her students toward a career in otolaryngology. In her
address to the freshman class of 1913, she said, “Women physicians are being sought as assistants to busy specialists in ophthalmology, laryngology, and otology. Such positions are particularly desirable for the young physician, for she has an opportunity to learn and at the same time to build up a practice [for] herself.”21 She mentored many female students, including Louise Mason Ingersoll, a 1914 graduate of WMCP who used the otolaryngological knowledge she acquired from Dr. Butler to perform mission work in Shanghai, China, related specifically to the treatment of ear, nose, and throat pathologies.22 As a respected, highly competent otolaryngologist and an ambassador of the specialty, Dr. Butler provided a blueprint for generations of future female otolaryngologists.

Succeeding in a male-dominated field
Emily Lois Van Loon, MD, succeeded Dr. Butler as the head of the department of otolaryngology at WMCP. A practicing otolaryngologist and an inventor within the field, Dr. Van Loon, along with Chevalier Jackson, MD, is credited with the development of the bronchoscope and bronchoscopic removal of foreign bodies.23 Notably, due to her treatment of police officers and firefighters in her otolaryngology clinic in Philadelphia, coupled with her groundbreaking presence as a woman in the field, Dr. Van Loon received the Elizabeth Blackwell Award from the New York Infirmary. This award is presented annually to a woman physician who shares two main qualities with Elizabeth Blackwell, namely “conspicuous professional achievement in a previously male-dominated occupation” and “achieve[ment] and serv[ice].”24 Dr. Van Loon achieved great success within the field of otolaryngology and provided a model for women otolaryngologists today.

Eleanor Maxine Bennett, MD, similarly defied the odds to become a well-accomplished otolaryngologist. After graduating as one of only four women in her medical school class at the Medical School at the University of Nebraska, Omaha, in 1942, Dr. Bennett served as professor and chair of otolaryngology at the University of Wisconsin (UW), Madison, in 1963. She is considered to be the first woman chairperson in any department among all major medical schools within the U.S, and she earned the
Despite the best efforts and notable accomplishments of women in otolaryngology over the last 5,000 years, women otolaryngologists continue to encounter a glass ceiling at all levels of training and practice. Akin to Dr. Butler’s quest to provide future generations of women the opportunity to practice otolaryngology, Dr. Bennett established an otolaryngology residency at UW that today continues to train approximately 15 residents annually. A woman of many firsts, Dr. Bennett continually broke free of limiting expectations ascribed to women within otolaryngology in the mid-20th century.

Decades later, Jeanne Vedder, MD, entered into two male-dominated fields at the same time: otolaryngology and the military. In 1976, the U.S. Air Force (USAF) began equally enlisting males and females for active duty. As the first woman otolaryngologist in the USAF, Dr. Vedder was responsible for treating patients, mentoring residents, and acting as department chair at the David Grant USAF Medical Center at Travis Air Force Base, Fairfield, CA. She helped lead the way for the women who have subsequently served as otolaryngologists in the USAF and for the approximately 60,000 women in the USAF today.

In 2010, three women otolaryngologists successfully realized their plan to establish a division of Women in Otolaryngology (WIO) Section within the American Academy of Otolaryngology–Head and Neck Surgery. The WIO Section is tailored specifically to the advancement of women otolaryngologists. Linda S. Brodsky, MD; Pell Ann Wardrop, MD; and Sujana Chandrasekhar, MD, FACS, founded the WIO to “provide the Academy a dynamic professional community of women and men who seek gender equality in the specialty.” Additionally, a WIO Section endowment has been funded to offer women otolaryngologists the financial backing needed to excel both in academic and private practice.

A path forward

Despite the best efforts and notable accomplishments of women in otolaryngology over the last 5,000 years, women otolaryngologists continue to encounter a glass ceiling at all levels of training and practice. Unquestionably, otolaryngology has experienced growth in the number of women who are in the field since the middle of the 20th century. In

REFERENCES (CONTINUED)

27. Akin to Dr. Butler’s quest to provide future generations of women the opportunity to practice otolaryngology, Dr. Bennett established an otolaryngology residency at UW that today continues to train approximately 15 residents annually. A woman of many firsts, Dr. Bennett continually broke free of limiting expectations ascribed to women within otolaryngology in the mid-20th century.
29. Akin to Dr. Butler’s quest to provide future generations of women the opportunity to practice otolaryngology, Dr. Bennett established an otolaryngology residency at UW that today continues to train approximately 15 residents annually. A woman of many firsts, Dr. Bennett continually broke free of limiting expectations ascribed to women within otolaryngology in the mid-20th century.
1963, only 0.3 percent of otolaryngologists were women, whereas in 2014 14.5 percent of the otolaryngologists in the U.S. were women. Nonetheless, the number of women in otolaryngology lags far behind the national average of 32.6 percent women across all specialties in 2014.

Gender inequities also exist in academic advancement and in National Institutes of Health (NIH) grant funding within the specialty. A 2014 study by Eloy and colleagues demonstrated that men disproportionately attained higher academic ranks in otolaryngology when compared with their women counterparts. Regardless, women in otolaryngology have continued to increase scholarly productivity within the academic arena, with authorship increasing from 14.5 percent to 22.5 percent between 1998 and 2008, all while receiving nearly $100,000 less in individual NIH grant funding than their male colleagues.

The reduction and ultimate elimination of gender inequality is an issue that extends beyond the scope of otolaryngology. However, steps can be taken to ensure that more women may overcome the barriers within our specialty. To level the field’s gender gap, today’s otolaryngologists will do well to follow the example of the women surgeons identified in this article, who constantly sought to encourage young women medical students to enter the field. This effort may be complemented by an exploration of the reasons behind the paucity of female otolaryngologists. If implicit and explicit biases toward women in otolaryngology exist, they must be exposed through objective research. Such studies may highlight possible inequities in areas including, but not limited to, the following: otolaryngology residency positions, evaluation of surgical skill, salary considerations, research funding, and consideration for promotion.

The onus lies on the entire otolaryngology community—men and women alike—to ensure equality for future generations of women otolaryngologists.

REFERENCES (CONTINUED)

Executive Director’s annual report

by David B. Hoyt, MD, FACS
As I near the end of my seventh year as Executive Director of the American College of Surgeons (ACS), it is my pleasure to offer this annual report on the major activities that ACS staff and volunteers have carried out in the last year.

Advocacy and Health Policy
Much of the focus of the College’s health policy and advocacy efforts has been on monitoring and assisting the Centers for Medicare & Medicaid Services’ (CMS) implementation of the Medicare Access and CHIP (Children’s Health Insurance Program) Reauthorization Act (MACRA). CMS released a final rule in October describing how Medicare payment would be reformed under MACRA, which calls for the establishment of a Quality Payment Program (QPP). The QPP will center, at least initially, on a Merit-based Incentive Payment System (MIPS) with eventual expansion to include Alternative Payment Models (APMs).

MIPS combines the CMS quality improvement incentive programs—the Physician Quality Reporting System (PQRS), the Value-Based Payment Modifier (VM), and the Medicare Electronic Health Record (EHR) Incentive Program—into one comprehensive program. The ACS submitted a comment letter June 27 to CMS regarding the proposed rule, which addresses the four components of MIPS: Quality, Resource Use, and Advancing Care Information, which correspond to the PQRS, VM, and EHR program, respectively; and Clinical Practice Improvement Activities—a new component. These elements of the new payment system are discussed in greater detail in the October and November issues of the Bulletin.

The proposed rule also would establish incentives for participation in certain APMs. The College’s comments address the criteria necessary for an APM model to be considered an Advanced APM—specifically, use of certified electronic health records technology, inclusion of quality measures comparable to MIPS, and acceptance of more than nominal financial risk.

In addition, the ACS is collaborating with Brandeis University, Waltham, MA, and the Center for Surgery and Public Health at the Brigham and Women’s Hospital, Boston, MA, to develop surgical APMs and has formed an APM task force. The College has sponsored a series of webinars to engage potential stakeholders and help build momentum for the initiative. The ACS Division of Advocacy and Health Policy (DAHP) is keeping the Center for Medicare & Medicaid Innovation (CMMI) apprised of our efforts.

We expect to have a proposal to submit by the end of 2016. The ACS lobbying team and Frank G. Opelka, MD, FACS, Medical Director, Quality and Health Policy, ACS DAHP, have been educating legislators and their staffs on how the ACS-driven APM will unite surgical disciplines into a single framework for building APM solutions.

Another provision in MACRA prevents CMS from implementing a policy that would have transitioned 10- and 90-day global codes to 0-day global codes. Instead, beginning in 2017, CMS will collect data on the number and level of visits furnished during the global period and, beginning in 2019, will use these data to improve the accuracy of the valuation of surgical services. The provision also allows 5 percent of the surgical payment to be withheld until information is reported at the end of the global period.

In a comment letter on the Medicare Physician Fee Schedule proposed rule, the ACS provided feedback on CMS’ collection of data on the number and level of visits associated with global codes. Members of the ACS General Surgery Coding and Reimbursement Committee (GSCRC) also met with CMS in February 2016 to discuss the College’s recommendations in more detail and followed up with a letter reiterating our views.

The ACS was disappointed that CMS proposed to collect data on all 10- and 90-day global services from all physicians who provide these services. This proposal contradicts MACRA’s intent, which was to allow CMS to collect data from a “representative sample” of physicians. The ACS also opposes CMS’ plan to collect data from physicians by using G-codes. The ACS has
Much of the focus of the College’s health policy and advocacy efforts has been on monitoring and assisting CMS’ implementation of MACRA.

informed CMS that this proposal is so burdensome that few physicians will be able to comply by January 1, 2017, and that the data CMS collects likely will be inaccurate and unusable. The ACS has urged CMS to proceed slowly, first developing a sound survey methodology. If CMS intends to move forward with claims-based data collection, we urge the agency to use Current Procedural Terminology (CPT) code 99024. If collecting accurate data is infeasible by January 2017, the College supports spending more time on further development of this policy with input from specialty societies.

On August 25, Linda Barney, MD, FACS, Vice-Chair, GSCRC, and Eric Whitacre, MD, FACS, a member of that committee, testified at a CMS listening session regarding the agency’s plan to collect data on medical visits associated with 10- and 90-day global codes. In addition, the ACS submitted comments September 6 in opposition to CMS’ approach to global codes data collection.

The proposed rule also provides values for new moderate sedation codes. CMS said it appeared that practice patterns for certain endoscopic procedures were changing and that anesthesia was increasingly being reported for these procedures even though reimbursement for these services was automatically included in payment to the physician furnishing the primary services. As a result, the agency proposes separate codes for moderate sedation.

In addition, the proposed rule updates the Medicare Shared Savings Program, which facilitates coordination and cooperation among providers. Providers and hospitals may participate in the Shared Savings Program by creating or participating in an Accountable Care Organization (ACO). CMS proposes revisions to ACO quality reporting measures that support alignment with the QPP.

Other provisions in the proposed rule pertain to implementation of the Protecting Access to Medicare Act and direct CMS to establish a program to promote appropriate-use criteria (AUC) for advanced diagnostic imaging services. The ACS recommends that CMS give providers more time before they are required to consult AUC to make clinical decisions so that the AUC program does not roll out simultaneously with the QPP.

The DAHP is continuing its efforts to draft a white paper on graduate medical education (GME) reform. This report is anticipated to be released early in the 115th Congress and to be the starting point for congressional efforts to examine the issue and propose legislation. The College’s white paper addresses workforce, finance, governance, and accountability issues.

To address the growing surgeon workforce shortage, Reps. Larry Bucshon, MD, FACS (R-IN), and Ami Bera, MD (D-CA), introduced H.R. 4959, the Ensuring Access to General Surgery Act of 2016. This legislation would direct the Secretary of the Department of Health and Human Services (HHS) to study the designation of a general surgery Health Professional Shortage Area (HPSA) using criteria that the Health Resources and Services Administration (HRSA) has developed to determine whether certain geographic areas (urban, suburban, or rural), population groups, or facilities are experiencing health professional shortages. HRSA has never designated an HPSA purely because of a shortage of surgeons.

The ACS continues to monitor congressional activity on Direct GME (DGME) and indirect medical education (IME) funding. House Ways and Means Committee Chairman Kevin Brady (R-TX) introduced the Medicare IME Pool Act of 2015, H.R. 3292, which instructs the Secretary of the HHS to reimburse IME funds to teaching hospitals in a lump sum, rather than through the current add-on payment these institutions receive per inpatient discharge. This lump sum change would occur for cost-reporting periods ending during or after fiscal year (FY) 2019. These lump-sum IME payments would be made to teaching hospitals in the same timeframe, approximately every two weeks, as the DGME payments.

The bill also would require that the HHS Secretary create a new IME pool, initially funded at $9.5 billion in FY 2019. If new teaching programs are added to the Medicare program, the Secretary must increase
the total amount of the IME pool. Beginning in FY 2020 and thereafter, the IME pool amount would be updated by the inpatient prospective payment system (IPPS) market basket update. Further, if any new teaching programs are added after FY 2019, the Secretary must increase the total IME pool to reflect the addition of new teaching programs. Finally, the bill requires the Secretary to maintain the existing formula that is used to derive IME payments.

The ACS worked with Reps. Joe Heck (R-NV) and Duncan Hunter (R-CA) to add language to H.R. 4909, the National Defense Authorization Act (NDAA), which would establish a Joint Trauma System (JTS) within the Department of Defense (DoD). This provision would be useful toward standardizing trauma care for the military by having the JTS serve as the reference body for all trauma care provided across the military health system (MHS), establish standards of care for trauma services provided at military medical treatment facilities (MTFs), and coordinate the translation of research into clinical practice.

The bill would establish a Joint Trauma Education and Training Directorate, which would ensure the readiness of military trauma care providers. This mandate would be accomplished, in part, by entering into partnerships with civilian academic medical centers and large metropolitan teaching hospitals that have Level I trauma centers. Because of the Military Health System Strategic Partnership American College of Surgeons (MHSSPACS), which facilitates collaboration and the exchange of information between the ACS and the MHS to advance high-quality, cost-effective care for surgical patients, this legislation is of heightened relevance to the ACS.

Nearly 300 physicians participated in the Advocacy portion of the 2016 ACS Leadership & Advocacy Summit in Washington, DC, in April. DAHP staff, political insiders, health care policy experts, and members of Congress provided details on efforts to reshape the nation’s health care system. In all, 231 physicians met with legislators and staff from 42 states to advance the College’s advocacy agenda.

The ACS is working to introduce the Responsible Data Transparency Act, championed by Rep. Bill Flores (R-TX), which would halt CMS’ disclosure of raw Medicare physician claims data to outside entities that file Freedom of Information Act (FOIA) requests. Congress and the ACS share the goal of maintaining transparency in the Medicare system for purposes of maintaining the highest quality of care for patients. However, for the last two years, the federal government has allowed third parties to file FOIA requests that CMS release raw physician claims data. These third parties, such as Propublica and Consumer Checkbook, have then used unproven methodologies to conduct performance analyses and have published the results on public websites.

In 2015, the ACS State Affairs team conducted a strategic review of state advocacy activities. Promoting and highlighting ACS verification and quality programs was one new area of focus to emerge. State Affairs staff is now working with Amy Liepert, MD, FACS, a member of the ACS Health Policy and Advocacy Group (HPAG), who will provide health services research support to develop a state-level scorecard to evaluate regional needs related to surgical care. Initial areas for assessment include research related to regional variation in access to surgical care, disparities in access to surgical care, coverage models, trauma care coordination, and use of registries to further clinical care. Dr. Liepert initially will work on a model for Wisconsin, which can then be replicated in each state.

The ACS Professional Association continued to expand its grassroots activity in 2015–2016 by setting up in-district meetings and arranging for Fellows to deliver political action committee checks. Furthermore, more than 140 Fellows in 48 states now serve on the Health Policy and Advocacy Council (HPAC), and Fellows have been using ACS SurgeonsVoice to
support a number of important federal bills. HPAC and DHAP continue to hold quarterly “Advocacy Insider” webinars on federal and state legislation.

Education
The ACS convened several national conferences over the last year to address Continuing Medical Education, transition to practice, simulation-based surgical education, and other topics, and participated in the planning of the National Surgical Patient Safety Summit with the American Association of Orthopaedic Surgeons in August.

The ACS Clinical Congress remains the premier annual surgical meeting. For this year’s meeting, October 16−20, in Washington, DC, the program comprised 24 Tracks, 128 Panel Sessions, 18 Didactic Courses, 14 Skills Courses, 45 Meet-the-Expert Luncheons, and 18 Town Hall Meetings. Three Special Sessions were offered on Firearm Injury Prevention, ACS Strong for Surgery, and Global Engagement. Details regarding Clinical Congress 2016 will be published in the January 2017 Bulletin.

Surgical Education and Self-Assessment Program (SESAP®) 16 was unveiled at Clinical Congress 2016 and includes a variety of apps for handheld devices. Additional SESAP products include the SESAP Sampler and SESAP Audio Companion.

The Annual ACS Comprehensive General Surgery Review Course provides a 3.5-day intensive review of essential content areas in general surgery. The course uses didactic and case-based formats. A total of 194 individuals participated in the 2016 course and gave the course an overall rating of 4.82 on a five-point scale.

In January 2016, Selected Readings in General Surgery (SRGS®) entered its ninth year as an ACS publication. SRGS continues to publish evidence-based reviews of the medical literature. SRGS users can earn up to 80 Self-Assessment credits annually. The SRGS package contains an overview of the literature; a concise review of 10 recently published articles, accompanied by expert commentary for each article; and an editorial on health care. Pre- and posttests comprise 40 multiple-choice questions.

Evidence-Based Decisions in Surgery (EBDS) includes concise, focused modules derived from practice guidelines. Modules are developed based on diagnoses that are relevant to the operations that general surgeons frequently perform. A total of 44 modules are available. A new educational model is being designed and will include discussion of key articles based on the review of evidence. Category 1 Continuing Medical Education (CME) credits will be provided for participation in this new activity.

The 12th Annual Surgeons as Leaders: From Operating Room to Boardroom Course took place in June, and the 23rd Annual Surgeons as Educators Course took place August 27−September 2.

A simulation-based education program for practicing surgeons, Fundamentals of Laparoscopic Surgery® (FLS), is in its 11th year and is a collaborative program between the Society of American Gastrointestinal and Endoscopic Surgeons (SAGES) and ACS. More than 10,000 residents, fellows, and practicing surgeons have received FLS certification. Expansion of the program continues with 80 testing centers throughout the U.S. and Canada, and one each in Singapore and Israel. Surgeons from more than 20 countries have completed the FLS examination.

The ACS offers many educational opportunities for surgical residents, which are as follows:

- The ACS Fundamentals of Surgery Curriculum® (ACS FSC) has set a new standard for cognitive simulation-based education to address diagnostic and patient management skills in surgery. ACS FSC now comprises 110 case scenarios encompassing 14 essential content areas.

- The ACS/Association of Program Directors in Surgery (APDS) Surgery Resident Skills Curriculum uses simulation to achieve specific learning objectives. Phase I modules focus on basic surgical skills and tasks and have undergone significant revision in the last two years. Released in May 2016, the 16 modules include new demon-
stration videos and additional evaluation tools. Stations for Objective Structured Assessment of Technical Skills (OSATS) have been added, along with a guide for administering OSATS. Review and revision of the Phase III modules that focus on team-based skills are under way. The Phase II modules that address advanced procedures will be focused on next, and opportunities to replace certain cumbersome and resource-intensive simulations with state-of-the-art simulators will be pursued.

ACS educational programs for medical students planning a career in surgery are as follows:

• The ACS/APDS/Association of Surgical Educators (ASE) Resident Prep Curriculum is being pilot-tested at several U.S. medical schools, and a certificate affirming satisfactory completion of the curriculum modules is being offered to medical students. The curriculum will be disseminated to course directors through an innovative “Curriculum Builder” website, which will allow course directors to easily align the curriculum goals and objectives with the needs of their students and the available resources at their medical schools. The program will launch this academic year.

• The ACS/ASE Medical Student Simulation-Based Surgical Skills Curriculum comprises 25 innovative simulation-based modules aimed at first- through third-year medical school students. Efforts are under way to support broad dissemination and evaluation of this curriculum.

The College has partnered with two universities to offer fellowships in surgical ethics and research—the MacLean Center Surgical Ethics Fellowship at the University of Chicago, IL, and the University of Wisconsin, Madison, Fellowship in Surgical Education.

The Committee on Emerging Surgical Technology and Education (CESTE) is being reorganized and will continue to play a pivotal role in evaluating new technologies, providing guidance regarding the appropriate time for introduction of new technologies into surgical practice, and training in new technologies. Systematic reviews are being conducted in collaboration with the Australian Safety and Efficacy Register of New Interventional Procedures-Surgical (ASERNIP-S) to guide safe introduction of new technologies and procedures into surgical practice.

The College offers a Patient Education program, the centerpieces of which are the Home Skills Kits. The Feeding Tube Skills Kit was recently completed, and the Central Line Skills Kit will be released soon. Additional skills kits are under development.

The Education for Better Recovery program offers educational material to cancer patients so they can be fully informed and actively participate in their recovery. Surgical prep brochures and e-learning materials are designed to inform and prepare patients for surgery, and use of the electronic materials may be applied in fulfilling meaningful use criteria of EHR.

In addition, opportunities to integrate the skills training activities of the Patient Education Program at the ACS Accredited Education Institutes (ACS-AEI) are being explored, and an updated Statement on Principles of Patient Education was approved at the Board of Regents meeting in February.

At present, 94 institutions are ACS-AEIs: 82 Comprehensive ACS-AEIs, and 12 Focused ACS-AEIs. A retreat was held in 2015 to design a new Maintenance of Accreditation model, which began phase-in this year. A new International Committee of the ACS-AEI Consortium was established in April. The ninth Annual ACS-AEI Consortium Meeting took place March 7–8 in Chicago with a record 222 attendees.

An ACS-AEI Fellowship Program was established to train the next generation of experts in this field and includes specific standards and criteria for accreditation; at present, eight ACS-AEI Accredited Fellowship Programs are available.

The ACS CME Accreditation Program now ranks as one of the largest within the Accreditation Council for Continuing Medical Education system. This program accredits all CME credit-bearing educational programs of ACS and the educational programs of
At present, 754 hospitals participate in the ACS NSQIP, representing a growth of 14 percent in the last year.

In May 2015, ACS NSQIP signed a five-year agreement with the Department of Defense (DoD), which includes a budget for 54 hospitals to enroll in ACS NSQIP and form a DoD collaborative. At the time, 18 DoD sites already were participating in ACS NSQIP with the goal of expanding to 36 new sites. To date, 13 new DoD sites have enrolled and are participating, and five are pending contract signature or onboarding. The remaining 18 DoD hospitals are expected to enroll soon.

ACS NSQIP continues to add pilot projects, including the TransQIP pilot developed in collaboration with the American Society of Transplant Surgeons, with 10 participating hospitals capturing variables on donors and recipients of liver and kidney transplantation. Other pilot projects include the Emergency General Surgery pilot, which will be offered in the new ACS NSQIP registry platform in 2017, and the Enhanced Recovery in NSQIP pilot.

An updated ACS NSQIP Surgical Risk Calculator was released in May, adding predictions for several postoperative complications. New risk outcomes included are readmission to the hospital, ileus, and leak of an intestinal anastomosis. The calculator receives approximately 1,500 hits daily. In July, the ACS NSQIP Pediatric Surgical Risk Calculator was released. It uses 17 patient predictors and the planned procedure to calculate the probability that patients will have any of nine different outcomes within 30 days following surgery (see related article, page 29).

The 2016 ACS NSQIP Annual Conference took place July 15–19 in San Diego, CA, with nearly 1,500 attendees from 690 medical institutions and 14 countries. The 2017 conference, Achieving Quality: Present and Future, will be directed at trainees.

The four-year Coalition for Quality in Geriatric Surgery (CQGS) Project, funded by the John A. Hartford Foundation, completed its first year in development. The CQGS aims to improve the care of older patients though a standards and verification program. The project team, led by Clifford Y. Ko, MD, MS, MSHS, FACS, and Ronnie Rosenthal, MD, FACS, focused on surgical societies that do not have accreditation programs. In 2015, the ACS accredited a total of 2,252 CME activities. Of these, 292 activities were jointly accredited. These numbers represent a significant growth in both ACS and joint providership activities.

The number of ACS members using the MyCME program to request transfer of their CME credits to the American Board of Surgery has increased steadily. From July 1, 2015, through April 29, 2016, more than 5,300 members used this service. Plans are under consideration to explore similar opportunities with other surgery specialty boards as well.

Steps are being taken to support surgeons’ efforts to meet state regulatory mandates. A complete list of requirements by state has been compiled and is available online as a reference source for practicing surgeons. Additional content is being developed to address various regulatory mandates, and plans are under way to provide guidance to individuals to address these mandates.

Continuous Quality Improvement (CQI)

At present, 754 hospitals participate in the ACS National Surgical Quality Improvement Program (ACS NSQIP®), representing a growth of 14 percent in the last year. At press time, another 56 hospitals were in various stages of onboarding. Pediatric NSQIP comprises 92 sites, an increase of 18 centers (24 percent) since October 2015. This interest from the pediatric community may be spurred on by sites planning to seek accreditation through the Children’s Surgery Verification Program.

ACS NSQIP collaboratives enable sites to share outcomes and best practices and work on quality improvement (QI) in organized, smaller groups. At present, 45 collaboratives have been formally established, with several more system-based collaboratives in development. The newly formed Northwest ACS NSQIP Collaborative is the first multinational collaborative comprising hospitals joining from seven northwest states, Alaska, and British Columbia.

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two deliverables: engaging stakeholders and setting preliminary standards. Working with 58 national stakeholder organizations, the CQGS team developed 308 preliminary standards under four domains: continuum of care, clinical care, program management, and patient outcomes and follow-up. Following an extensive RAND-based review process, the project team settled on 88 standards, which will be released for additional stakeholder comment in January 2017 (see related article, page 22).

The first-draft standards of the soon-to-launch Children’s Surgery Verification (CSV) program were supported by the Society of Pediatric Anesthesia and the American Pediatric Surgical Association. The pilot phase of the program launched in April 2015, and within a month, six site visits were completed. The experiences of the pilot sites and surveyors confirmed that the standards are applicable, clear, and measurable. Nearly 125 sites have expressed interest in pursuing verification. The Children’s Hospital Association strongly supports this initiative and estimates that 200 hospitals will participate in the CSV program. The full CSV program is scheduled to launch later this year.

At present, 813 centers participate in the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP), 725 of which are fully accredited. From October 2014 through August 2016, 655 site visits had been completed using the MBSAQIP standards, and 61 surgeon surveyors are expected to perform 270 site visits this year.

The second version of the MBSAQIP standards took effect October 1, and ongoing education is being provided to assist centers in compliance.

The Decreasing Readmissions through Opportunities Provided (DROP), the first MBSAQIP national quality collaborative project, has concluded, and the MBSAQIP Quality Subcommittee has launched the next national project, Employing New Enhanced Recovery Goals to Bariatric Surgery, which seeks to enhance patient experiences through improved pain management, fewer opioid side effects, decreased readmissions, and quicker return to normal activity.

In addition, the MBSAQIP registry has been designated as a PQRS Qualified Clinical Data Registry (QCDR) for the third consecutive year. Public reporting at the surgeon level has been added where required by CMS and will be displayed on both the MBSAQIP website and the CMS Physician Compare site.

The ACS continued development of the Surgeon Specific Registry (SSR) as a tool for surgeons to log and track cases and comply with certain regulatory requirements. The following three reporting options are again available through the SSR for surgeons participating in the 2016 PQRS reporting cycle:

- General Surgery Measures Group for general surgeons (PQRS-Qualified Registry)
- Individual Measure reporting for surgical specialties (PQRS-Qualified Registry)—43 PQRS individual measures for surgeons across several specialties
- QCDR, including trauma measures, for trauma surgeons

The ACS has proposed the use of Phases of Care Measures, which are inclusive of multiple subspecialties. ACS Clinical Scholars used several ACS Quality Programs, including the CQGS project, to align the measures. In July, the measures were submitted to CMS for inclusion in the Measures under Consideration list.

The Division of Research and Optimal Patient Care (DROPC) and DAHP are collaborating to prepare for upcoming implementation of MIPS in 2017. An SSR Quality Advisory Committee provides guidance, expertise, feedback, and user experiences on quality measurement through the SSR, especially with PQRS.

The College continues work on the quality manual, which is being drafted to help health care institutions improve quality processes and outcomes. The final phase of editing is under way, as is exploratory work to evaluate the feasibility of developing an adjunctive or integrated Surgical Quality Verification Program.
The ACS **Registry Project** is approximately a year into a three-year implementation process of migrating all ACS clinical registries into a single platform that will share a data entry platform, data warehouse, and reporting tools. The ACS has partnered with Quintiles on this initiative to build the “registry of the future”; the first release is scheduled for December 2016 and will feature a new SSR and a Trauma Uploader tool. At the same time, Quintiles and ACS staff are meeting regularly to define and specify requirements for the new registry platform. Over the next few months, the new system will be built in an Agile method that allows work to be done iteratively and tested by the ACS to ensure proper functionality. Testing will also be done with end users to ensure they have input into the new system.

The **DROP Committee (DROPC)** has discussed concerns regarding public reporting at its last two meetings. To address these issues, the committee agreed to integrate Patient-Reported Outcome Measures (PROMs) into ACS registries, starting with ACS NSQIP, followed by all other registries once the registry integration project is complete.

The **Committee on Perioperative Care (CPC)** developed several new and updated position statements, which the Board of Regents approved. These statements pertain to health care industry representatives in the operating room (OR); safe surgery checklist and ensuring correct patient, correct site, and correct procedure surgery; prevention of unintentionally retained surgical items after surgery; sharps safety; documentation and reporting of accidental punctures and lacerations during surgery; and distractions in the OR.

Following the Association of periOperative Registered Nurses’ publication of guidelines for OR attire, the CPC received a number of inquiries from ACS Fellows, non-member surgeons, institutions, and other organizations asking for a position statement addressing this topic. ACS leadership met with the chair of the CPC to develop an ACS position statement on surgical attire. The position statement was published in the October Bulletin.

The **Surgical Research Committee (SRC)** met April 14 to review applications for the 2016 John L. and Julius H. Jacobson II Promising Investigator Award (JPIA). The number of applicants this year nearly doubled from 2015.

After extensive discussion, SRC members suggested incorporating new topics to update and rebrand the Outcomes Research Course as the Health Services Research Methods Course. The revised course, led by Arden M. Morris, MD, FACS, and Caprice C. Greenberg, MD, FACS, is designed for clinical and health services researchers with varying degrees of experience in the field and will take place December 8−10 at ACS headquarters.

The ACS offered a one-day **Surgeons Leading Quality Course** in conjunction with Clinical Congress 2015. In all, 60 individuals participated in the program, which was developed as part of the Surgical Unit Based Safety Project with grant support from the Agency for Healthcare Research and Quality (AHRQ). Through the MHSSPACS, the Surgeons Leading Quality Course was adapted to suit the needs of DoD sites participating in ACS NSQIP. The DoD has requested a second course, scheduled for January 2017. Another adaptation of the Surgeons Leading Quality Course—the pilot Residents Leading Quality Course—took place October 16, immediately preceding Clinical Congress 2016.

Under the **Voluntary Public Reporting on Hospital Compare** sole source contract with CMS, the ACS will continue to publicly report three surgery-related, risk-adjusted outcomes performance measures for hospitals participating in ACS NSQIP. The Hospital Compare website was last updated in October.

The **Comparative Effectiveness of Metabolic and Bariatric Surgical Procedures Using PROMs** project is a four-year initiative that aims to evaluate the three most common metabolic and bariatric procedures (sleeve, bypass, and band) on the basis of patient-centered, patient-reported, one-year outcomes from data collected through the MBSAQIP. Massachusetts General Hospital will be the prime awardee, with ACS as a subcontractor.
The ACS Registry Project is approximately a year into a three-year implementation process of migrating all ACS clinical registries into a single platform that will share a data entry platform, data warehouse, and reporting tools. The ACS has partnered with Quintiles on this initiative to build the “registry of the future”; the first release is scheduled for December 2016 and will feature a new SSR and a Trauma Uploader tool.

The College anticipates being awarded the opportunity to participate in a project on Leveraging Advanced Informatics to Automate Data Collection of Healthcare Associated Infections (HAI) and Other Surgical Performance Measures—a four-year project supported by AHRQ. The College also anticipates leading the Comprehensive Unit-based Safety Program for Enhanced Recovery Protocol for Surgery, a five-year project funded by AHRQ that aims to measurably improve patient outcomes through implementation of enhanced recovery after surgery (ERAS) practices in hospitals. The goal is to enroll nearly 1,000 practices spanning five service lines: colorectal, bariatric, orthopaedic, gynecology, and emergency general surgery.

The ACS continues to provide opportunities for residents to work on ACS Quality Programs through the ACS Clinical Scholars in Residence Program. Four Clinical Scholars are working on CQI activities.

**Trauma Programs**

With the 10th edition of the Advanced Trauma Life Support (ATLS®) program scheduled for release in 2017, the ACS intends to implement a new business model in the following phases:

- **Phase 1**—Education model: Delivery modalities, teaching techniques
- **Phase 2**—Financial model: Revenue stream, product offerings, tier pricing
- **Phase 3**—Regulatory model: Compliance audits, disciplinary actions, site visits
- **Phase 4**—Translation model: External versus internal translations
- **Phase 5**—Revisions model: On-demand revisions

Implementation of Phases 1 and 2 is being finalized, and work has begun on Phase 3.

We are in the final stages of revising the manual and mobile learning (mATLS) course. The 10th edition will be available in March 2017, and courses following the 10th edition format will be offered starting in July.

The Basic Endovascular Skills for Trauma (BEST) course—acquired through an agreement with the University of Maryland R. Adams Cowley Shock Trauma Center, Baltimore—provides didactic and hands-on skills training (through use of simulators and cadavers) of endovascular techniques in patients with life-threatening abdominal and pelvic hemorrhage.

The Committee on Trauma (COT) is advocating for a public health/trauma system approach to firearm injury prevention, specifically the implementation of evidence-based prevention programs through its network of trauma centers. Following a survey of COT members and a Town Hall during the 2016 COT Annual Meeting, the Committee on Injury Prevention developed a paper outlining COT members’ views and opportunities to improve firearm injury prevention, which was accepted for publication in the Journal of Trauma and for presentation at an American Association for the Surgery of Trauma (AAST) session.

The COT has taken the position that trauma center designation should be based on population need. An article in the September Bulletin highlights the Needs Based Assessment of Trauma Systems tool that the COT has developed.

The COT, a sponsor of a recent report from the National Academies on Science, Engineering, and Medicine (NASEM), strongly supports the findings and 11 recommendations in A National Trauma Care System: Integrating Military and Civilian Trauma Systems to Achieve Zero Preventable Deaths after Injury. A COT position paper has been drafted as a testament to our support in response to the NASEM
recommendations, which has been accepted for publication in the *Journal of Trauma and Acute Care Surgery*. An October *Bulletin* article describes the position statement, and a portfolio of white papers will be developed to provide details and guidance on areas of focus by the COT. Another important effort related to the NASEM recommendations is the creation of a registry on preventable trauma deaths, which is in development.

As of August, 440 total trauma centers had received COT verification (see Figure 1, this page, for a more detailed breakdown).

As of August 2016, 514 trauma centers were participating in the Trauma Quality Improvement Program (TQIP)® (see Figure 2, this page, for a more detailed breakdown).

The Annual TQIP Conference took place November 5–7 in Orlando, FL. The conference featured the launch of new guidelines for end-of-life/palliative care in trauma, a keynote address by J. Wayne Meredith, MD, FACS, Past-Medical Director, ACS Trauma Programs and Past-COT Chair, and a session featuring the trauma team from Orlando Regional Medical Center describing their experiences related to the Pulse nightclub shooting.

TQIP launched the new program for Level III trauma centers in July 2016 and has already enrolled 52 centers. In addition to risk-adjusted benchmarking, we are offering an online course and educational materials customized to Level III center needs.

The ACS and the Hartford Consensus™ have launched a new website, *BleedingControl.org*, which is designed to assist the public and first responders in the event of a mass casualty or other bleeding control emergency. The site contains easily understood diagrams, videos, and other resources that may be useful in responding quickly to these life-threatening events. As the site evolves, it is anticipated that it also will list bleeding control training courses offered under the auspices of the COT. To further the site’s reach, the College has created a Twitter handle: @bleedingcontrol.

### Cancer Programs

At present, 1,518 cancer programs have Commission on Cancer (COC) accreditation; 472 cancer programs are due for survey in 2016, and 30 new cancer programs applied for accreditation in 2016. As of August, 24 programs had withdrawn or had their accreditation discontinued, and 20 programs were recipients of the 2015 Outstanding Achievement Award.

Six pilot surveys for the National Accreditation Program for Rectal Cancer (NAPRC) were completed this spring. The steering committee convened in June to review the results of the pilot surveys and to modify the survey process and standards manual based on feedback from each of six participating centers. Phase II is now under way. The steering committee is using information from the National Cancer Database (NCDB) to finalize the measures submission process. The ACS is collaborating with the American College of Radiology, College of American Pathologists, and American Society of Colon and Rectal Surgeons (ASCRS) to develop the educational program that will serve as the backbone of the program.

The NCDB completed a call for data in the first quarter of 2016, and more than 9.3 million cancer patient records were submitted to the NCDB in January; 1.4 million of these are new cases diagnosed in 2014, representing approximately 70 percent of all newly diagnosed cases in the U.S.
College staff attended an event to roll out an 80% by 2018 initiative aimed at increasing colorectal cancer (CRC) screening to 80 percent of all Americans ages 50 and older and is assisting the Illinois Comprehensive Cancer Control Coalition with its state screening plan.

The CoC and the National Colorectal Cancer Roundtable held a Hospital Strategy meeting to discuss the role of hospitals in the 80% by 2018 initiative. Two publications resulted: What Can Hospitals Do to Advance 80% by 2018? and What Can Gastroenterologists and Endoscopists Do to Advance 80% by 2018? The latter was co-branded by the ACS and other national medical organizations.

The Third Annual Advocacy Committee Planning Meeting took place February 8–9 in Washington, DC. After a robust discussion of legislative and regulatory policy issues affecting the quality of cancer care, committee members went to Capitol Hill to discuss five pending bills:

- Resolution Recognizing CoC Accreditation
- Removing Barriers to Colorectal Cancer Screening Act
- Cancer Care Payment Reform Act
- Cancer Drug Coverage Parity Act
- Planning Actively for Cancer Treatment Act

The College’s Clinical Research Program (ACS CRP) plans to publish Operative Standards for Cancer Surgery, Volume 2, which will cover the areas of esophagus, gastric, melanoma, rectum, and thyroid cancer surgery, in 2017. Controversies in Surgical Oncology—a series of 10 articles being published in Annals of Surgical Oncology—is based on chapters from Volume One. Discussion of a pediatric surgery edition of Operative Standards for Cancer Surgery is under way.

Two new CRP studies were approved for funding by the Patient Centered Outcomes Research Institute (PCORI); both include an ACS subcontract and will use the NCDB special study mechanism.


Interest in the National Accreditation Program for Breast Centers (NAPBC) remains strong. More than 600 U.S. centers have NAPBC accreditation. A team of six cross-trained surveyors perform these collaborative surveys. Seven new surveyors were recruited in June to accommodate program growth, bringing the surveyor team to 40. The Cancer Programs leadership team continues to identify opportunities for increased collaboration between the CoC and NAPBC.

Member Services
The ACS now has 78,297 members; 64,329 are Fellows (57,263 U.S., 1,330 Canadian, and 5,736 International). Of these Fellows, 8,145 are senior status, and 18,580 are retired; both groups are dues-exempt. From August 1, 2015, to August 1, 2016, 1,116 Associate Fellows joined the College for a total of 2,543 Associate Fellow members; 3,426 residents became members for a total of 9,278 Resident Members; 1,213 medical students became members for a total of 1,858 Medical Student Members; and 197 affiliate members joined for a total of 289 Affiliate Members.

This year’s Initiate class totals 1,823 with 1,256 U.S., 21 Canadian, and 546 international Initiates from 69 countries; 384 Initiates are women, and 1,439 are men. Class size continues to rise and is at its highest point.

Member Services has engaged in the following recruitment and retention initiatives:

- The Realize the Potential of Your Profession campaign continued this year with networking events in Sacramento, CA; Seattle, WA; and New York, NY. More than 30 individuals attended each event.
- A new Fellows survey was conducted to determine areas for improvement and reasons for becoming members.
The Regents were asked to contact non-member surgeons at their institutions and encourage them to apply for ACS Fellowship. They also were asked to contact Fellows in their geographic area and specialty who were delinquent in their dues payments.

Former Fellows terminated over the last five years for nonpayment of dues were contacted and provided with an offer to reinstate their membership via a trial pilot program.

The Member Recognition Workgroup is hosting “reunions” for the Initiate classes of 1966 and 1991 at Convocation this year.

The College continues to add new chapters and to expand the range of services available to them. Details are as follows:

• The Trinidad and Tobago Chapter was chartered as the newest international chapter.

• An Association Management Services pilot program is under way with participation from four chapters.

• The first Chapter Officer Leadership Program will occur in March 2017. This program is designed exclusively for domestic chapter officers seeking to develop their leadership skills.

• A total of 13 webinars have been presented in the last year to provide chapter leaders with strategies and tools to run a successful chapter.

Activities carried out by the Board of Governors (B/G) workgroups include the following:

• Developed ACS statement on concurrent surgery, which was added to the ACS Statements on Principles

• Completion of the 2016 B/G annual survey on such topics as chapter issues/concerns, acute care general surgery, gun violence, and ACS advocacy

• Revision of the Chapter Guidebook

• Establishment of four ACS Communities for International Fellows

• Updates to the ACS NSQIP surgical site infection prevention guidelines and development of guidelines on management of postoperative fever

• Development of resources on the impaired surgeon, burnout, the disruptive surgeon, healthy lifestyles, environmental hazards in the OR, suicide prevention, and coaching

• Development of an Onboarding Checklist for Surgeons

The Young Fellows Association (YFA) has engaged in the following activities:

• Paired 22 mentors/mentees for annual YFA Speed Mentoring Program

• Distributed videos on the value of ACS membership

• Converted 67 Associate Fellows to Fellows

• Worked with Chapter Services to identify at least one YFA representative per chapter

• Conducted a study on OR attire restrictions

• Developed Speed Mentoring abstract for presentation at the Scientific Forum and publication in JACS

Resident and Associate Society (RAS) activities include the following:

• Started the JACS Journal Club to encourage members to read and comment on journal articles
• Had a leadership retreat on the present and future needs of young surgeons

• Started a Military Subcommittee to offer insight into post-residency skills maintenance

• Developed a survey to examine handoff training at different institutions

**Operation Giving Back (OGB)** has established a Committee on Global Engagement, which held its first meeting in July, and OGB’s Domestic Engagement Subcommittee also has been established, with proposed activities include taking inventory of critical access clinics and hospitals, creating a best practice toolkit for domestic volunteerism, encouraging and facilitating rural surgery rotations for residents, and creating an advocacy plan to provide incentives to surgeons in rural areas.

The Subcommittee on International Engagement has been assigned to develop ACS-branded educational products, connect with reliable local partners in low- and middle-income countries, and meet with the Ministers of Health of Ethiopia and Kenya, leaders of the Ethiopian and Kenyan surgical societies, and other organizations to establish opportunities for collaboration.

Other OGB activities are as follows:

• Involvement in disaster response initiatives, including relief efforts following the Ecuador earthquake

• Creation of a disaster responder registry

• Selection of Surgical Volunteerism and Humanitarian Award winners

The **MHSSPACS** has been involved in establishing the Military-ACS NSQIP collaborative described previously; 27 military treatment facilities (MTFs) now participate in ACS NSQIP. A total of 60 military physicians and nurses participated in the Surgeons Leading Quality Course arranged in collaboration with the DoD and attended the ACS NSQIP National Conference in San Diego. Two informal MTF site visits have been conducted—one at Walter Reed National Military Medical Center, Bethesda, MD, and one at Camp Pendleton Navy Center, San Diego. The Military-ACS NSQIP Collaborative will begin by focusing on a narrow quality issue central to each MTF: the surgical checklist to avoid wrong site surgery and retained foreign objects.

Staff is working on development of a MHSSPACS education and training curriculum. The MHSSPACS convened a week-long meeting of subject matter experts with deployment and education experience and worked with DoD representatives to develop a list of knowledge points, skills, and abilities for military surgeons in austere environments. This effort resulted in a task list that includes nine major domains and 500 elements and is anchored by the ACGME core competencies. This program will be distributed in a survey format to more than 700 surgeons with deployment experience who will rank them by importance and frequency of use.

A validation test (both knowledge- and skill-based) will be developed and will eventually lead to a blueprint for a curriculum for the deploying surgeon.

As noted earlier, the MHSSPACS is playing an important role in responding to the recommendations in the NASEM report. The Pentagon has requested that the ACS conduct a capabilities-based assessment to focus on the Joint Trauma System including sustainment, education, and training, and research.

Other MHSSPACS activities are as follows:

• Resurrected the Excelsior Surgical Society, establishing bylaws and a charter and developing a process of electing officers

• Met with the Director of the U.S. Combat Casualty Care Research Program to identify gaps in military medicine that will be the focus of DoD-funded research in the civilian setting

• Worked with the Coalition for National Trauma Research to obtain government funding for the Combat Casualty Care Research Program
WiSC also established the Mary Edwards Walker Inspiring Women in Surgery Award to recognize an individual’s significant contributions to the advancement of women in the field of surgery. The inaugural award was presented to Mary Maniscalco-Theberge, MD, FACS, at Clinical Congress 2016.

The International Relations Committee (IRC) continues to work on the following projects to improve the experiences of international members and guest physicians:

- Finalization of new protocols for consideration of international membership applications
- Selection of the first International Chapter Initiative awardees
- Extending invitations to 20 international scholars and travelers to attend Clinical Congress 2016 and to two international scholars to participate in the ACS NSQIP conference in July
- Establishing the first ACS/American Society of Breast Surgeons International Scholarship, which will be awarded in January 2017
- Creating a new Community Surgeons Travel Award for a rural or small town surgeon from the Philippines

The Scholarships Committee of the College awards talented surgeons and surgeons-in-training with educational opportunities in the U.S. and abroad. A new scholarship, to be shared with American Hepato-Pancreato-Biliary Association, will be offered in 2017.

The Women in Surgery Committee (WiSC) crafted the ACS Statement on the Importance of Parental Leave, recognizing that a successful surgical career should not preclude a surgeon’s choice to be a parent. abolished the Mary Edwards Walker Inspiring Women in Surgery Award to recognize an individual’s significant contributions to the advancement of women in the field of surgery. The inaugural award was presented to Mary Maniscalco-Theberge, MD, FACS, at Clinical Congress 2016. In addition, the WiSC has developed a series of podcasts to highlight women surgeon leaders and continues to sponsor mentorship programs.

The ACS continues to manage the Society of Surgical Chairs (SSC), which now has 180 dues-paying members in the U.S. and Canada, up from 157 in 2010. The number of women members has grown from four in 2010 to 16 in 2016, and a new women’s group met for the first time in April. The SSC mentorship program continues to expand. This spring a year-round program was launched, matching 32 experienced chairs with more junior chairs, based on a detailed survey of interested members.

Integrated Communications

The ACS Public Profile and Visibility team led an initiative to publicize the long-awaited findings from the Flexibility in Duty Hour Requirements for Surgical Trainees (FIRST) Trial. The FIRST Trial showed that allowing trainees to work longer shifts or take less time off between shifts is not associated with a greater likelihood of patient morbidity or mortality. FIRST Trial results were published in the New England Journal of Medicine in February and presented concurrently at the 2016 Academic Surgical Congress in Jacksonville, FL.

On May 17, the ACGME announced that it was issuing a multicenter research trial waiver, along with seed funding, to the FIRST Trial for the 2016–2017 academic year.

Another major initiative of the Division of Integrated Communications this past year has been collaboration with the COT to create Bleedingcontrol.org, discussed previously in this article. The website provides visitors with immediate access to instruction to stop bleeding until first responders can arrive.

Efforts are under way to transition Bulletin readers from the print version to online only. To make your online reading experience more enjoyable, this past year we introduced more user-friendly versions of the Bulletin. Each month, members receive an e-mail alerting them when the new issue is available online and featuring a link that takes them to the...
site. Readers are given three options: they can read the Bulletin website, read an interactive version of the magazine that looks exactly like the print edition, or download the app.

The Bulletin celebrated 100 years of publication. In acknowledgement of that milestone, David L. Nahrwold, MD, FACS, has written A Mirror Reflecting Surgery, Surgeons, and Their College: The Bulletin of the American College of Surgeons. Signed copies of the book were available for purchase at Clinical Congress.

A standard template for designing and developing content for the ACS newsletters has been implemented to ensure they all have a consistent look and feel. These publications are easily viewed on a computer, tablet, or smartphone. The redesigned newsletters launched in April with our most widely distributed newsletter, ACS NewsScope.

This past year, the ACS boosted its efforts to use video to engage key audiences—particularly current and prospective members. The ACS Web team posted and rotated more than 100 videos on the website covering a range of topics, including the results of the FIRST Trial, how surgeons use ACS NSQIP to improve quality in their hospitals, and the value of mentors.

Two new video series were posted on our website. The first series, developed in consultation with the Division of Member Services, is a quartet of videos that showcase the value of ACS Fellowship. The second series, Straight from the Source, developed in consultation with the Division of Education, highlights the value of ACS educational programs.

The College’s social media presence continues to grow. The 104 ACS Communities continue to attract a range of members. The communities have become home to more than 4,100 unique contributors who have posted more than 39,000 messages in approximately 6,500 discussion threads, not including private messages. During this two-year period, there have been nearly 2 million page views (see article on page 87 for more details).

Furthermore, we continue to see upward participation trajectories on our Facebook, Twitter, and LinkedIn pages. By August 15, nearly 20,000 individuals had “Liked” our Facebook page, compared with 12,355 at the same point last year. We had a total of 28,275 Twitter followers—nearly 6,000 more than at the same point last year. And the College now has 9,075 LinkedIn followers, an increase of 2,180 followers over the last year. In addition to sharing ACS news on our LinkedIn site, we have a “Careers” tab to recruit top talent.

In July, JACS launched a redesigned home page at journalacs.org. The layout is more user-friendly, allowing readers to find JACS content quickly, and includes more surgical videos and images, as well as a complete list of the JACS CME articles for the month. The new responsive design is improved for use across all digital devices.

As noted earlier, JACS recently began collaborating with the RAS-ACS to launch an online literature appraisal forum aimed at engaging RAS members with JACS content and encouraging younger surgeons to apply what they learn from discussion of these articles to their own clinical practice. A winning JACS article is selected by ACS Resident members, who then discuss the article via social media with input and commentary from respected surgeons. The inaugural discussion took place in June and generated more than 65,000 impressions on Twitter. Future discussions are projected to occur quarterly.

The Division of Integrated Communications collaborated with Weber/Shandwick on the following initiatives:

• Supported the ACS networking event series described earlier.

• Supported the creation and coordination of Surgeon Retooling Reimagined—a groundbreaking effort to create a national model for the retooling, credentialing, and privileging of surgeons in practice, particu-
larly as it relates to developing ongoing proficiency in surgical procedures and technologies. This event took place at the Methodist Institute for Technology, Innovation & Education in Houston, TX.

- Produced the daily Clinical Congress Highlights.

The College developed 561 marketing and design projects. In addition, Integrated Communications collaborated with Education on a targeted e-mail campaign to surgeons in 14 states recommending courses that might help them fulfill their respective states’ maintenance of licensure requirements.

ACS Foundation

The ACS Foundation saw an increase in contributions this year of more than 11 percent from last year. There was a positive return from the ACS Foundation annual appeals in support of the Greatest Needs Fund, which supports areas not sustained with ACS revenue streams. The ACS Foundation supports the following activities:

- More than 50 international guest scholarships, research fellowships, and traveling scholarships
- ATLS training in Mongolia and Kenya
- OGB’s strategic plan for greater outreach
- Home Skills Kits
- Surgical skills courses at Clinical Congress

The ACS Foundation is tracking the career progress of its past scholarship recipients to show the long-term impact that awarding funding that can have on surgical careers and patient care. Many recipients have credited the ACS with the start in their surgical research careers, which are having a lifesaving, transformative impact on surgical patients.

Support teams

The ACS remains financially sound thanks to the hard work and strategic planning of our Finance and Accounting teams. Our Convention and Meetings team continues to do a phenomenal job of coordinating the logistics not only of the Clinical Congress but of all ACS educational conferences and thousands of internal and external meetings. This area also worked on the pilot Chapter Management Program described earlier.

Our Human Resources and Performance Improvement teams continue to recruit top talent, and provide a range of opportunities for the staff to grow professionally and personally. Our Information Technology staff support many of the electronic programs and services described throughout this report.

Through the commitment of the staff and volunteers of the ACS, this organization continues to lead the way in ensuring all Americans have access to high-quality surgical care. It is an honor and privilege to continue to serve as your ACS Executive Director.
The benefits of attending a 2017 ACS Surgical Coding Workshop

by Jan Nagle, MS, RPh

Each year, the American College of Surgeons (ACS) hosts a series of two-day workshops on correct reporting of Current Procedural Terminology (CPT)* codes with an emphasis on codes commonly used by general surgeons. Led by ACS practice management consultants, these programs include practical explanations for reporting changes, real-life case examples, and educational materials developed by the American Medical Association (AMA).

Who should attend an ACS Surgical Coding Workshop?
The workshops are beneficial for surgeons, administrators, managers, coders, and reimbursement staff. Team attendance is strongly encouraged to ensure accurate, consistent, and complete coding. If the physician is an ACS member, team members or practice employees may attend the workshop at the ACS member rate.

Why should I attend a coding workshop?
When accurate coding is aligned with a clear understanding of payment policies, practices tend to improve their profit margins. Attending an ACS coding workshop increases participants’ knowledge of coding principles and helps them to reduce coding errors and the risk of an audit. The workshop also provides information regarding new codes and audit trends. Furthermore, attendees have the opportunity to share their different coding and practice management ideas, knowledge, and experiences with the other attendees.

What is covered each day of the workshop?
In 2017, the first day of the workshop will focus on correct coding. Topics for discussion include the following: reviewing the accuracy of evaluation and management (E/M) coding against Centers for Medicare & Medicaid Services benchmarks; assessing the built-in coding features of your electronic health record system for risks; using the 10th revision of the International Classification of Diseases codes to enhance payment; monitoring and managing your online reputation; addressing deficiencies in practice accounts receivable management; and sharpening your ability to review financial reports.

The second day of the workshop centers on surgical case coding. The instructor will discuss the information that should be included in an operative note if a surgeon is seeking reimbursement for an operation performed with an assistant or co-surgeon.

Other topics that will be discussed on the second day include the following:

• The difference between CPT and Centers for Medicare & Medicaid Services rules for coding and billing

• Services included in the global surgical package and what should be reported separately

• Use of modifiers and their effects on reimbursement

• How to report and get paid for unlisted procedures

• Coding for excisional breast biopsy or partial mastectomy

• How to initiate a successful appeal when receiving incorrect payment

• When and how to report E/M services for major and minor procedures, especially trauma

• The difference between returning a patient to the operating room to treat a surgical complication and a staged procedure

• Procedures correctly documented and reported that are unrelated to operations done previously in the global period

Do we need to attend another workshop in 2017?
The College recommends attending a workshop once a year because the AMA updates

*All specific references to CPT codes and descriptions are © 2015 American Medical Association. All rights reserved. CPT and CodeManager are registered trademarks of the American Medical Association.
the CPT code set annually. Moreover, improvements in coding constructs, additions of new technology, and changes to coding and reimbursement rules and payment policies make it beneficial to attend regularly.

Can I earn CME credit?
Physician attendees are eligible to receive Continuing Medical Education (CME) credits through the ACS. Physicians are eligible for 6.5 CME credits for each day of attendance. In addition, nonphysician attendees who are members of the American Academy of Professional Coders are eligible for 6.5 continuing education units for each day of attendance.

When and where will the 2017 ACS surgical coding workshops take place?
Dates and locations are as follows:

- January 26–27: Las Vegas, NV
- May 11–12: Oak Brook, IL (Suburban Chicago)
- August 10–11: Nashville, TN
- November 10–11: Chicago, IL (Downtown)

How do I register?
Register for the two-day workshop online at facs.org/advocacy/practmanagement/workshops/dates or by phone at 312-642-8310. The College offers a special rate for members and their coding staff, but ACS membership is not a requirement for attendance. The member price is $650 per course or $995 for both days. The nonmember price is $750 per day or $1,095 for both days. ACS Fellows and their staff should have their ACS member number available and enter it for each individual registering.

For hotel reservations, contact the hotel that is hosting the workshop. For special pricing, indicate that you are attending the ACS Surgical Coding Workshop (see Table 1, this page). The College also offers airfare discounts on United Airlines. Contact an ACS travel counselor at 800-456-4147 or ACSTravel@facs.org, or contact United Airlines by phone at 800-521-4041 or online at www.united.com. When booking individual travel, be sure to indicate the name of the meeting and refer to the ACS file numbers provided for any applicable discounts. The ACS file numbers are Agreement Code: 973454; ZCode: ZTEZ.

What other coding resources does the College offer?
To assist surgeons in their efforts to address coding questions, the ACS offers the following resources:

- The Coding Hotline (800-227-7911): Available Monday–Friday (except holidays), 9:00 am–6:00 pm Eastern time, Coding Hotline staff will answer five free coding questions per year for each Fellow of the ACS. For additional information about the ACS Coding Hotline, visit the ACS website at facs.org/advocacy/practmanagement/.

- Coding and practice management corner: This column, published periodically in the Bulletin, provides tips on a range of reimbursement-related issues. Topics covered in past years have included coding for hernia and other complex abdominal repairs, debridement, and sentinel lymph node mapping and its relation to biopsy. This month’s column focuses on modifier 25 (see page 65). These and other articles are available on the ACS website at facs.org/advocacy/practmanagement/cpt.

### TABLE 1. 2017 SURGICAL CODING WORKSHOPS

<table>
<thead>
<tr>
<th>City</th>
<th>Date</th>
<th>Hotel/venue</th>
<th>Hotel phone</th>
<th>Rate</th>
<th>Hotel cut-off date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Las Vegas, NV</td>
<td>January 26–27</td>
<td>The Venetian Las Vegas</td>
<td>888-283-6423</td>
<td>$241</td>
<td>1/4/2017</td>
</tr>
<tr>
<td>Oak Brook, IL (Suburban Chicago)</td>
<td>May 11–12</td>
<td>The Hyatt Lodge at McDonald’s Campus</td>
<td>888-421-1442</td>
<td>$149</td>
<td>4/19/2017</td>
</tr>
<tr>
<td>Nashville, TN</td>
<td>August 10–11</td>
<td>Loews Vanderbilt Hotel</td>
<td>800-336-3335</td>
<td>$184</td>
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</tr>
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<td>Chicago, IL (Downtown)</td>
<td>November 10–11</td>
<td>Hyatt Chicago Magnificent Mile</td>
<td>888-591-1234</td>
<td>$199</td>
<td>10/20/2017</td>
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The Centers for Medicare & Medicaid Services (CMS) has again identified the potential overuse and misuse of Current Procedural Terminology (CPT®) code modifier 25. In the recently published proposed rule for the calendar year (CY) 2017 Medicare Physician Fee Schedule, CMS indicates that its CY 2015 Medicare claims review shows that 19 percent of the codes that describe 0-day global services were billed more than 50 percent of the time, with an evaluation and management (E/M) service with modifier 25 appended. CMS maintains that the routine billing of separate E/M services may indicate a possible problem with the valuation of the procedure.

This issue has been raised on multiple occasions since 2005, when the Office of the Inspector General (OIG) published an analysis showing that 35 percent of Medicare claims for modifier 25 did not meet Medicare program requirements. Since then, CMS and private payors have increased their scrutiny of codes reported with this modifier, sometimes resulting in significant repayment to Medicare. For example, earlier this year, the U.S. Attorney’s Office for the Northern District of Georgia reached a settlement with a dermatology practice to pay $1.9 million to settle claims that they violated the False Claims Act by billing Medicare for E/M services that were prohibited under Medicare rules.

To understand why modifier 25 is under this type of scrutiny, surgeons need to understand how its use is defined. Simply put, modifier 25 is appended to an E/M code when a procedure and a separate and significant E/M service is performed by the same physician during the same session or on the same date. The definition of what is “separate and significant” is at the heart of whether both an E/M...
with modifier 25 and a procedure code may be reported together.

**Definition of modifier 25**
Medicare requires that modifier 25 be used only on claims for E/M services and only when the E/M service is provided by the same physician on the same day as a global procedure or service. In addition, payment is made only if the physician indicates that the service is for a significant, separately identifiable E/M service that is above and beyond the usual preoperative and postoperative work required on the day of the procedure. The physician must appropriately and sufficiently document both the medically necessary E/M service and the procedure in the patient’s medical record to support the claim for these services, even though the documentation is not required to submit with the claim.

CPT, on the other hand, defines modifier 25 as a significant, separately identifiable E/M service that the same physician or other qualified health care professional provides on the same day as the procedure or other service. The CPT codebook also states that a significant, separately identifiable E/M service is substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported.

**Significant and separately identifiable**
What exactly does significant and separately identifiable mean? How do you know when you have performed this service and therefore need to document a significant and separately identifiable E/M service? It is important to note that the relative value unit (RVU) for each minor procedure includes pre-service work that may include pre-evaluation time, patient positioning time, and time to scrub and dress before the procedure (see Table 1, this page, for examples). As shown, the Medicare payment for incising and draining an abscess (10060) in the office includes 16 minutes of pre-service time. Medicare payment for performing a diagnostic colonoscopy (45378) includes 27 minutes of pre-service time. The RVUs for each of these procedures also includes intra-service time (in effect, the time it takes to perform the procedure), as well as post-procedure time. For both services, significant pre-service time is dedicated to evaluation: eight minutes for the abscess and 19 minutes for the colonoscopy.

Reporting an E/M code and a procedure code when your evaluation is limited to assessing the specific problem (for example, an abscess) is essentially double billing for the pre-service evaluation. Your E/M must significantly exceed the pre-service evaluation already paid as part of the procedure for it to qualify as significant and separately identifiable. If it does not, only the procedure should be billed. A different diagnosis code is not needed, and in most cases the diagnosis code for the E/M code and the procedure code will be the same. What must be documented is the history, exam, and decision-making process (all for a new patient and two of three for an established patient) that includes attention to more than the patient’s targeted chief

<table>
<thead>
<tr>
<th>CPT code</th>
<th>Global period in days</th>
<th>Procedure</th>
<th>Pre-evaluation time</th>
<th>Patient positioning time</th>
<th>Other pre-service time (dress/scrub)</th>
<th>Total pre-service time</th>
</tr>
</thead>
<tbody>
<tr>
<td>10060</td>
<td>10</td>
<td>Incision and drainage abscess</td>
<td>8</td>
<td>3</td>
<td>5</td>
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<td>32551</td>
<td>0</td>
<td>Tube thoracostomy</td>
<td>30</td>
<td>3</td>
<td>10</td>
<td>43</td>
</tr>
<tr>
<td>36561</td>
<td>10</td>
<td>Insert CVA [central venous access] with port</td>
<td>20</td>
<td>5</td>
<td>10</td>
<td>35</td>
</tr>
<tr>
<td>45378</td>
<td>0</td>
<td>Colonoscopy, diagnostic</td>
<td>19</td>
<td>3</td>
<td>5</td>
<td>27</td>
</tr>
<tr>
<td>49421</td>
<td>0</td>
<td>Insert intraperitoneal catheter, open</td>
<td>33</td>
<td>3</td>
<td>10</td>
<td>46</td>
</tr>
</tbody>
</table>

Source: CY 2016 Medicare Physician Fee Schedule Time/Visit Database
complaint that is the reason for the minor procedure.

**Avoiding misuse of modifier 25**

To avoid overuse or misuse of modifier 25 and reduce the risk of an audit and repayment demand by payors, the ACS offers the following recommendations:

- Do not automatically report an E/M code every time you perform a minor procedure in an office or facility.

- Append modifier 25 to the E/M code on the claim, not to the procedure code.

- Recognize that every procedure includes pre-service time as part of the fee.

- If you perform an E/M service above and beyond the pre-service time associated with the procedure, make sure that the extended E/M work is medically necessary; don’t evaluate other body areas or organ systems unless a good clinical rationale for doing so can be provided.

- Both the medically necessary E/M service and the procedure must be appropriately and sufficiently documented in the patient’s medical record to support the need for modifier 25, even though

**EXAMPLES OF PROPER USE OF MODIFIER 25**

**Example of an encounter resulting in the reporting of both a procedure code and E/M code with modifier 25, with two different diagnoses:** A woman arrives at your office with a suspicious lesion on her arm. She also complains that her left leg has been swelling and she has pain deep in her thigh. Before performing the biopsy on her arm, you take a history related to her complaint of leg swelling with pain and examine the patient, including palpating the lower abdomen and assessing the lower extremities for varicosities and phlebitis. You counsel her to wear compression stockings and elevate her legs and schedule a follow-up to determine if conservative therapy is helpful. Report the biopsy procedure code and an appropriate E/M code with modifier 25. Two separate diagnoses should be reported on the claim.

**Example of an encounter resulting in only reporting a procedure code:** A woman arrives at your office for a repeat injection of steroid at the base of her right thumb to relieve arthritis pain and swelling. She mentions that she has recently had the same pain on her left hand. After a focused exam of her left hand, you decide to perform a second injection. Report the injection code with modifier 59 and modifiers to indicate left thumb and right thumb as appropriate. No separate E/M code should be reported.

**Example of an encounter resulting in only reporting a procedure code:** A patient arrives at your office complaining of bright red blood from the rectum. You conduct a detailed history and physical exam including abdominal, rectal, and genitourinary examination. You then perform a diagnostic anoscopy. Your medical decision making is aided by the anoscopy findings but is based on the history and physical exam. Report the anoscopy and an appropriate E/M code with modifier 25. Only one diagnosis should be reported.
the documentation is not required to be submitted with the claim.

• Modifier 25 may be used in the rare circumstance of an E/M service the day before a major operation and represents a significant, separately identifiable service; it likely would be associated with a different diagnosis (for example, evaluation of a cough that might affect the operation).

• Different diagnoses are not required to report the E/M service on the same date as the procedure or other service. As an example, a patient who has been treated in the past for gastroesophageal reflux disease (GERD) and is scheduled to have an upper endoscopy now complains of exacerbation of known irritable bowel syndrome (IBS) and asks that you review the medications for this condition. The upper endoscopy is performed for the workup of GERD and the medications for IBS are adjusted. The work associated with the E/M related to IBS would be reported with the E/M code and modifier 25 appended to indicate this is a separate service.

Disclaimer
Accurate coding is the responsibility of the provider. This summary is intended only to serve as a resource to assist in the billing process.

REFERENCES
Over the years, the American Society of Clinical Oncology (ASCO) and the National Comprehensive Cancer Network (NCCN) have established and updated standards of quality multidisciplinary cancer care and disease-specific treatment guidelines. However, until recently, little critical effort has been made to define standards for the technical conduct of cancer operations. This gap is surprising, given that surgical resection is the component of multidisciplinary cancer care that is both most likely to lead to the cure of solid tumors and most likely to vary in the way it is delivered.

What is coming in Volume 2?
To address this critical need, the American College of Surgeons (ACS) and the Alliance for Clinical Trials in Oncology collaborated to publish the first volume of Operative Standards for Cancer Surgery in 2015. The first in a planned series of surgical manuals, the manual focused on curative operations for patients with cancer of the pancreas, breast, lung, and colon. The second volume in the series, which will be published in early 2017, describes operations for cancers of the esophagus, stomach, rectum, thyroid, and skin (melanoma).

Both volumes illustrate the specific surgical steps required to complete cancer operations. They go well beyond the standard surgical atlas by defining the technical elements of surgery necessary to achieve optimal therapeutic outcomes, establishing minimum standards for the performance of cancer operations, and identifying key surgical questions in need of further investigation in clinical trials. These minimum standards are ideal for use in the context of cooperative group clinical trials.

Within each disease site, all operations are deconstructed into their critical oncologic elements—the technical elements of each operation that are believed to have the most significant influence on survival and/or quality of life. A thorough description of the proper performance of these oncologic steps is then clearly presented based on a review of available evidence supplemented by expert consensus. For example, the lymph node stations that should be removed as part of an optimal lymphadenectomy for pancreatic cancer to optimize both staging and long-term survival are reviewed, and the steps necessary to clear those lymph node basins are described and illustrated.

Key questions related to the conduct of each operation—questions for which clear answers to guide standard surgical practice continue to remain elusive—are also posed and answered following rigorous, systematic reviews of the literature. Templates that can be used to facilitate operative reporting also are included for each disease site.

The authors for each disease site include representatives from all the major national societies and cooperative groups, as well as international experts. Together, they serve on the ACS Clinical Research Program Cancer Care Standards Development Committee. In addition to publishing these manuals, the committee, led by Matthew H. G. Katz, MD, FACS, and Nirmal Veeramachaneni, MD, FACS, has been charged with oversight of the surgical components of clinical trials run by the Alliance for Clinical Trials in Oncology.

The first two volumes in this series are available in print and digitally. Future editions in the series, which will focus on other cancer disease sites, will be published online to facilitate inclusion of films, educational materials, and other media.
The American College of Surgeons (ACS) Operation Giving Back (OGB) program and the ACS Archives offer members unique opportunities to engage with the College on a broad scale. The OGB allows members to submit profiles describing their volunteerism interests so they can be matched with agencies that need humanitarian assistance both internationally and domestically. Through OGB, members also may volunteer to provide assistance in the event of a disaster. The Archives appeals specifically to history enthusiasts and researchers, allowing them to interact directly with the College’s collection of archival files. We encourage you to take advantage of these engagement opportunities as a benefit of your membership in the ACS.

**Engage in surgical volunteerism through OGB**

OGB’s mission is to leverage the passion, skills, and humanitarian ethos of the surgical community to meet the needs of medically underserved patients domestically and globally. OGB provides the tools necessary to facilitate humanitarian outreach among surgeons of all specialties and at all stages of their career. By delivering information on opportunities to volunteer through patient care, education, training, systems strengthening, advocacy efforts, and donation of needed equipment and supplies, OGB focuses these resources to address critical public health issues as they relate to the provision of safe, timely, and necessary surgical care around the globe.

**Become a partner organization**

A central feature of our program is to match participating partner organizations and their available opportunities with volunteers. Using our portal, organizations wishing to partner with OGB can post opportunities and connect with volunteers.

OGB recently introduced a new Web portal that allows individuals and organizations to post and search for volunteerism opportunities in several areas, including service, fellowship, funding, education, and research.

In addition, OGB continually posts and updates our resources and toolkits to provide you with helpful information along your journey to providing service. Visit the OGB homepage at [facs.org/ogb](https://facs.org/ogb) today to find out more information and sign up for the portal and other program features. For more information, e-mail [ogb@facs.org](mailto:ogb@facs.org).

**ACS Archives provides historical context**

The legacy of the College provides a historical context for members to have a sense of who they are and where they have come from as surgeons. The ACS Archives gathers and preserves original College source materials such as meeting minutes, correspondence, reports, publications, and photos—the unique raw materials used primarily by historians. We also conduct oral history interviews of ACS Past-Presidents and make the videos and transcripts available in the Archives catalog.

However, on a day-to-day basis, the Archives’ first priority is to provide access to its research assistance. Sometimes this involves working with in-person users to facilitate their research on general topics, such as medical motion pictures,
hospital standardization, or the evolution of the requirements for Fellowship. At other times it means providing answers to specific questions such as:

- Was my grandfather a Fellow?
- Do you have information on the Canadian founders of the College?
- Was our hospital accredited by the ACS in 1937?
- Can you provide a photo for the article I am writing?
- Who were my fellow Initiates from the Convocation of 1965?
- Can you send me information on Dr. Jones for a book I am writing?
- Do you have any records of the 1985 Planning Committee meeting?
- I wrote an article for *Surgery, Gynecology & Obstetrics* in 1980. Can you send me a copy?

Search the Archives Catalog at [facs.org/archivescatalog](http://facs.org/archivescatalog) to find detailed descriptions of our holdings and to see some photos and videos. You can search by keyword and browse by topic, subject name, creator, or collection, and you can view groups of selected photos and videos.

If you are planning to visit the ACS headquarters in Chicago, IL, arrange for a brief tour of the Archives by emailing dbarber@facs.org. Or visit [facs.org/archives](http://facs.org/archives) to learn about the history of the College and how to use the Archives. Members are always given priority access, and all research and reproduction fees are waived.

History devotees are encouraged to join the ACS Surgical History Group (SHG). Members may sign in with a username and password at [acscommunities.facs.org/home](http://acscommunities.facs.org/home) and join the History of Surgery online community. The SHG sponsors various events at Clinical Congress, including a Poster Session, a history presentation given at the SHG breakfast, and a special history panel session. Also watch for regular From the Archives columns in upcoming issues of the *Bulletin*.

### Member benefits

The College is committed to using its resources, including the human capital of its thousands of members, to enhance the care of surgical patients around the world through OGB. In addition, the College is committed to preserving its more than 100-year history for future generations of health care professionals through the ACS Archives. Members looking for a way to engage with the College are encouraged to participate in these programs.
A patient arrives in the emergency department with the following comorbidities: renal failure, diabetes, obesity, and hypertension. The patient, whose chief complaint is chest pain, is reported to the triage unit with back pain—a secondary complaint—because the patient has been previously treated at the facility for back issues. In fact, the patient was seen earlier in the day for a cortisone shot.

Because of the preconceptions born from the patient’s recent medical history, the primary nurse skips performing an independent evaluation of the patient, who is found deceased a short time later.

What are cognitive biases?
This case study showcases several cognitive biases. More than 100 cognitive biases are believed to exist. They are flaws or distortions in judgment and decision making, which have become increasingly recognized as contributors to patient safety events, such as unintended retention of foreign objects, wrong site surgeries, delays in treatment, and patient falls.

According to a 2015 report from the National Academies of Sciences, Engineering, and Medicine, Improving Diagnosis in Health Care, diagnostic errors are associated with 6 percent to 17 percent of the adverse events that occur in hospitals, with 28 percent of diagnostic errors being attributed to cognitive bias.*

Examples of cognitive bias include the following:

- Anchoring bias: Giving weight to and reliance on initial information or impressions
- Ascertainment bias: Shaping decision making based on prior expectations
- Availability bias: Judging the likelihood of a diagnosis based on the ease with which examples can be retrieved

Several factors contribute to the presence of cognitive biases in medical decision making. Personal factors, such as fatigue or emotional state, may play a role, as can patient factors, such as presenting with many comorbidities or without a complete medical history.

- Confirmation bias: Selectively noticing or seeking information that confirms an opinion or impression
- Diagnostic momentum: After a label has been assigned, momentum builds, reducing the ability to consider alternatives
- Framing effect: How information is presented or how a question is asked may affect future decisions
- Search satisficing/premature closure: Cease looking for findings once a potential cause has been identified or accept a diagnosis before considering or verifying all information

Recognizing cognitive bias
Several factors can contribute to the presence of cognitive biases in medical decision making. Personal factors, such as fatigue or emotional state, may play a role, as may patient factors, such as presenting with many comorbidities or without a complete medical history.

System factors also may play a role, with issues stemming from workflow designs, poor teamwork or communication, and insufficient time to gather and interpret information.

As evidenced in the case study described at the beginning of this column, it is important that health care organizations recognize cognitive biases and put systems into place to alleviate the problem.

The Joint Commission recently published a Quick Safety e-newsletter on cognitive biases, which identified several safety actions to mitigate the effects of cognitive bias, including the following:

- Enhance knowledge and awareness of cognitive biases
- Enhance professional reasoning, critical thinking, and decision-making skills
- Enhance work system conditions and workflow designs that affect cognition
- Promote an organizational culture that supports the decision-making process

For a more detailed explanation of the types of cognitive biases that exist, as well as more information on safety actions to alleviate these biases, read Quick Safety 28: Cognitive biases in health care.†

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

The bittersweet truth about diabetes is that it can be a challenge for both the practitioner and the patient to understand the consequences of the disease and the best ways to treat it. Early on in medical history, authors noted shorter lifespans, sexual dysfunction, and alterations in appetite of those whom had a “sweet taste” to their urine.1

Worldwide epidemic
Although the understanding of diabetes has increased, so too has its presence in the global population. Diabetes is a progressively growing epidemic in the U.S. as well. In fact, 29 million people in the U.S. are diabetic, with an even larger number who are prediabetic.2

The micro- and macrovascular complications related to this disease extend beyond those related to an elevated glucose level. Even in the modern era, the loss of eyesight, renal function, and even limb amputations are more common in diabetics than in non-diabetics.3 Furthermore, diabetes has been linked to increased morbidity and mortality in the setting of acute illness.4 The likelihood of morbidity resulting from wound healing and infectious complications is put to the test when a diabetic sustains an acute traumatic injury. These patients are more likely to have wound infections than burn patients, as well as prolonged intensive care unit (ICU) stays and days on the ventilator compared with non-diabetic injured patients.4,5

Effects on injured patients
To examine the effect of diabetes mellitus on cases of injury reported in the National Trauma Data Bank® (NTDB®) research dataset for admissions year 2014, medical records were searched by comorbidity code 11 (diabetes mellitus). The records were then divided into two groups: those for patients with diabetes (94,399) and those for patients without (866,157). A total of 792,761 records contained a discharge status. In comparing the diabetic group to the non-diabetic group respectively, 50 percent and 70.3 percent of patients were discharged to home; 16.3 percent and 11.4 percent to acute care/rehab; and almost twice as many to a skilled nursing facility—29.3 percent and 15.2 percent. There were 40 percent more deaths in the diabetic group—4.4 percent versus 3.2 percent (see Figures 1 and 2, page 75). The diabetic patients were more than 20 years older on average (68 years of age) than the non-diabetic group (an average of 47 years old). The diabetic group had an average hospital length of stay of 6.2 days versus the non-diabetic group’s 4.9 days. Patients were on the ventilator for an average of 7.2 and 5.9 days, respectively. Of those tested for alcohol, 22 percent of the diabetics had alcohol present, whereas more than one-third (35 percent) of non-diabetics tested positive for alcohol. Direct effects of glucose derangements can lead to injury from motor vehicle collisions and falls.6 However, a patient’s diabetes is more often a secondary disease process needing to be treated while they recover. Health care professionals’ understanding of the breadth of consequences that can come from having diabetes is on the rise. As its presence in the health care population becomes more common, one should not lose

Don’t sugarcoat it
sight of the critical nature this diagnosis has on the well-being and recovery of our patients. Patients often ask trauma surgeons for prognoses. When it comes to diabetic trauma, surgeons should not sugarcoat it.

Throughout the year, we will be highlighting NTDB data through brief reports in the Bulletin. The National Trauma Data Bank Annual Report 2015 is available on the ACS website 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 was provided by Chrystal Caden-Price, Data Analyst, NTDB.

REFERENCES
Barbara Lee Bass, MD, FACS, the John F. and Carolyn Bookout Distinguished Endowed Chair and chair, department of surgery at the Houston Methodist Hospital, TX, was elected President-Elect of the American College of Surgeons (ACS) at the Annual Business Meeting of the Members October 19 in Washington, DC. The First and Second Vice-Presidents-Elect also were elected.

**Barbara Lee Bass, MD, FACS**, the John F. and Carolyn Bookout Distinguished Endowed Chair and chair, department of surgery at the Houston Methodist Hospital, TX, was elected President-Elect of the American College of Surgeons (ACS) at the Annual Business Meeting of the Members October 19 in Washington, DC. The First and Second Vice-Presidents-Elect also were elected.

**President-Elect**

Dr. Bass is highly respected for her outstanding clinical and academic contributions to the field of general surgery and her commitment to teaching the next generation of surgeons. Dr. Bass is the executive director of the Houston Methodist Institute for Technology, Innovation and Education (MITIE), a state-of-the-art education and research facility developed to safely train practicing health care professionals in new technologies and procedures. She is professor of surgery at Weill Cornell Medical College, New York, NY, and a senior member of the Houston Methodist Hospital Research Institute.

Before assuming these roles at Houston Methodist in 2005, Dr. Bass was professor of surgery (1994–2005), associate chair for research and academic affairs, and general surgery residency program director, department of surgery, University of Maryland, Baltimore (1999–2005), where in 1997, she was interim chair, department of surgery. While at the University of Maryland, Dr. Bass also served as chief, gastrointestinal surgical research (1994–2005), Veterans Affairs (VA) Medical Center, Baltimore. Earlier appointments included faculty positions at the George Washington University School of Medicine, Washington, DC; the Uniformed Services University of the Health Sciences (USUHS); and the Walter Reed Army Institute of Research, Bethesda, MD.

A Fellow of the College since 1988 and the 2013 recipient of the College’s highest honor—the Distinguished Service Award—Dr. Bass served as an ACS Regent (2001–2010) and on the Executive Committee of the Board of Regents (2005–2009). As a Regent, she was a member of the Finance Committee (2005–2010), Member Services Liaison Committee (2004–2008), Central Judiciary Committee (2002–2005), and the Scholarship Committee. She is a Past-Chair of both the ACS Committee on Education (2003–2006) and the Clinical Congress Program Committee (2005–2011).


Dr. Bass has championed the National Surgical Quality Improvement Program (NSQIP) since its inception at the VA. While at the VA Medical Center in Baltimore, she helped to launch the program, and served as a principal investigator at a participating institution in the Agency for Healthcare Research and Quality’s testing of the program (1994–2002). She went

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A contributor to a number of ACS educational initiatives, Dr. Bass was an author of the Surgical Education and Self-Assessment Program (SESAP®) (1996–2002). During her term as an ACS Regent and Chair of the American Board of Surgery (ABS), she served on the American Surgical Association’s Blue Ribbon Committee, cosponsored by the ACS, to evaluate and recommend changes in surgical training. As Chair of the Program Committee, she led the Clinical Congress strategic planning process in 2006. As a result, the annual meeting was restructured progressively in 2007–2010 to facilitate access to high-quality specialty and program-specific content tracks. Programmatic review, targeted expansion, a review course for board examination preparation, Meet-the-Expert Luncheons, and Town Hall meetings were added to the Clinical Congress during this process. Dr. Bass continued to serve as a consultant to the Program Committee until 2014.

She was recently appointed Co-Chair of the Committee on Skills Training for Surgeons in Practice with Ajit K. Sachdeva, MD, FACS, FRCSC, Director, ACS Division of Education. This committee will address retooling needs and strategies for practicing surgeons who need to acquire new skills. To launch this effort, she hosted the Surgeon Retooling Reimagined symposium at MITIE earlier this year.

Dr. Bass has held leadership roles in many other surgical associations, including chair, ABS; president, Society for Surgery of the Alimentary Tract; and president, Society of Surgical Chairs. She has inspired other women in surgery and, as a result, has received the Nina Starr Braunwald Award and the Olga Jonasson Distinguished Member Award from the Association of Women Surgeons.

A mentor to more than 30 pre- and postdoctoral fellows, she has authored or co-authored 145 peer-reviewed papers, delivered 52 named lectures, and presented 109 invited talks. Dr. Bass’ research programs in gastrointestinal cell biology, computational surgery, surgical outcomes sciences, and clinical research have been funded by the National Institutes of Health (NIH), the VA Research program, the National Science Foundation, and other groups. Her first grant was an ACS Faculty Research Award (1987). She has served as a member of the NIH Surgery and Bioengineering Section and has served on the editorial boards or as associate editor of many surgical journals, including the Journal of the American College of Surgeons, Annals of Surgery, and Surgery.

Dr. Bass graduated summa cum laude with a bachelor of science degree from Tufts University, Medford, MA (1975). She earned her medical doctorate (MD) from the University of Virginia, Charlottesville (1979), where she was elected to the Alpha Omega Alpha Honorary Society. She completed her surgical internship and general surgery residency at George Washington University (1986), while completing gastrointestinal surgical research fellowship and serving as Captain, U.S. Army Medical Corps (1982–1984).

**Vice-President-Elects**

The First Vice-President-Elect is Charles D. Mabry, MD, FACS, a general surgeon from Pine Bluff, AR, and associate professor of surgery and practice management advisor to the chair, department of surgery, University of Arkansas for Medical Sciences, Little Rock. Dr. Mabry also is medical director of...
Dr. Mabry’s command of analytical data and effective communication skills led to his appointment as an ACS representative on the American Medical Association Relative Value Update Committee. In a related activity, he serves on the ACS General Surgery Coding and Reimbursement Committee.

quality, Jefferson Regional Medical Center, Pine Bluff.
Dr. Mabry serves on the Governor’s Trauma Advisory Committee for the State of Arkansas and chairs the committee’s Quality Improvement Subcommittee. He is Chairman of the Board for the Arkansas Preferred Provider Organization and previously served on the Continuing Medical Education Committee and as Vice-Chair of the Board for the Arkansas Foundation for Medical Care. In addition, he has served on the Governor’s Advisory Council for Emergency Medical Service—Training Committee.

A Fellow of the College since 1984, Dr. Mabry has been a tireless and committed volunteer since he joined the Young Surgeons Committee in 1989. He was a member of the committee until 1993 and then went on to serve as Vice-Chair through 1995. His command of analytical data and effective communication skills led to his appointment as an ACS representative to the American Medical Association Relative Value Update Committee (1995—present).

Dr. Mabry served three terms on the Board of Regents (2002—2011). As a Regent, he was a member of the Finance Committee (2003—2011), the Executive Committee (2010—2011), and the Advisory Council for Pediatric Surgery (2002—2003); he chaired the Member Services Liaison Committee (2008—2011) and the Health Policy Steering Committee (2006—2009).

Dr. Mabry also has served on the Board of Governors Committee on Socioeconomic Issues (2007—2009, 2011—2013) and the Health Policy and Advocacy Workgroup (2013—2014), the Program Committee (2006—2009, 2011—2014), and the Communications Committee (1991—1995, 2002—2003). Dr. Mabry is a member of the ACS Health Policy Advisory Group and Chair of the Health Policy Advisory Council. He is a Past-President of the Arkansas Chapter, Past-Chair of the Arkansas Committee on Trauma, and member of the Arkansas Committee on Applicants.

Dr. Mabry is a 1971 graduate of the University of Central Arkansas, Conway. He earned his medical degree and completed his general surgery residency at the University of Arkansas for Medical Sciences (1975 and 1979, respectively).

The Second Vice-President-Elect is Basil A. Pruitt, Jr., MD, FACS, FCCM, MCCM, a Past-Governor of the ACS. Dr. Pruitt is the Dr. Ferdinand P. Herff Chair in Surgery, clinical professor of surgery, department of surgery, trauma division, University of Texas Health Science Center at San Antonio, and professor of surgery at USUHS. Dr. Pruitt is an esteemed leader in four broad areas: burn, trauma, injury, and critical care surgery; biomedical research and scholarship; organizational leadership and development; and mentorship.

Between 1967 and 1968, Dr. Pruitt was chief of surgery and chief of professional services at the busiest evacuation hospital in Vietnam (400—500 major operations per month) and then chief of the trauma research team, studying cardiopulmonary responses to injury in combat casualties. Dr. Pruitt served as Commander and Director of the U.S. Army Institute of Surgical Research for 27 years and became a trailblazer in the management of trauma, burn, and critical care patients worldwide.

Dr. Pruitt has been recognized with appointments to NIH
Dr. Pruitt is an esteemed leader in four broad areas: burn, trauma, injury, and critical care surgery; biomedical research and scholarship; organizational leadership and development; and mentorship.

He has served as a reviewer and referee for the Hong Kong Research Grants Council, the BC (British Columbia) Health Research Foundation and the Alberta Heritage Foundation, the U.S. VA, and the NIH. Perhaps Dr. Pruitt’s most enduring legacy is his mentorship of a cadre of leading physicians and scientists, including 46 directors of burn centers, more than 20 department chairs, and 11 past-presidents of the American Burn Association.

He has received national and international commendations for his contributions to patient care. A few examples include the National Safety Council’s Surgeons Award for Distinguished Service to Safety, the Danis Prize of the Société Internationale de Chirurgie, the Medallion for Scientific Achievement of the American Surgical Association, the Distinguished Investigator Award of the Society of Critical Care Medicine, the Whitaker International Burns Prize, the Tanner-Vandeput-Boswick International Burn Prize, the Lifetime Achievement Award of the Society of University Surgeons, the Roswell Park Medal, and the King Faisal International Prize in Medicine.


He also has played an active role on the Committee on Trauma (1974–1980; Senior Member, 1980–1984), the International Relations Committee (1982–1989; Chair, 1987–1989), and the Surgical History Group (2013–present; Chair, Program Committee, 2014–present). Dr. Pruitt also has served as an Advanced Trauma Life Support® instructor (1981–present), on the SESAP development committees, as a Scudder Orator (1984), and as an Excelsior Surgical Society/Edward D. Churchill Lecturer (1988). He served on the Executive Committee (1974–1980) and as a Councilor (1981–1984) of the South Texas Chapter of the ACS.

In addition to his many years of service to the College, Dr. Pruitt has served as president of 12 surgical societies, including the American Burn Association, the American Association for the Surgery of Trauma, the American Surgical Association, the Halsted Society, the International Society for Burn Injuries, Southern Surgical Association, and the Western Surgical Association. He is an honorary fellow of the Society of Black Academic Surgeons and an honorary member of the Japanese Association for Acute Medicine. He served for 20 years as the associate editor and 17 years as the editor-in-chief of the *Journal of Trauma*.

Dr. Pruitt graduated from Harvard College, Boston, MA, (1952) and Tufts Medical School (1957). He completed his initial surgical training at Boston City Hospital (1962) and his surgical residency at Brooke General Hospital, San Antonio (1964).
Two new members of the American College of Surgeons (ACS) Board of Regents, Anthony Atala, MD, FACS, and Fabrizio Michelassi, MD, FACS, were elected at the Annual Business Meeting of Members, October 19, in Washington, DC. In addition, new Board of Governors (B/G) Committee members have been elected.

**Regents**

Dr. Atala is director, Wake Forest Institute for Regenerative Medicine, and W. Boyce Professor and Chair, department of urology, Wake Forest Baptist Medical Center, Winston-Salem, NC. Dr. Atala is a practicing surgeon and researcher in regenerative medicine. His groundbreaking, award-winning work has focused on growing human cells, tissues, and organs, as well as advances in three-dimensional printing.

A Fellow of the College since 1996, Dr. Atala has served in several leadership positions in the ACS, including ACS Governor (2008–2014) and Chair, Advisory Council for Urology (2011–2015). Before chairing the Advisory Council, Dr. Atala was a member of the panel (2001–2011). He also has served on the Program Committee (2007–2011), the Surgical Research Committee (member, 2006–2011; Executive Committee, 2011–2014), the Scientific Forum Committee (2002–2007), the Advisory Council Chairs (2011–2015), and the B/G Committee to Study the Fiscal Affairs of the College (2009–2014).

Dr. Michelassi is the Lewis Atterbury Stimson Professor and Chair, Weill Cornell Medicine, and surgeon-in-chief, New York-Presbyterian/Weill Cornell Medicine, New York, NY. Dr. Michelassi is a renowned gastrointestinal surgeon with expertise in the surgical treatment of gastrointestinal and pancreatic cancers, as well as inflammatory bowel disease, such as Crohn's disease and ulcerative colitis.

An ACS Fellow since 1987, Dr. Michelassi has held several leadership positions in the organization. Most recently, he was Chair of the B/G (2014–2016, member 2010–2014). As a Governor, he served on the B/G Committee on Surgical Infections (2011–2013), the Committee on Socioeconomic Issues (2011), and the Ad Hoc Committee to Restructure the B/G Committees (2012–2013). He also has served on the International Relations Committee (2003–2009, Vice-
In addition, the following individuals were reappointed to the Board of Regents:

- **Margaret M. Dunn, MD, MBA, FACS,** dean of medicine and professor of surgery, Wright State University Boonshoft School of Medicine, Dayton, OH (third term)

- **James W. Gigantelli, MD, FACS,** professor and interim chair, department of ophthalmology and visual sciences, University of Nebraska Medical Center, and assistant dean of governmental affairs, University of Nebraska College of Medicine, Omaha (second term)

- **Michael J. Zinner, MD, FACS,** founding chief executive officer and executive medical director, Miami Cancer Institute at Baptist Health South Florida, Coral Gables (third term)

**B/G Executive Committee**

The B/G elected the following Officers of the Board of Governors Executive Committee:

- **Chair:** Diana L. Farmer, MD, FACS, FRCS, a pediatric surgeon, Pearl Stamps Stewart Professor of Surgery, and chair, department of surgery, University of California, Davis, Health System, Sacramento, CA

- **Vice-Chair:** Steven C. Stain, MD, FACS, a general surgeon and Henry and Sally Schaffer Chair and Professor, department of surgery, Albany Medical Center, NY

- **Secretary:** Susan K. Mosier, MD, MBA, FACS, an ophthalmologist, Secretary, Kansas Department of Health and Environment, and State Health Officer for Kansas, Topeka

**S. Rob Todd, MD, FACS, FCCM,** has been selected to serve an initial one-year term on the Executive Committee of the B/G. Dr. Todd is professor and chief, section of acute care surgery, department of surgery, and program director, surgical critical care residency, Baylor College of Medicine; and chief, general surgery, and director, Ginni and Richard Mithoff Trauma Center, Ben Taub Hospital, Houston, TX.

Elected to an initial two-year term on the B/G Executive Committee was **Nicole S. Gibran, MD, FACS,** David and Nancy Auth-Washington Research Foundation Endowed Chair for Restorative Burn Surgery; professor, department of surgery; director, UW Medicine Regional Burn Center at Harborview Medical Center; and adjunct professor, department of medicine, division of dermatology, University of Washington, Seattle. ♦
The American College of Surgeons (ACS), in association with Pfizer, Inc., is accepting nominations for the 2017 Surgical Volunteerism Award(s) and Surgical Humanitarian Award. All nominations must be received by February 28, 2017.

Volunteerism Awards
The ACS/Pfizer Surgical Volunteerism Award—offered in four potential categories annually—recognizes surgeons who are committed to giving back to society by making significant contributions to surgical care through organized volunteer activities. The awards for domestic, international, and military outreach are intended for ACS Fellows in active surgical practice whose volunteer activities go above and beyond the usual professional commitment or retired Fellows who have been involved in volunteerism in the course of active practice and into retirement. Resident Members and Associate Fellows of the ACS who have been involved in significant surgical volunteer activities during their postgraduate surgical training are eligible for the Resident award. Surgeons of all specialties are eligible for each of these awards.

For the purposes of these awards, “volunteerism” is defined as professional work in which one’s time or talents are donated for charitable clinical, educational, or other worthwhile activities related to surgery. Volunteerism in this case does not refer to uncompensated care provided as a matter of necessity in most clinical practices. Instead, volunteerism should be characterized by prospective, planned surgical care to underserved patients with no anticipation of reimbursement or economic gain.

Humanitarian Award
The ACS/Pfizer Surgical Humanitarian Award recognizes an ACS Fellow whose career has been dedicated to ensuring the provision of surgical care to underserved populations without expectation of commensurate reimbursement. This award is intended for surgeons who have dedicated a significant portion of their surgical careers to full-time or near full-time humanitarian efforts rather than routine surgical practice. Examples include a career committed to missionary surgery, the founding and ongoing operations of a charitable organization dedicated to providing surgical care to the underserved, or a retirement characterized by surgical volunteer outreach. Having received compensation for this work does not preclude a nominee from consideration and, in fact, may be expected based on the extent of the professional obligation.

Nominations
Nominations will be evaluated by the ACS Board of Governors’ Surgical Volunteerism and Humanitarian Awards Workgroup and their selections will be forwarded to the Board of Governors Executive Committee for final approval.

The following conditions apply to the nominations process:

• Self-nominations are permissible but require at least one outside letter of support

• Re-nomination of previous nominees is acceptable but requires completion of a new application

The ACS recommends that nominators plan a minimum of 30 minutes to complete the application form. For the nominee to have a fair review, detailed information is required, including the following:

• Demographic information about the nominee and nominator

• Details about the nominator’s relationship to the nominee, along with background information on the nominee’s surgical career

• Completion of narrative sections requesting detailed information
about the nominee’s volunteerism or humanitarian work, including the type of service they provide, the sustainability of the programs in which they are involved, any advocacy efforts in which they may have been involved, along with additional roles they have played.

• It helps to tell a story with your nomination. Specific examples and anecdotes are encouraged.

• The information provided will be shared with your nominee during our verification process. It may be worthwhile to obtain input from the nominee in advance.

• The nomination form does not need to be completed in one sitting. You may start an application and then come back to enhance it with additional detailed information you have obtained about the nominee.

The nomination website will open January 3, 2017, for electronic submission and can be accessed through the Operation Giving Back (OGB) section of the ACS website at facs.org/ogb. For more information, contact OGB at ogb@facs.org.

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Form No. 914009-10/16

Excellence in Awards and Recognition Since 1938

DEC 2016 BULLETIN American College of Surgeons
The 2017 Nominating Committee of the Fellows (NCF) and the Nominating Committee of the Board of Governors (NCBG) will select nominees for leadership positions in the College as follows.

Call for nominations for Officers-Elect

The 2017 Nominating Committee of the Fellows (NCF) will select nominees for the three Officer-Elect positions of the American College of Surgeons (ACS): President-Elect, First Vice-President-Elect, and Second Vice-President-Elect. The deadline for submitting nominations is Friday, February 24, 2017.

Criteria for consideration

For candidates to receive full consideration from the NCF, they must meet the following criteria:

- Nominees must be loyal members of the College who have demonstrated outstanding integrity along with an unquestioned devotion to the highest principles of surgical practice.
- Nominees must have demonstrated leadership qualities, such as service and active participation on ACS committees or in other components of the College.
- The ACS encourages consideration of women and other underrepresented minorities for all leadership positions.

All nominations must include:

- A letter of nomination
- A personal statement detailing the candidate’s ACS service and interest in the position (for President-Elect position only)
- A current curriculum vitae
- The name of one individual who can serve as a reference

Further details

Entities such as surgical specialty societies, ACS Advisory Councils, and ACS chapters that want to make a nomination must provide a description of their selection process and the total list of applicants reviewed. Any attempt to contact members of the NCF by a candidate or on behalf of a candidate will be viewed in a negative manner and may result in disqualification. Applications submitted without the requested information will not be considered.

Nominations may be submitted to officerandbrnominations@facs.org. If you have any questions, contact Betty Sanders, staff liaison for the NCBG, at 312-202-5360 or bsanders@facs.org.

Call for nominations for ACS Board of Regents

The 2017 NCBG will select nominees for pending vacancies on the Board of Regents to be filled at Clinical Congress 2017. The deadline for submitting nominations is Friday, February 24, 2017.

Criteria

Candidates must meet the following NCBG guidelines to be considered for nomination to the Board of Regents:

- Nominees must be loyal members of the College who have demonstrated outstanding integrity along with an unquestioned devotion to the highest principles of surgical practice.
- Nominees must have demonstrated leadership qualities, such as service and active participation on ACS committees or in other components of the College.
- The ACS encourages consideration of women and other underrepresented minorities for all leadership positions.
- The NCBG recognizes the importance of the Board
of Regents representing all who practice surgery, including surgeons in academic and community practice, regardless of practice location or configuration.

- Individuals of all surgical specialties will be considered, although special consideration will be given to those from general surgery and its specialties and cardiothoracic surgery.

- Only individuals who are in and expected to remain in active surgical practice for their entire term may be nominated for election or reelection to the Board of Regents.

All nominations must include:

- A letter of nomination
- A personal statement from the candidate detailing his or her ACS service and interest in the position
- A current curriculum vitae
- The name of one individual who can serve as a reference

In addition, entities such as surgical specialty societies, ACS Advisory Councils, and ACS Chapters that intend to make a nomination must propose at least two nominees and provide a description of their selection process, along with the complete list of applicants reviewed.

Any attempt to contact members of the NCBG by a candidate or on behalf of a candidate will be viewed in a negative manner and may result in disqualification. Applications submitted without the requested information will not be considered.

Nominations may be submitted to officerandbrrnominations@facs.org. If you have any questions, please contact Betty Sanders, Staff Liaison for the NCBG, at 312-202-5360 or bsanders@facs.org.

For information only, the current members of the Board of Regents who will be considered for re-election are (all MD, FACS) James K. Elsey, Gerald M. Fried, B. J. Hancock, and Lenworth M. Jacobs, Jr.

Coming in January in JACS, and online now

American College of Surgeons and Surgical Infection Society:
Surgical Site Infection Guidelines, 2016 Update

Kristen A. Ban, MD; Joseph P. Minei, MD, FACS; Christine Laronga, MD, FACS; and colleagues present an update to prior surgical site infection guidelines based on the current literature. The results are a collaborative effort between surgeons and infection experts representing various stakeholders, including the American College of Surgeons (ACS), the ACS National Surgical Quality Improvement Program, and the Surgical Infection Society.

This article and all other JACS content is available at www.journalacs.org.
INTRODUCING
A Mirror Reflecting Surgery, Surgeons, and their College:
The Bulletin of the American College of Surgeons

David L. Nahrwold, MD, FACS, wrote this engaging account of the rich history of the Bulletin of the American College of Surgeons. Dr. Nahrwold served as a Regent, Chairman of the Board of Governors, First Vice-President, and Interim Director of the American College of Surgeons, and received its Distinguished Service Award. He is co-author, with Peter J. Kernahan, MD, PhD, FACS, of A Century of Surgeons and Surgery: The American College of Surgeons 1913–2012.

Price: $15.95

Published by the American College of Surgeons.
The American College of Surgeons (ACS) online community platform, ACS Communities, recently began its third year and shows no signs of slowing down. Under the leadership of Tyler G. Hughes, MD, FACS, Editor-in-Chief, the communities have already become one of the most popular benefits of membership in the College, and the network continues to grow both in terms of number of communities and member engagement.

### Popular member benefit

At press time, 104 ACS Communities were online, 69 of which are open and 35 of which are closed. Any member may join or leave an open community as desired, but closed communities are available only to members of specific committees, governing bodies, and so on. With more than 23,300 members, the General Surgery community is by far the largest, but 36 other communities have more than 1,000 members each. Communities exist for specialties and subspecialties (for example, Colon and Rectal, Pediatric, and Minimally Invasive Surgery); demographic categories (Rural Surgeons, Women Surgeons, and so on); and for chapters, committees, and other areas of interest to members of the College. There’s even an active community for surgeons who share a love of writing.

In terms of number of posts, the most popular communities are General Surgery, Breast Surgery, Colon and Rectal Surgery, Rural Surgery, Women Surgeons, Endocrine Surgery, Minimally Invasive Surgery, History of Surgery, Trauma Surgery, and Bariatric Surgery. The most popular closed community is the Board of Regents and Board of Governors community.

Since its inception, nearly 2.2 million pages have been viewed by the 23,846 members who have agreed to the community terms of use, and those members have logged in more than 635,000 times. More than 11,000 members have uploaded their profile photos, and more than 4,200 unique visitors have posted 6,500 new threads to the discussions. A total of 39,000 messages have been posted in ACS Communities. Many of the most popular discussion threads have received dozens of replies. Some of the hottest topics during the first two years of the ACS Communities were Maintenance of Certification and retirement, colon perforations, surgical attire, robotic surgery, current standards of care, open cholecystectomies, board certification, and surgical training.

### An ACS mainstay

Perhaps the greatest accomplishment of the ACS Communities in its first two years is that it has woven itself into the fabric of College members’ everyday lives. Dr. Hughes and College staff regularly receive correspondence from members who say that the ACS Communities is of great value to them, and many who rarely post themselves attest to checking in on their communities every day. More than two-thirds of those surgeons who visit do so via desktop, while the rest enjoy access via phones and tablets. The ACS Communities app and a responsive version of the site make it easy to enter the communities from mobile devices. The average session lasts nearly 3.5 minutes—a lot of time for a busy surgeon.

As ACS Communities embarks on its third year, improvements are planned and more communities will emerge, allowing members to tap into the collective intelligence of their colleagues even more easily. As one member put it, “What an exceptional educational tool it has proven to be, and what a great way it has been for surgeons like me to be able to interact with and share ideas and experiences with so many (frequently geographically disparate) colleagues.”

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by Jerry Schwartz

ACS Communities begins third year
Three Fellows of the American College of Surgeons (ACS) were elected to the National Academy of Medicine (NAM) October 17. In addition, two Fellows who were elected to the NAM last year were officially inducted into the academy.

The three newly elected Fellows are as follows:

- **L. D. Britt, MD, MPH, DSc(Hon), FACS, FCCM, FRCSEng(Hon), FRCSEd(Hon), FWACS(Hon), FRCSI(Hon), FCS(SA) (Hon), FRCGlasg(Hon)**, Henry Ford Professor and Edward J. Brickhouse Chair, department of surgery, Eastern Virginia Medical School, Norfolk

- **Melina R. Kibbe, MD, FACS**, the Zach D. Owens Distinguished Professor and chair, department of surgery, University of North Carolina School of Medicine, Chapel Hill

- **Allan D. Kirk, MD, PhD, FACS**, David C. Sabiston, Jr., Professor and chair, department of surgery, Duke University School of Medicine, Durham, NC

Drs. Britt, Kibbe, and Kirk were among 70 regular members and nine international members elected. Election to NAM is considered one of the highest honors in the fields of health and medicine and recognizes individuals who have demonstrated outstanding professional achievement and commitment to service.

“These newly elected members are outstanding professionals who care deeply about advancing health and health care in the U.S. and globally,” said NAM president Victor J. Dzau, MD, during the academy’s annual meeting. “Their expertise will help our organization address pressing health challenges and improve health, science, and medicine for the benefit of us all. It is my privilege to welcome these accomplished individuals to the National Academy of Medicine.”

In addition, the following two previously elected Fellows were officially inducted into the NAM:

- **Julie A. Freischlag, MD, FACS**, Past-Chair, ACS Board of Regents, vice-chancellor for human health sciences and dean of the University of California, Davis, School of Medicine

- **Beth Y. Karlan, MD, FACS**, professor, obstetrics and gynecology; director, Women’s Cancer Program, Samuel Oschin Comprehensive Cancer Institute; and director, division of gynecologic oncology, Cedars-Sinai Medical Center, Los Angeles

For more information about individuals elected or inducted to the NAM this year, go to www8.nationalacademies.org/onpinews/newsitem.aspx?RecordID=10172016b. ♦
Members in the news

Raul Coimbra, MD, PhD, FACS, surgeon-in-chief, and director, trauma center, University of California (UC), San Diego, Medical Center, was installed as president of the American Association for the Surgery of Trauma (AAST) at the September 75th Annual Meeting of the AAST and Clinical Congress of Acute Care Surgery in Waikoloa, HI. Dr. Coimbra is executive vice-chair, department of surgery, and chief, division of trauma, surgical critical care, burns and acute care surgery at the UC San Diego School of Medicine. He is the executive director of the World Coalition for Trauma Care and chair of the Data and Trauma Registry Committee of the Division of Injury of the World Health Organization.

In addition, Michael F. Rotondo, MD, FACS, was elected president-elect at the AAST’s annual business meeting and will assume the AAST presidency at the organization’s 2017 annual meeting in Baltimore, MD. Dr. Rotondo is chief executive officer, University of Rochester Medical Faculty Group, and vice-dean for Clinical Affairs and a professor of surgery, University of Rochester, NY. He is Medical Director, American College of Surgeons (ACS) Trauma Programs, and Past-Chair of the ACS Committee on Trauma.

Philip R. Corvo, MD, MA, FACS, chairman of surgery and director of surgical critical care, Saint Mary’s Hospital, Waterbury, CT, is the 2016 recipient of the Connecticut State Medical Society Healthcare Leader and Innovator Award. He received the award in recognition of his leadership and commitment to innovative surgical quality initiatives. Dr. Corvo, an American College of Surgeons (ACS) Governor, has held several positions in the Connecticut Chapter, including President. He has supported the ACS through the years as a strategic planner assisting state chapters with health care quality improvement.
In addition, Dr. Corvo is president and co-founder, Connecticut Surgical Quality Collaborative, which comprises all 28 acute-care Connecticut hospitals that meet regularly to share outcomes reported to the ACS National Surgical Quality Improvement Program and to discuss successes, best practices, and enhanced recovery after surgery protocols.

Neil F. Jones, MD, FACS, FRCS, was elected 2016 president of the American Society for Surgery of the Hand. Dr. Jones is chief of hand surgery, professor of orthopaedic surgery, and professor of plastic and reconstructive surgery, University of California, Irvine. In addition, Dr. Jones is a consultant in hand surgery and microsurgery at Shriners Hospital Los Angeles and Children's Hospital of Orange County. Dr. Jones is internationally recognized for his expertise in microsurgical reconstruction of the hand and upper limb and toe-to-hand transfers in children. He is past-president of the American Society for Reconstructive Microsurgery.

Michel S. Makaroun, MD, FACS, was elected vice-president of the Society of Vascular Surgery at the group's annual meeting this summer in Washington, DC. Dr. Makaroun is professor and chief, division of vascular surgery, University of Pittsburgh School of Medicine, PA.

Two officers of the South Florida Chapter of the ACS have filled leadership positions in domestic and international organizations focused on treating obesity. ACS Governor Raul J. Rosenthal, MD, FACS, FASMBS, President of the ACS South Florida Chapter, was elected 2015–2016 president of the American Society for Bariatric and Metabolic Surgery in New Orleans, LA. Dr. Rosenthal serves as director, general surgery residency program; director, bariatric and [minimally invasive surgery] fellowship program Cleveland Clinic Florida, Weston; and professor of surgery, Herbert Wertheim School of Medicine, Florida International University and Charles E. Schmidt College of Medicine, Florida Atlantic University, Boca Raton. In addition, Dr. Rosenthal was recently selected for membership in the American Surgical Association. Natan Zundel, MD, FACS, FASMBS, Secretary/Treasurer of the chapter, presided as 2015–2016 president at the World Federation of Obesity Surgery at the World Bariatric Congress held earlier this year in Rio de Janeiro, Brazil. Dr. Zundel is clinical professor of surgery and vice-chairman, department of surgery, Herbert Wertheim College, Florida International University, and is medical director, Bariatric and Metabolic Institute, Jackson North Medical Center, Miami. In addition, Dr. Zundel received honorary membership from the Spanish Society for the Surgery of Obesity and Metabolic Disorders in July 2016 and honorary membership from the Chinese Association of Bariatric and Metabolic Surgery.
Two American College of Surgeons (ACS) leaders were honored recently, as follows:

• Ajit K. Sachdeva, MD, FACS, FRCSC, Director of the American College of Surgeons (ACS) Division of Education, received the Lifetime Achievement Award from the Indian American Surgical Association (IASA) during the IASA annual meeting in Washington, DC, in October 2016. Dr. Sachdeva also delivered a keynote address at the meeting (see photo, this page).

• Dr. Sachdeva attended the annual meeting of the Royal College of Physicians and Surgeons of Canada (RCPSC) in Niagara Falls, ON, and was invited to serve as a member of the Platform Party at the Annual Convocation of RCPSC (see photo, this page).

• Dr. Sachdeva was invited to serve as visiting professor and deliver the Debra J. Graham, MD, FACS, Endowed Lecture in Surgical Education at the University Hospitals Cleveland Medical Center, OH, in September 2016 (see photo, this page).

• Carlos A. Pellegrini, MD, FACS, FRCSI(Hon) FRCS(Hon) FRCSEd(Hon), ACS Past-President, was recognized for his outstanding service for 10 years as Co-Chair of the ACS Accredited Education Institutes (ACS-AEI) Program, during the Annual ACS-AEI Postgraduate Course hosted by Beth Israel Deaconess Medical Center, Boston, MA, in September 2016 (see photo, this page).
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Texas Chapters hold first Advocacy Day

Leaders from the North and South Texas Chapters of the American College of Surgeons (ACS) met in Austin in September for their first Texas Advocacy Day. After receiving a grant from the ACS, the Texas Chapters chose to focus their meetings with state legislators on graduate medical education (GME).

The event began with a dinner that included an address by Stacey Silverman, PhD, Deputy Assistant Commissioner of Academic Quality, Texas Higher Education Coordinating Board, which is responsible for GME in the state. Dr. Silverman highlighted the fact that the state spends $180,000 per medical student and that exporting medical students out of state costs Texas hundreds of millions of dollars. State Rep. Trent Ashby (R), who sponsored the Uniform Emergency Volunteer Health Practitioners Act (UEVHPA) bill for the ACS a few years ago, and State Sen. Charles Schwertner (R), an orthopaedic surgeon, also attended the dinner. Both commented on the need for more residency slots in Texas.

Darren Whitehurst, vice-president of advocacy, Texas Medical Association, briefed the group the following morning and offered advice on how to advocate within the legislative system. Participants then met with their elected officials at the Texas State Capitol.

GSACS meets in the “Hostess City of the South”

The Georgia Society of the ACS (GSACS) Annual Meeting took place August 19–21, in Savannah, GA. For the second year, the GSACS partnered with the Georgia Trauma Foundation to include A Day of Trauma. Peter M. Rhee, MD, FACS, chief of acute care surgery, Grady Memorial Hospital, and medical director, Marcus Trauma Center, Atlanta, delivered the keynote address, Traumatic Brain Injury: What Are We Really Doing Differently?

GSACS President Christopher K. Senkowski, MD, FACS, welcomed guests to a GSACS breakfast meeting with the
exhibitors before the opening address from then-ACS First Vice-President, Walter J. Pories, MD, FACS, professor of surgery, biochemistry and kinesiology at East Carolina University, Greenville, NC. Attendees enjoyed presentations on such topics as breast cancer in the era of precision medicine, robotics and the future of minimally invasive thoracic surgery, thyroid cancer treatment strategies, implementation of the Medicare Access and CHIP (Children’s Health Insurance Program) Reauthorization Act (MACRA), treatment of solid lesions in the liver, and abdominal wall reconstruction.

After dinner, the annual surgical skills competition got under way. The winning team was from Mercer University School of Medicine at The Medical Center of Central Georgia, Atlanta.

New officers were elected, and Thomas E. Reeve III, MD, FACS, a general surgeon from Carrollton, assumed the presidency.

Massachusetts Chapter participates in Advocacy Day

On September 20, members of the Massachusetts Chapter of the ACS (MCACS) participated in the chapter’s fourth Advocacy Day. The event took place in the Great Hall of Flags of the Massachusetts State House, Boston, and more than 80 health care professional and political leaders participated, including chapter members, trauma personnel, first responders, law enforcement officials, government officials, and legislators and their staff.

The program focused on the theme of the Surgical Experience in Response to Firearm Violence. Peter Koutoujian, Sheriff of Middlesex County, moderated a panel session featuring speakers from Boston trauma centers, including Michael P. Hirsh, MD, FACS, UMass Memorial Hospital; Eric Goralnick, MD, MS, Brigham and Women’s Hospital; and David R. King, MD, FACS, of Massachusetts General Hospital, who spoke about operationalizing the “Stop the Bleed” campaign. The MCACS arranged to have enough combat-quality tourniquets available for all members of the legislature.

William Evans, Commissioner, Boston Police Department, spoke on the importance of surgeon
involvement in policy discussions, while House Speaker Robert DeLeo (D) emphasized that the important relationships that surgeons have established with Massachusetts State House members that have enabled passage of several pieces of legislation that were designed to protect patient access and prevent injuries. In addition, the fourth John Collins Warren Award was presented to Sen. Jason Lewis (D). MCACS presented the award to Senator Lewis for his work on health care policy in the Massachusetts Senate.

In the afternoon, registered medical personnel had personal appointments with their legislators or their aides and brought tourniquets to demonstrate their ease of use as a lifesaving measure.

**Support for residents and young surgeons in Southern California Chapter**

The Southern California Chapter of the ACS (SCCACS) held its annual three-day Scientific Conference earlier this year, attracting 355 surgeons and residents and comprising 38 plenary oral presentations, 20 oral poster presentations, and eight subspecialty sessions.

Surgical residents from 11 surgical training programs in the Southern California area participated, and the SCCACS held a Young Surgeons breakfast, during which work/life balance was discussed with distinguished guest surgeons. The Young Surgeons group also awarded three $1,200 travel stipends to defray meeting costs. The 2016 awardees were Dawn Elfenbein, MD, University of California (UC), Irvine; Susanne Warner, MD, City of Hope National Cancer Center; and Ali Zarrinpar, MD, University of California, Los Angeles.

Also at the meeting, the Resident Research Awards were given to the top three papers. The 2016 winners were as follows:

- **First place:** Jessica Reynolds, MD, Los Angeles County University of Southern California Medical Center ($500)
- **Second place:** Aaron Parrish, MD, Harbor-UC Los Angeles Medical Center ($300)
- **Third place:** Syed Pairawan, MD, Loma Linda University Medical Center, CA ($200)

Maris Jones, MD, John Wayne Cancer Institute, Santa Monica, won the 2016 Physician-in-Training Cancer Research Paper Competition, also held in conjunction with the SCCACS Annual Scientific Meeting, for her paper, Second Primary Melanoma: Risk Factors, Histopathologic Features, Survival and Implications for Follow-Up.

For the eighth year, the SCCACS held a Surgical Jeopardy competition at the Annual Scientific Meeting. The winning team was the UC, Irvine, team, represented by Sarath Sujatha-Bhaskar, MD, and John Gahagan, MD. In this session, Southern California residency programs competed.
The Michigan delegation included ACS Governor Mark Puls, MD, FACS; Nicolas J. Mouawad, MD, MPH, MBA; Donn M. Schroder, MD, FACS; Amalia Stefanou, MD, FACS, and Majid T. Aized, MD.

The group met with U.S. Sens. Gary Peters (D-MI) and Debbie Stabenow (D-MI) and Reps. Dan Benishek, MD, FACS (R-MI), and Dan Kildee (D-MI). The meetings focused on issues that are important to surgeons, including surgeons and MACRA implementation; liability protections for trauma providers and the Health Care Safety Net Enhancement Act; funding for cancer initiatives and accreditation of cancer programs through passage of a Resolution Recognizing Commission on Cancer Accreditation; the Removing Barriers to Colorectal Cancer Screening Act; surgical workforce in underserved areas provisions in the Ensuring Access to General Surgery Act of 2016; and the Responsible Data Transparency Act.

Chapter Speed Networking at Clinical Congress
The ACS Board of Governors Chapter Activities Domestic and International Workgroups hosted its annual Chapter Speed Networking event October 18 at Clinical Congress.

During the event, chapter leaders, administrators, and Governors learned about best practices through “table talks” on a spectrum of topics that are relevant to managing domestic and international chapters. Topics included advocacy, chapter administration, membership recruitment and retention, Operation Giving Back, and international chapter development. Approximately 60 people attended the event and a networking reception that followed.

Dr. Maier participates in ATLS Provider Course in Shenzhen, China
Ronald V. Maier, MD, FACS, FRCSEd(Hon), then-First Vice-
President of the ACS, visited Shenzhen, People’s Republic of China, September 22–26, to review the Inaugural Advanced Trauma Life Support (ATLS®) Provider Course organized by the China Chapter (CHKC-ACS). During his visit, Dr. Maier attended a Chapter Reception; the Hong Kong Surgical Forum; the Shenzhen Surgical Forum organized by the department of surgery, University of Hong Kong; and the Inaugural ATLS course.

The CHKC-ACS has conducted ATLS courses in Hong Kong in collaboration with the department of surgery of The University of Hong Kong since 1997. The establishment of the university’s affiliated hospital in Shenzhen, Guangdong Province, provides the platform for a training site in mainland China. With a translated student manual, the Inaugural Provider Course, delivered entirely in Putonghua, was conducted at the University of Hong Kong-Shenzhen Hospital. Chapter leaders who participated in the event include Richard Lo, MD, FACS, Governor of the CHKCA-ACS; John Wong, MB, BS, FACS(Hon), President of CHKC-ACS; Chung-Mau Lo, MB, BS, FACS(Hon), head, department of surgery, The University of Hong Kong; Gilberto Leung, MB, BS, FACS, ATLS Program Director of CHKC-ACS; and Daniel Tong, MD, director of the Inaugural Provider Course in Shenzhen, as well as central and provincial government officials of the People’s Republic of China. The 16 trainees came from four different provinces; several were identified as candidates for the first Instructor Course in Putonghua in December 2016.

Physicians in mainland China have obtained ATLS training in Hong Kong and other countries for a number of years, but this course represents a major step toward the formal introduction of ATLS into a country with 2 million licensed physicians whose participation in internationally accredited training has until now been limited by a language barrier. This historic event will have a significant impact on patient care in China and the ATLS International community.

**Italy Chapter hosts Annual Meeting with other surgical societies**

The 2016 Annual Meeting of the ACS Italy Chapter took place September 25–29 in Rome. The meeting was held in conjunction with the Italian Society of Surgery and in association with many other surgical societies, including the MCACS.

The ACS Italy Chapter sponsored three sessions, which included lymphatics, environment and tumors, and surgical training.

The following members of the Italy Chapter participated as faculty: Corradino Campisi, MD, PhD, FACS; Massimo Carlini, MD, FACS; Massimo Chiarugi, MD, FACS; Antonio di Cataldo, MD, FACS, Governor; Nicola Di Lorenzo, MD, FACS, Second Vice-President; Achille Lucio
China Chapter
(from left): Professor Wong; Prof. Richard Lo; Dr. Maier; Prof. CM Lo, MB, BS, FACS(Hon), head, department of surgery, University of Hong Kong; and Professor Leung

News from the Portugal Chapter
The Esophageal and Gastric Cancer Initiative—a joint meeting of the Grupo de Investigação do Cancro Digestivo, the International Gastric Cancer Association, and the ACS—took place in Lisbon, Portugal, June 16–18. This conference was the inaugural meeting of the European Chapters of the ACS and was organized and promoted by the ACS Portugal Chapter.

The State Secretary of Health and the presidents of the organizing societies addressed the audience in the Opening Ceremony. The Lisbon Initiative was a scientific meeting of experts in esophageal and gastric cancer. The participation of ACS Fellows from Europe and other regions as speakers was impressive. The Initiative addressed the New Trends of Multimodal Approach to Upper GI [gastrointestinal] Cancers. The scientific program has focused on some of the hottest topics in esophageal and gastric cancer, from bench biology to clinical oncology, and from guidelines to individual patient treatment. The 348 attendees were specialists in various fields of upper GI cancer, and young physicians participated in the discussions.

Dr. Maier chaired a special session on the Challenges for the ACS Overseas, which addressed strategies for recruiting ACS members and fortifying the network of European chapters. Presidents and Governors from the European chapters, including Austria-Hungary, Belgium,
France, Germany, Greece, Ireland, Israel, Italy, Portugal, Spain, and Switzerland, who lectured on several topics, including The Value of Membership for the ACS European Surgeons; Strategies to Enlarge the Recruitment for FACS, RAS, and Students Among European Chapters; ACS Quality Programs and Fellowship Opportunities; [Continuing Medical Education] for Senior Trainees: What Can the European Chapters Do?; Research Fellowship in the USA: Implications for the European Surgical Trainee and the ACS; and Leaping Forward: A Network among European Chapters.

The European chapter leaders also discussed their vision to consolidate and to move their common organizational structure forward. This inaugural regional meeting of the European ACS chapters will open up a new trend of regional meetings and will strengthen networking among the ACS European chapters.

**Dr. Townsend speaks at ACS Korea Chapter meeting**

ACS President Courtney M. Townsend Jr., MD, FACS, was the guest speaker at the Annual Meeting of the Korean Surgical Society, November 3–5, in Seoul, South Korea. Dr. Townsend, who gave a presentation on Education and the Quality Programs of the ACS, also attended the ACS Korea Chapter Meeting November 3. He offered an update on ACS activities in a session moderated by Choong Bai Kim, MD, FACS, President of the ACS Korea Chapter. Other topics presented at the meeting included Impressions of a New FACS by H.S. Chang, MD, PhD, FACS, Chapter Secretary General; Quality Improvement Projects by Sun Whe Kim, MD, FACS, Governor; Academic-Society Based Surgical Quality Improvement Project Cholecystectomy and Surgical Quality Improvement Project Thyroidectomy by H.K. Lee, MD, FACS; and a course on off-the-job training in trauma during general surgery residency by C. Y. Park, MD, FACS.

**Dr. Richardson participates in Saudi Arabia Chapter’s 25th anniversary celebration**

The Saudi Arabia Chapter of the ACS held its annual meeting September 28 and celebrated its 25th anniversary. Dr. Richardson attended the meeting, which took place at the Amwaj Rotana Hotel, Dubai, UAE. A total of 60 surgeons representing a variety of specialties and nations attended.

The meeting was divided into a scientific program, during which several surgeons presented their research and scientific projects, followed by a special business session that included presentations of chapter member activities, including College programs such as the ACS National Surgical Quality Improvement Program, as well as quality programs in bariatric surgery, organ transplantation, and trauma.
The chapter presented a gift to Dr. Richardson (see above image) designed by the Saudi Arabia Chapter Governor Jamal Jomah, MB, BS, FACS, FRCS(Ed). Each faculty member delivered several lectures followed by a discussion.

Members of the Chapter Council were named, with the additions of several new members. The social program included a visit to the opera house, a city tour, a daytime canal cruise, and a faculty dinner.

The Saudi Arabia media covered several events, including sessions on three-dimensional simulations and printing and plastic surgery, health insurance and its impact on medical practices, trauma incidence and prevention in Saudi Arabia, and pedestrian injuries during the Hajj Pilgrimage. ♦
International chapters offered opportunity to develop an ACS-based education course

The International Relations Committee of the American College of Surgeons (ACS) is pleased to announce a special opportunity for international ACS Chapters provided by the Dr. Pon Satitpunwaycha Fund. The Dr. Pon Fund, as it is known, will allow international chapters to create a local educational course that includes faculty from the ACS. The deadline for applications is January 16, 2017.

The goals of this competitive grant program are as follows:

• To promote surgical education to the international surgical community

• To encourage the active involvement of the international chapters in ACS activities

A total of $25,000 per year will be made available to international chapters to develop educational courses in their own countries. Subject to the quality, merit, and requirements of each proposal, grants up to $12,500 will be awarded to up to two chapters, one of which may be preferentially designated for a developing nation as defined by the World Bank. An international chapter may use the grant to present the ACS General Surgery Review Course or to develop other surgery-focused courses in its home country. The grant is intended to cover necessary costs, such as the travel expenses of ACS faculty who will teach the course. The grant is not expected to cover all expenses related to course material, venue rental, audiovisual equipment, or food; therefore, chapter funds should be used to support those expenses.

International chapters will submit an application consisting of the following, in this order, submitted as a single PDF document:

• The title of the proposed course.

• A description/purpose of activity explaining why such a course is needed in the country, the targeted audience (surgeons, trainees, nurses, or other), and learning objectives.

• Duration of the course (one to 2.5 days) and the proposed date for presentation.

• Course format (lectures, hands-on sessions, or other). Submission of a preliminary program is required.

• Names of proposed faculty, both local and international. International faculty will ideally support or represent 50 percent to 60 percent of the faculty.

• A letter of support from the organizing institution or university.

• U.S.-based ACS Fellows will ideally represent 40 percent to 50 percent of the faculty.

• A conflict of interest form must be submitted for each faculty member.

• Costs broken out by category (travel, materials, and so on).

• A detailed report of activities must be submitted at the conclusion of the event. In addition, a detailed financial breakdown of grant use is required.

All proposals must be made by an officer of an international ACS chapter and should be submitted electronically to the International Liaison at kearly@facs.org by January 16, 2017. All applicants will be notified of the outcome in early April 2017.

Additional program details are as follows:

• Preference will be given to proposals from chapters that demonstrate additional funds from other sources. Preference will also be given to proposals for programs that can be replicated in other international chapters.

• The chapter must demonstrate ways it will encourage surgical trainees and medical students to attend and participate in their event.

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

DECEMBER

Massachusetts Chapter
December 3
Boston, MA
Contact: Amy O’Keeffe, aokeeffe@prri.com, www.mcacs.org/

New Jersey Chapter
December 3
Iselin, NJ
Contact: Andrea Donelan, njsurgeons@aol.com, www.nj-acs.org/

Philippines Chapter
December 6
Manila, Philippines
Contact: Vicky Pamintuan, Tel. 011-63-632-7432119

Brooklyn-Long Island Chapter
Annual Clinic Day
December 7
Uniondale, NY
Contact: Teresa Barzyz, acsteresa@aol.com, www.bliacs.org

Montana-Wyoming Chapter and Idaho Chapter
January 27–29
Teton, WY
Contact: Cyan Sportsman, csportsman21@outlook.com, squ.re/2dK13CI

JANUARY 2017

Southern California Chapter
January 20–22
Santa Barbara, CA
Contact: James Dowden, jdowden@prodigy.net, www.socalsurgeons.org/

North Dakota and South Dakota Chapters
April 28–29,
West Fargo, ND
Contact: Leann Benson, leann@ndmed.com

Florida Chapter
April 28–29
Orlando, FL
Contact: Stacy Manthos, smanthos@floridafacs.org

FUTURE CLINICAL CONGRESSES

2017
October 22–26
San Diego, CA

2018
October 21–25
Boston, MA

2019
October 27–31
San Francisco, CA

FEBRUARY

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

North & South Texas Chapters
February 23–25
Austin, TX
Janna Pecquet, janna@southtexasacs.org, www.ntexas.org/ and www.southtexasacs.org/

APRIL

Indiana Chapter
April 22–23
French Lick, Indiana
Contact: Tom Dixon, tdixon@ismanet.org, www.infacs.org

Northern California Chapter
April 28–29
Berkeley, CA
Contact: Christina McDevitt, nccacs@att.net, www.nccacs.org