Empowerment over charity:

How surgeons turned Armenia’s tragedy into an opportunity
Contents

FEATURES

COVER STORY: Empowerment over charity: How surgeons turned Armenia’s tragedy into an opportunity
Stephan Ariyan, MD, MBA, FACS

Leading without a title
John M. Wieland, MD, MHCM, FACS

Not your father’s ACS:
The view from the Chair of the YFA
Jacob Moalem, MD, FACS

The view from the Chair of the RAS-ACS
by Maya Babu, MD, MBA

COLUMNS

Looking forward
David B. Hoyt, MD, FACS

What surgeons should know about...Preparing for MACRA implementation
Matthew Coffron, MA, and Vinita Ollapally, JD

ACS Clinical Research Program: Dissemination and implementation: Translating cancer guidelines and clinical trial outcomes into everyday practice
Lee G. Wilke, MD, FACS; Diana Dickson-Witmer, MD, FACS; and Judy C. Boughey, MD, FACS

Your ACS benefits: SRGS and the COT trauma education programs: Keeping surgeons current on the provision of optimal patient care
Lewis M. Flint, MD, FACS; Whitney Greer; Ronald M. Stewart, MD, FACS; Monique N. Drago, EdD; and Ryan M. Hieronymus, MBA

NEWS

ACS and AGS release geriatric perioperative recommendations
Last chance to register for 2016 ACS-AEI Consortium Meeting
Dr. Sachdeva delivers Distinguished Professor Lecture at USC
Final month to apply for 12th annual Jacobson Promising Investigator Award

SCHOLARSHIPS

ACS awards Claude H. Organ, Jr., MD, FACS, Traveling Fellowship to Dr. Joseph

MEETINGS CALENDAR

Calendar of events
The American College of Surgeons is dedicated to improving the care of the surgical patient and to safeguarding standards of care in an optimal and ethical practice environment.

CLINICAL CONGRESS 2016

Call FOR SUBMISSIONS

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

Scientific Forum

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

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

Video-Based Education

VIDEO PRESENTATIONS

Submit Information

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

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

Officers
J. David Richardson, MD, FACS  
Louisville, KY  
PRESIDENT
Andrew L. Warshaw, MD, FACS  
Boston, MA  
IMMEDIATE PAST-PRESIDENT
Ronald V. Maier, MD, FACS  
Seattle, WA  
FIRST VICE-PRESIDENT
Walter J. Pories, MD, FACS  
Greenville, NC  
SECOND VICE-PRESIDENT
Edward E. Cornwell III, MD, FACS, FCCM  
Galveston, TX  
CHAIR
A. Brent Eastman, MD, FACS  
Baltimore, MD  
VICE-CHAIR
J. David Richardson, MD, FACS  
Washington, DC  
SECRETARY
William G. Cioffi, Jr., MD, FACS  
Chicago, IL  
TREASURER
Andrew L. Warshaw, MD, FACS  
Washington, DC  
CHIEF FINANCIAL OFFICER

Officers-Elect
(take office October 2016)
Courtney M. Townsend, Jr., MD, FACS  
Galveston, TX  
PRESIDENT-ELECT
Hilary A. Sanfey, MB, BCH, MHPE, FACS  
Springfield, IL  
FIRST VICE-PRESIDENT-ELECT
Gay L. Vincent, CPA  
Chicago, IL  
SECOND VICE-PRESIDENT-ELECT

Board of Regents
*Valerie W. Rusch, MD, FACS  
New York, NY  
CHAIR
*Michael J. Zinner, MD, FACS  
Boston, MA  
VICE-CHAIR
John L. D. Atkinson, MD, FACS  
Rochester, MN  
SECRETARY
James C. Denneny III, MD, FACS  
Alexandria, VA  
TREASURER
Margaret M. Dunn, MD, FACS  
Dayton, OH  
DIRECTOR
Timothy J. Eberlein, MD, FACS  
St. Louis, MO  
DIRECTOR
James K. Elsey, MD, FACS  
Atlanta, GA  
DIRECTOR

Advisory Council to the Board of Regents
(Past- Presidents)
Kathryn D. Anderson, MD, FACS  
Eastvale, CA  
W. Gerald Austen, MD, FACS  
Boston, MA  
L. D. Britt, MD, MPH, FACS, FCCM  
Norfolk, VA  
John L. Cameron, MD, FACS  
Baltimore, MD  
Edward M. Copeland III, MD, FACS  
Gainesville, FL  
A. Brent Eastman, MD, FACS  
Rancho Santa Fe, CA  
Gerald B. Healy, MD, FACS  
Wellesley, MA  
R. Scott Jones, MD, FACS  
Charlottesville, VA  
Edward R. Laws, MD, FACS  
Boston, MA  
LaSalle D. Leffall, Jr., MD, FACS  
Atlanta, GA  
David G. Murray, MD, FACS  
Syracuse, NY  
Patricia J. Numann, MD, FACS  
Syracuse, NY  
Carlos A. Pellegrini, MD, FACS  
Seattle, WA  
Richard R. Sabo, MD, FACS  
Bozeman, MT  
Seymour I. Schwartz, MD, FACS  
Rochester, NY  
Frank C. Spencer, MD, FACS  
New York, NY  
Andrew L. Warshaw, MD, FACS  
Boston, MA

Board of Governors/Executive Committee
Fabrizio Michelassi, MD, FACS  
New York, NY  
CHAIR
Diana L. Farmer, MD, FACS  
Sacramento, CA  
VICE-CHAIR
Steven C. Stain, MD, FACS  
Albany, NY  
SECRETARY
Daniel L. Dent, MD, FACS  
San Antonio, TX  
TREASURER
Francis D. Ferdinand, MD, FACS  
Wynnewood, PA  
DIRECTOR
James W. Fleshman, Jr., MD, FACS, FASCRS  
Dallas, TX  
DIRECTOR
Susan K. Mosier, MD, FACS  
Lawrence, KS  
DIRECTOR

Executive Staff
EXECUTIVE DIRECTOR  
David B. Hoyt, MD, FACS
DIVISION OF ADVOCACY AND HEALTH POLICY  
Frank G. Opelka, MD, FACS  
Medical Director, Quality and Health Policy
Patrick V. Bailey, MD, FACS  
Medical Director, Advocacy
Christian Shalgian  
Director

AMERICAN COLLEGE OF SURGEONS FOUNDATION
Shane Hollett  
Executive Director
ALLIANCE/AMERICAN COLLEGE OF SURGEONS
CLINICAL RESEARCH PROGRAM  
Kelly K. Hunt, MD, FACS  
Chair
CONVENTION AND MEETINGS  
Robert Hope  
Director
DIVISION OF EDUCATION  
Ajit K. Sachdeva, MD, FACS, FRCSC  
Director
EXECUTIVE SERVICES  
Jane J. Lee-Kwon, MPS  
Director, Executive Operations
Maxine Rogers  
Director, Leadership Operations
FINANCE AND FACILITIES  
Gay L. Vincent, CPA  
Director
HUMAN RESOURCES AND OPERATIONS  
Michelle McGovern  
Director
INFORMATION TECHNOLOGY  
Howard Tansman  
Director
DIVISION OF INTEGRATED COMMUNICATIONS  
Lynn Kahn  
Director
JOURNAL OF THE AMERICAN COLLEGE OF SURGEONS  
Timothy J. Eberlein, MD, FACS  
Editor-in-Chief
DIVISION OF MEMBER SERVICES  
Patricia L. Turner, MD, FACS  
Director
M. Margaret Knudson, MD, FACS  
Director
David P. Winchester, MD, FACS  
Director
M. Margaret Knudson, MD, FACS  
Medical Director, Military Health Systems Strategic Partnership
Kimberly T. Tewson  
Director, Operation Giving Back
PERFORMANCE IMPROVEMENT  
Will Chapleau, RN, EMT-P  
Director
DIVISION OF RESEARCH AND OPTIMAL PATIENT CARE  
Clifford Y. Ko, MD, MS, FACS  
Director
Cancer  
David P. Winchester, MD, FACS  
Medical Director
Trauma  
Michael F. Rotondo, MD, FACS  
Medical Director
Author bios*

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

DR. ARIYAN (a) is professor of surgery, plastic surgery, surgical oncology, and otolaryngology, Yale University School of Medicine; associate chief, department of surgery, Yale-New Haven Hospital; and director, melanoma program, Smilow Cancer Hospital, Yale Cancer Center, New Haven, CT.

DR. BABU (b) is a postgraduate year-6 resident in neurosurgery, Mayo Clinic, Rochester, MN, and Chair, American College of Surgeons (ACS) Resident and Associate Society.

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

MR. COFFRON (d) is Manager, Policy Development, ACS Division of Advocacy and Health Policy, Washington, DC.

DR. DICKSON-WITMER (e) is medical director, Christiana Care Breast Center and Breast Program, Helen F. Graham Cancer Center, Newark, DE, and clinical assistant professor of surgery, Jefferson Medical College, Thomas Jefferson University, Philadelphia, PA. She is Co-Chair, ACS-CRP Dissemination and Implementation Committee.

MS. DRAGO (f) is Trauma Education Program Manager, ACS Division of Research and Optimal Patient Care, Chicago, IL.

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

DR. FLINT (h) is Editor-in-Chief, Selected Readings in General Surgery (SRGS), ACS Division of Education, Chicago, IL.

MS. GREER (i) is Managing Editor, SRGS, ACS Division of Education.

continued on next page
Author bios continued

**MR. HIERONYMUS** (j) is Trauma Education Project Manager, ACS Division of Research and Optimal Patient Care.

**DR. MOALEM** (k) is an endocrine surgeon and associate professor, University of Rochester Medical Center, NY, and Chair, ACS Young Fellows Association.

**DR. NANCE** (l) is Templeton Professor of Surgery and director, pediatric trauma program, Children’s Hospital of Philadelphia, PA.

**MS. OLLAPALLY** (m) is Regulatory Affairs Manager, ACS Division of Advocacy and Health Policy.

**DR. PELLEGRINI** (n) is chief medical officer, UW Medicine, and vice-president for medical affairs, University of Washington, Seattle. He is a Past-President of the ACS.

**DR. STEWART** (o) is chair, department of surgery, University of Texas Health Science Center at San Antonio, and Chair, ACS COT.

**MS. TIEBERG** (p) is Manager, Chapter Services, ACS Division of Member Services, Chicago, IL.

**DR. WIELAND** (q) is medical director of surgical services, OSF St. Joseph Medical Center, Bloomington, IL.

**DR. WILKE** (r) is professor of surgery; director, University of Wisconsin (UW) Breast Center; interim division chair of general surgery, UW department of surgery; and Hendricks Chair in Breast Cancer Research at UW Health/UW School of Medicine and Public Health, Madison. She is Chair, ACS-CRP Dissemination and Implementation Committee.
Looking forward

by David B. Hoyt, MD, FACS

Providing surgeons with the resources, tools, information, and training they need to provide quality care to the surgical patient has been the primary goal of the American College of Surgeons (ACS) since the organization’s founding in 1913. Given the regulatory demands on surgeons today, it is more important than ever that the ACS fulfill this commitment. To help surgeons better meet these evolving expectations, the ACS has been engaged in an effort to integrate and redesign our quality program database software.

A legacy

The College’s commitment to quality improvement dates back to its founding, when Ernest Amory Codman, MD, FACS, introduced The End Result Idea. This concept centered on the notion that every hospital and every surgeon should follow every patient long enough to determine whether the treatment was successful, and if not, why not. Dr. Codman also was responsible for the creation of the College’s first registry—the Registry of Bone Sarcoma. This repository was the precursor to later ACS databases, including the National Cancer Data Base (NCDB) and the National Trauma Data Bank® (NTDB®), as well as more recent quality improvement programs, including the National Surgical Quality Improvement Program (ACS NSQIP®), Pediatric NSQIP, the Surgeon Specific Registry™ (SSR), and the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP™).

These and all other ACS quality programs are grounded in four key principles:

- Set the standards individualized to the patient and backed by research.
- Build the right infrastructure, one with the right mix of appropriate staffing levels, specialists, equipment, and checklists.

The newly reimagined ACS quality database system...will not only allow the ACS to migrate all of our clinical registries into a common, consolidated warehouse and reporting platform, but it also will allow for EHR integration.
• Use the right data; that is, data drawn from medical records, backed by research, that track patients post-discharge, and are continuously updated

• Verify with outside experts through external peer review

**Registries: Increasingly relevant**
Meeting these standards and helping to ease the financial and administrative burdens that many surgeons are experiencing in today’s highly regulated health care environment are the underpinnings of our database software redesign project. More specifically, the ACS recognizes that Fellows need coordinated quality measurement systems and registries to comply with increasing demands for public reporting, performance-based payment reforms, and Maintenance of Certification (MOC) requirements.

A range of public reporting websites are now available, including the Centers for Medicare & Medicaid Services (CMS) Physician Compare program and ProPublica’s so-called Surgeon Scorecard. The College has significant concerns regarding both of these public reporting systems because they use Medicare billing data to measure performance and surgeon complication rates rather than risk-adjusted clinical data, such as the information used to generate ACS NSQIP outcomes reports. The College maintains that risk-adjusted clinical data are a better reflection of performance and other complicating factors that may affect patient outcomes.

The College has worked closely with CMS to ensure that information collected in the SSR is compatible with CMS’ Physician Quality Reporting System (PQRS). The SSR has been approved as a PQRS registry for individual eligible providers (EPs) to participate in traditional registry-based reporting, and the MBSAQIP has been approved as a Qualified Clinical Data Registry. Physicians and other EPs who fail to satisfy PQRS reporting requirements face penalties on their Medicare Part B billings.

As the Medicare program transitions to implementation of the Medicare Access and CHIP (Children’s Health Insurance Program) Reauthorization Act (MACRA), new payment systems will be put in motion. However, the Merit-based Incentive Payment System and alternative payment models that are set for implementation in 2019 will likely rely on outcome measures and registries to determine reimbursement. As a result, surgeon participation in the ACS clinical data registries will remain eminently important.

In addition, the Health Information Technology for Economic and Clinical Health (HITECH) Act authorizes the U.S. Department of Health and Human Services to provide incentives to EPs who meet meaningful use criteria for the use of electronic health records (EHRs) and to penalize those who do not meet the program’s objectives. Many surgeons, particularly those in small practices, find it difficult to meet the meaningful use criteria and can ill-afford to take any additional financial hits for noncompliance. Furthermore, PQRS has an EHR-based reporting option as well.

Moreover, the American Board of Surgery and other surgical boards have been gradually implementing MOC mandates. Part 4 of MOC focuses on assessment of practice performance. The SSR provides surgeons with information about procedure-specific outcomes in their own practices and allows them to benchmark their performance against the results of other participants in the national database. This feedback will help surgeons self-evaluate and identify areas for improvement.

**A collaborative effort**
The newly reimagined ACS quality database system responds to all of these concerns. It will not only allow the ACS to migrate all of our clinical registries
If you have comments or suggestions about this or other issues, please send them to Dr. Hoyt at lookingforward@facs.org.

into a common, consolidated warehouse and reporting platform, but it will allow for EHR integration. Furthermore, the new system will have Web portal data entry capabilities and will be deployable to all mobile devices.

Strategic planning for this effort began about two years ago, and a three-year implementation program is now under way. We anticipate that the new program will be completed in time to allow surgeons to effectively and smoothly comply with MACRA’s implementation.

Many members of the ACS leadership and staff have played a significant role in developing this program with our outside vendor, Quintiles. (See sidebar, this page, for a list of some of the key players in this endeavor.) We are extremely excited about the potential of this project and how it will help ACS members be better able to receive fair compensation, measure their performance, and, most importantly, improve the quality of surgical care.

♦

LEADERS OF THE SOFTWARE INTEGRATION PROJECT

**ACS LEADERS**

David B. Hoyt, MD, FACS, Executive Director, ACS
Clifford Y. Ko, MD, MS, MSHS, FACS, Division of Research and Optimal Patient Care (DROPC)
Sameera Ali, MPH, Continuous Quality Improvement
Amy J. Sachs, ACS Registry Operations, ACS NSQIP
Mark Palmer, Performance Improvement
Gay L. Vincent, CPA, Finance
Howard Tanzman, Information Technology
Jean Clemency, Trauma Programs
Avery B. Nathens, MD, PhD, FACS, TQIP
Melanie Neal, NTDB
David P. Winchester, MD, FACS, Cancer Programs
Ryan McCabe, NCDB
Teresa Fraker, MBSAQIP
Joe Bonura, SSR

**QUINTILES PROJECT LEADERS**

Richard Thomas, chief information office and president, technology solutions
Brian J. Kelly, MD, president, payer and provider solutions
Jason Colquitt, vice-president, technology solutions
Jared Howerton, business analyst lead, information technology
Rory Mutagh, director, enterprise architect, information technology
Sarah Morris Kraft, program manager, information technology
James Kouba, AP, encore research and development
Mark Anderson, business analyst, information technology
Bryan Strothmann, senior business analyst, information technology

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

Empowerment over charity:

How surgeons turned Armenia’s tragedy into an opportunity

by Stephan Ariyan, MD, MBA, FACS
The provision of surgical services in underserved and disaster-stricken areas of the world is becoming an issue of increased interest. At the same time—and most experts on the subject would agree—although traditional medical missions have had positive short-term benefits for patients, training native physicians to deliver the type of care available in economically strong countries has a greater long-term and sustainable impact. As this trend of training local physicians in resource-poor regions continues to evolve, I thought it would be useful to describe how a team of U.S. health care providers responded in the aftermath of an earthquake that struck Armenia in 1988, registering 7.0 on the Richter scale. Indeed, the lessons learned from that event are as meaningful today as they were nearly 28 years ago.

The earthquake hits
It was a typically cold morning on December 7, 1988, for Artashes Aznauryan, MD, the Minister of Health for the Soviet Republic of Armenia—a country of approximately 3.5 million people at that time. Dr. Aznauryan was in his office in Yerevan, the nation’s capital, reviewing reports from his section managers, when he felt a rumbling under his feet and noticed that the tea in the glass resting on his desk was shaking.

Less than 30 minutes later, one of his assistants informed him that they seemed to have lost telephone contact with the hospital in Spitak, located 74 miles northwest of Yerevan. At the time, Spitak was a city of young, educated, middle-class families with new schools, new factories, and a new hospital. The republic was proud of this modern city and was hopeful for its future.

Dr. Aznauryan told his assistant to check with the telephone company to see if there were any disruptions to the transmission lines. The assistant reported that there was complete disruption of telephone communications with Spitak. He had called the police headquarters in Yerevan and been informed that wireless communications with the city had yielded no response. The police were sending a helicopter to assess the situation.

Sensing a potential tragedy, Dr. Aznauryan immediately dispatched his deputy and several physicians to Spitak. They soon reported that a major earthquake had hit; all the buildings were either collapsed or damaged severely.

Dr. Aznauryan had a serious situation at hand. The physicians and nurses in Yerevan worked in shifts, and the day shift personnel had already gone home, leaving the smaller afternoon shift in the capital’s hospitals to provide care to the victims of the earthquake. He rushed to the state television station to announce the catastrophe and to ask that physicians and nurses return to their hospital posts. Every single physician and nurse immediately reported back to work.
Dr. Aznauryan assembled his division managers to mobilize a communications post and sent all available ambulances with as many physicians and nurses as could fit in the vehicles to the scene. The drive to Spitak was slow because of road damage from the earthquake, and by the time the first teams arrived, the sun had already set. Working by the headlights of the ambulances, first responders began rescuing the victims buried beneath the rubble. Physicians later described the scene, where they found some victims who were alive but pinned under structural collapse. To free these patients, amputations of arms or legs often were performed using local anesthesia and with the aid of flashlights.

The next several days confirmed the republic leaders’ worst fears: approximately 25,000 men, women, and children had died, and an estimated 130,000—nearly 80 percent of Spitak’s population—had experienced traumatic injuries. In no more than 20 seconds, the earthquake had essentially destroyed the city.*

**Responding to the request for help**

At the time of the earthquake, I was professor of surgery and chief of plastic surgery at Yale University School of Medicine, New Haven, CT. On the morning of December 8, my administrative assistant informed me that there had been a telephone call earlier from the Soviet Union Embassy in Washington, DC. We returned the call to the First Secretary of the Soviet Embassy, who informed me of the catastrophic earthquake and asked if I would be willing to go to Armenia to offer my professional assistance.

Since that time, it has been suggested that whereas the then-Soviet leader Mikhail Gorbachev had been trying to reform the Soviet system with his policy of Perestroika (a political movement for reformation within the Communist Party of the Soviet Union during the 1980s) this earthquake actually may have played a role in improving relations between the Soviets and the West. Mr. Gorbachev happened to be in the U.S. on an official state visit at the time of the earthquake and cut the trip short to return to Armenia and evaluate the magnitude of this disaster. He then formally reached out to the West and requested humanitarian aid—the first such request from the USSR since World War II.

During our telephone conversation, I explained to the Secretary that while some of the rescued citizens would die in spite of all efforts, it was possible for others to receive adequate care from their own physicians. The bulk of the survivors had experienced severe injuries and would need subsequent reconstructive surgery. I informed the Secretary that I would form a surgical team as soon as possible, but, in the meantime, they should bring in dialysis machines to care for the many patients who would sustain renal shutdown from their crush injuries and the resultant myoglobinuria. That aid was quickly provided by a team from the University of California, Los Angeles.

AmeriCares, a not-for-profit relief organization headquartered in Stamford, CT, was one of the first U.S. agencies to arrive in Armenia and evacuate patients to the U.S. One of the first U.S. facilities to treat victims of the disaster was Yale-New Haven Hospital, CT, which accepted two patients.

I went to Yerevan with Jeffrey Heinrich, PA-C, EdD, a physician assistant (PA) in my plastic surgery section, to assess the medical needs of the earthquake victims. We met with Dr. Aznauryan, who briefed us on recent developments and progress, and deputies of the Ministry of Health, who described the infrastructure and levels of training of physicians and nurses in Armenia. We were able to visit several hospitals and evaluate the seriously injured patients and the many more who had less severe injuries but would still need reconstructive surgery.

Some physicians spoke English, but most did not, and virtually all of the nurses spoke only Armenian and Russian. Specialty surgeons were largely trained in Armenia, but many competed for these training positions in Moscow before returning to their homeland. Many surgeons said they had trained in the subspecialties of plastic surgery (such as burns, hand surgery, microsurgery, facial fracture surgery, facial cleft surgery, reconstructive surgery, and cosmetic surgery), but we were unable to identify any plastic surgeons who had trained in the provision of the full scope of plastic surgery services as we know them in the U.S.

Anesthesia was administered by physicians trained in that specialty, but many procedures we witnessed were performed under general mask anesthesia; few patients who were under general anesthesia were intubated, even patients who were undergoing surgery in the prone position. Regional block anesthesia was nowhere to be found.

Nursing education was under the direction of a physician in the Ministry of Health, and nursing care appeared to be at a level not seen in the U.S. since the early 20th century. Nurses were given no clinical responsibilities and served simply as caretakers. They
had no role in the dressing of wounds or monitoring of vital signs. Indeed, patient families were encouraged and expected to attend to the patients’ nursing and feeding needs.

**Two alternatives**

It was apparent that U.S. surgeons who would travel to Armenia to volunteer their services would be unable to communicate in a common language with their colleagues regarding day-to-day patient management. Teams of surgeons, anesthesiologists, and nurses would have to be formed to be effective providers.

Alternatively, patients could be flown to a western country for reconstructive surgery. Unfortunately, to be suitable for this option, patients would have to be strong enough to sit in an airplane seat for many hours of flight, making it an impractical solution for those patients who most needed our care.

On our return to the U.S., the leadership of the Armenian General Benevolent Union (AGBU)—a not-for-profit organization established in 1906 to care for Armenians in the diaspora—asked for my assessment of the situation. It was my belief that the only meaningful long-term solution for the many patients who could not travel would be to train a team of Armenian physicians and nurses in the Western team approach in the U.S. and return them to their country to treat those patients. We could subsequently assist in training additional teams to sustain this work, but this approach would require a serious commitment of time and money.

To my surprise, the AGBU, under the leadership of president Louise Manoogian Simone (1989–2002), accepted this challenge and quickly raised $500,000 from private donors. Shortly thereafter, AGBU

---

**FIGURE 1.**

Letter from the ECFMG offering to serve as sponsoring organization for the physicians from Armenia.
leadership arranged for me to meet with Leila Karagheusian, the 91-year-old surviving daughter of Mihran Karagheusian, a New York, NY, rug manufacturer and philanthropist who started the Karagheusian Foundation in 1921. After asking many thoughtful and incisive questions, Ms. Karagheusian wrote a check for $1 million. Eventually, the U.S. Agency for International Development (USAID) provided a matching grant, resulting in $3 million in funding for this AGBU project.

With funding in hand, we contacted Dr. Aznauryan to explain the two proposed projects. The Minister of Health chose the offer of a long-term commitment to education and training to upgrade the Armenian health care system. He assigned Sevak Avakian, MD, Deputy Minister of Health for Foreign Affairs in Armenia, to this effort.

Assembling and training the team

The next step was to select the team of physicians and nurses from Armenia for training in the U.S.

We had the full support of Yale School of Medicine and Yale-New Haven Hospital. Paul Barash, MD, chairman, department of anesthesia, and Karen Camp, RN, deputy director of nursing, surgical services, joined the team. We had several meetings to plan the selection process and training curriculum for the Armenian team. The planning group included the Yale team, Dr. Avakian, and Regina Ohanyan of the AGBU, who served as administrative coordinator.

We determined that we would need to train two surgeons in plastic surgery; two anesthesiologists in modern anesthesia technology; and 12 nurses in intraoperative, recovery room, intensive care, and floor nursing care methods. Most importantly, we needed to train these health care providers in the team approach in which nurses are accepted partners in patient care from admission to discharge.

We then concluded that each of the physicians would need direct, hands-on clinical training; observation alone would be insufficient. Dr. Barash and I proceeded to apply for formal approval from the Accreditation Council for Graduate Medical Education for training of the two surgeons in plastic surgery, and the two anesthesiologists through our two respective residency review committees (RRCs). The RRC for plastic surgery, under the chairmanship of Leonard T. Furlow, Jr., MD, FACS, concluded that we had enough cases to warrant the addition of two residents to our program, as did the RRC for anesthesia.

For these four physicians to have hands-on clinical training, they would first need to pass the Educational Commission for Foreign Medical Graduates (ECFMG) examination as required under federal law. Any infringement of this requirement would result in immediate loss of all federal research grants to Yale University. However, we realized that we would not have time to teach them enough English language to pass the exam before their arrival in the U.S.

Our other option was to get Yale University to apply to the ECFMG for an institutional exemption. I contacted the ECFMG to get instructions on how to apply for the exemption and in the course of these discussions the ECFMG’s leadership decided to become a sponsoring institution of the program, thereby eliminating the need for Yale to apply for such an exemption (see Figure 1, page 13).

We then traveled to Yerevan to discuss this program with the Ministry of Health. We asked the Ministry of Health to select 18 surgeons and 18 anesthesiologists from whom we would select two candidates from each specialty. We also asked the ministry to select 48 to 50 nurses from whom we would select 12 participants. I also felt it was most important to select individuals who would be committed to returning to and remaining in Armenia to ensure the sustainability of our efforts.

<table>
<thead>
<tr>
<th>TABLE 1. CONSORTIUM</th>
</tr>
</thead>
<tbody>
<tr>
<td>AGBU • Armenian Relief Society • USAID</td>
</tr>
<tr>
<td>Plastic and reconstructive surgery center</td>
</tr>
<tr>
<td>• American-standard academic plastic surgery section at medical university</td>
</tr>
<tr>
<td>Nurse/physician exchange program</td>
</tr>
<tr>
<td>• American nurse managers/plastic surgeons to establish training programs in:</td>
</tr>
<tr>
<td>– Mental health/psychiatry</td>
</tr>
<tr>
<td>– Pharmaceuticals</td>
</tr>
<tr>
<td>– Bioengineering for returning medical team</td>
</tr>
</tbody>
</table>
We spoke with all the candidates and explained that they would need to devote many hours of training in preparation for their trip, be willing to leave their families for one year, and undergo long and arduous training in the U.S. After a week in Armenia, we selected the 16 members and added one pharmacist to the team. One surgeon, Gagik Stamboltsyan, MD, was trained as a microsurgeon, and the other, Garegin Babloyan, MD, was a vascular surgeon; both trained in Moscow and had returned to work in Armenia. The anesthesiologists, Armenuhi Khartian, MD, and Garen Manvelyan, MD, both trained in Armenia. The entire team began a comprehensive course in English under the supervision of teachers selected by the AGBU. This group of physicians and nurses arrived in the U.S. in September 1990 to begin 12 months of intensive, comprehensive plastic surgery training.

Our intention was for all of these health care providers to work at our hospital as a team: the two surgeons operating under our supervision would each work with one of the Armenian anesthesiologists in training and with assistance from one Armenian scrub nurse who was, in turn, trained by one of our nurse instructors. The patient would then be cared for in the recovery room by another Armenian nurse who was being trained in postoperative care. Once the patient returned to the floor, another Armenian nurse being trained by another nurse instructor would provide floor care.

Ms. Camp, with the help of the operating room (OR) supervisor, Luba Dowling, RN, selected which Armenian nurses would be trained in intensive care, including advanced monitoring, respiratory care, and electrocardiogram interpretation. If a patient needed care in the surgical intensive care unit (SICU), one of the Armenian nurses in training would be assigned to that patient. In this manner, the physicians and nurses were fully immersed in the management of patients as a team. In fact, we housed them all in groups in several apartments on the same floor of a building one block from the hospital to encourage their daily integration as a team.

Their intensive training continued for the full year, with periodic reviews of their progress and development. In the meantime, the AGBU formed a consortium with the Armenian Relief Society and USAID to develop five additional programs in Armenia to prepare for the returning medical team, including the commencement of their care of the patients, as well as their continued training (see Table 1, page 14). The consortium’s plan was to establish (1) a plastic and reconstructive surgery center (PRSC) in Yerevan; (2) an Armenian nurse/physician exchange program (NPEP); and (3) additional programs to provide support and training in mental health and psychiatric outreach, pharmacy, and biomedical engineering. I will limit my discussion to the first two programs, as they are specifically relevant to surgery.

The PRSC was established through the efforts of the AGBU to provide a fully equipped state-of-the-art OR and SICU, as well as support for equipment, medical supplies, and pharmaceuticals in preparation for the team returning to Armenia. Another goal of this program was to establish a U.S.-standard academic section of plastic surgery at the Yerevan Medical Institute to train additional plastic surgeons.

The NPEP was established to provide ongoing training for the team of physicians and nurses returning to Armenia. The goal of this program was to send U.S. nurse managers to Armenia to continue the nurses’ training, to help them develop their management skills, and to establish programs for the Armenian nurses to train additional nurses. Arrangements also were made for various plastic surgeons to
travel from U.S. academic programs to help establish training programs for the Armenian surgeons.

**A new era**

Meanwhile, the Armenian team completed their prescribed training in September 1991 with a commencement exercise attended by the leadership of the Yale School of Medicine, the Yale-New Haven Hospital, and the AGBU (see photos, page 15 and this page). We selected Dr. Stamboltsyan to serve as chief of this plastic surgery team and to head the program in Armenia. The team returned to Armenia and began their work at the new PRSC in Yerevan.

The Soviet Union was experiencing a complete transformation in the same time frame, resulting in the dissolution of the USSR and the establishment of independent republics, including the Republic of Armenia in 1991. Planning and negotiations for implementation of these various programs commenced with Dr. Aznauryan and was completed by Mihran Nazaretian, MD, the Minister of Health of the new Republic of Armenia. Armenia’s independence made for more seamless progress and development of the original plan.

The AGBU continued its support, adding three American members to the PRSC: a unit administrator, a head nurse for the OR, and a head nurse for the SICU. The ORs and SICU were equipped with the latest anesthesia machines, physiological monitors, and ventilators. A medical library was established with the donation of English language textbooks and subscriptions to various medical journals. Mary H. McGrath, MD, MPH, FACS, a Past-Regent and Past First Vice-President of the American College of Surgeons (ACS), was instrumental in securing approval from the Plastic Surgery Educational Foundation for the use of the handbook, *Plastic Surgery Essentials for Students*.

Plastic surgeons from several American academic programs, many of whom are members of the ACS, the American Association of Plastic Surgeons (AAPS), and the American Council of Academic Plastic Surgeons (ACAPS), traveled to Armenia to participate in this program, including (all MD, FACS) Gregory Borah, Julia Terzis, Mimis Cohen, Theodore Chaglassian, and Lloyd Gayle.

This program proved to be timely—as the various Soviet states became independent republics, tensions mounted and borders were closed. Soon thereafter, fighting broke out between Russia and Georgia over North Ossetia in Russia and South Ossetia in Georgia. This conflict led to numerous casualties. When the fighting ended, the President of the Republic of Georgia, Zviad Gamsakhurdia, contacted the U.S. State Department to inquire about sending some of the seriously injured patients to the U.S. for reconstructive surgery. The U.S. State Department informed him that this course of action was possible but suggested, instead, that the casualties be treated in the neighboring Republic of Armenia, which already had an American-trained plastic surgical team in place. The transfer of these patients to Armenia was arranged, and many civilian casualties were treated by the Armenian team.

**Long-term outcomes**

In subsequent years, the team developed an academic training program in plastic surgery at the Yerevan Medical Institute. The training program was established by Dr. Stamboltsyan and two additional surgeons—Armen
Hovhannesyan, MD, who trained in Moscow, and Artavazd Sahakian, MD, who trained in France. These three surgeons trained three more plastic surgeons between 1994 and 1997. One of these surgeons, Gevorg Yaghjyan, MD, came to Yale for a year of research in plastic surgery. Dr. Yaghjyan returned to join the faculty at the Yerevan Medical Institute and established an academic foundation for the residency program in plastic surgery; he later became deputy dean of the medical school.

The team has trained 46 plastic surgeons as of December 2015 and now has a certifying examination issued by the Armenian Board of Plastic Surgery. Dr. Stamboltsyan became Minister of Health (1997–1998) and then returned once more to lead the PRSC. He was elected to Parliament in 2003 and became Chairman of the Committee for Health.

In 2005, Dr. Stamboltsyan and four of his colleagues (Drs. Hovhannesyan, Leon Torosian, Karen Danielyan, and Yaghjyan), formed the Armenian Association of Plastic, Reconstructive and Aesthetic Surgeons. In 2007, together with their colleagues from the Republic of Georgia, this association hosted the First International Congress of the Armenian Association of Plastic, Reconstructive, and Aesthetic Surgeons.

I attended the 4th International Congress in Yerevan in November 2013 (see photo, this page). It was the eve of the 25th anniversary of the earthquake in Spitak, and the meeting took place in the Madegaran amphitheater, a library of historical documents dating back two millennia. Papers were presented over three days by plastic surgeons from Armenia, Georgia, Russia, the U.S., Austria, Poland, Germany, Spain, and Japan.

Lessons learned
We learned quite a bit from this experience, including the following lessons:

• Don’t be afraid to aim high.

• If an opportunity arises, from a tragedy or a necessity, be aware that powerful allies are willing to help.

• Governments are more than willing to take chances on unique programs if they have the potential to benefit many of their citizens.

• Many sources of financial support—from individual donations to foundations to governmental agencies—are available.

• Regulatory agencies are more than willing to offer guidance and identify unique mechanisms of certification.

• Many resources are available in our own institutions that are willing to contribute to the success of the endeavor.

• We can rely on the assistance of many individual supporters.

The accomplishments of this team of professionals have proven to be extraordinary, thanks in large part to the help of our colleagues in New Haven and across America. This team of health care professionals from Armenia, who sacrificed so much, has remained together and has worked to further the training of countless others in their home country. Above all else, their success can be attributed to their choosing empowerment over charity.

Note
This article is based on Dr. Ariyan’s presidential address at the annual meeting of the American Association of Plastic Surgeons, April 12, 2015, Scottsdale, AZ.
Leading without a title

by John M. Wieland, MD, MHCM, FACS
I never worried about not having a title in my organization until one was given to me. Shortly after finishing a master’s program in health care management at Harvard School of Public Health, Boston, MA, I was asked to be the first director of surgical services at OSF St. Joseph Medical Center, Bloomington, IL.

I was flattered by the offer and readily accepted, both emotionally and contractually. In the back-and-forth of the paperwork, I found myself reflecting on my new title and its acronym—DOSS, which sounded like obsolete computer language. I approached hospital administrators and asked for a more descriptive title. “Oh, it’s funny you mentioned that, Dr. Wieland,” they said. “We were thinking about making the new position a manager-level job, and we could call you the manager of surgical services.” Mentally translating the new acronym into MOSS, it didn’t seem like much of an improvement. I countered that one of my main responsibilities would be leadership development, and they offered me the title of manager of leadership development—MOLD. I had gone from a plant to a fungus. I submitted that, although leadership development was important, this new role was about increasing physician engagement. I also mentioned that it was widely accepted that surgeons have never responded well to the idea of being managed. To their credit, the hospital leadership team returned the role to director status, and offered to make me director of physician engagement—DOPE. Admittedly, I had been called worse, but I refused to stop there.

In this new position, I acknowledged that both leadership development and physician engagement were vital to the institution’s success. Together, I offered, these concepts are about aligning resources within the organization. Seeing their heads nodding in agreement, I may have then gone too far. I mentioned that the hospital leadership team members all had the term chief in their titles (chief executive officer, chief operating officer, chief medical officer, and so on), and this designation would perhaps command the highest measure of respect from my colleagues. Sure enough, the administration proposed the title of chief resource alignment physician. You can work that one out on your own.

It is said the first thing to do when you’ve dug yourself into a hole is to stop digging. Although this story is tongue-in-cheek, its message is important—leadership is not about titles. In health care, leadership is about motivating and even inspiring people to work together toward organizational goals and improve the lives of our patients. Leadership is about creating emotional buy-in and commitment and working harder for a greater purpose. A title is unnecessary; what is necessary is conviction, communication, and collaboration. This article looks at all three key elements of effective leadership and offers personal examples of how they function in today’s health care environment.

**Ripple effect**

*I alone cannot change the world, but I can cast a stone across the waters to create many ripples.*

—Mother Teresa

I keep a plaque with this quote from Mother Theresa on the wall of my office as a reminder of the effects of my actions—both intended and unintended—and because it invokes pleasant memories of role models.
and mentors I have had throughout my training and career. It challenges me to be mindful of the ripple effects that my decisions or actions have on colleagues, patients, and other members of the hospital community.

As the practice of surgery has changed over the last two decades, leaders have been challenged to stay current with the technical as well as the political issues that affect our profession. Some of our greatest challenges, however, involve keeping our colleagues engaged and motivated in their jobs. Many healthcare leaders are keenly aware of the enormous challenges facing our profession, which stem in part from a lack of engagement on the part of practicing surgeons and from rising levels of job dissatisfaction among surgeons. Many recent studies indicate increasing levels of burnout and growing numbers of surgeons who are retiring earlier than planned. A crushing regulatory environment, economic pressures, and increasing information technology burdens are often cited as reasons for this exodus from the profession.

It also has been reported that most physicians would not recommend a career in medicine to their children. My partners and I have lamented these sad facts and figures. Rather than wail and gnash my teeth, however, I have always tried to maintain an optimistic attitude toward these sobering statistics. In fact, a career in medicine is an incredible opportunity for leadership, as well as an ideal setting for the kind of management approach that must come from the grassroots of our profession. We were all trained to be leaders, but in these turbulent times, surgeons need to dig in and work even harder to inspire and motivate younger surgeons and our peers. Our medical colleagues need to be able to look to us to be decisive in our treatment of patients; to be confident in our ability to communicate with patients, family members, nurses, and peers; and to be collaborative with our colleagues in co-managing complex disease processes and/or comorbidities in our patients.

For titled and untitled administrators, these challenges represent opportunities as well. The pessimists would have us believe that our profession is deteriorating and devolving from some idyllic notion of past greatness. Conversely, I believe we are learning to adapt to our current circumstances. Our greatest days are, and will always be, ahead of us if we adopt the approach of surveying the landscape, leveraging our collective strengths, and maintaining an unshakable focus on improving patient care by improving surgical outcomes.

Our work environment has changed dramatically in the last few decades. We now have four generations in the workforce working side by side. Coming from different backgrounds and different cultures, surgeons today have varying definitions of a healthy work-life balance. All of us have different priorities that respond to different management and leadership styles. Therefore, our own leadership style requires flexibility.

I recently asked the chief medical officer at St. Joseph how he so effectively managed to lead our diverse medical staff with its various ethnicities, cultural interactions, and age ranges. He borrowed a quote from a speech by former President Bill Clinton, and said, “John, leading this group is a lot like being the caretaker at a cemetery. I have a lot of people under me, but nobody is listening to anything I say.” (Personal communication with the author, May 27, 2015.)

If nobody is listening, how do we lead? When working with highly educated and trained individuals, a confrontational or authoritative approach is most often met with resistance. In my experience, having the formal authority of a title and its positional power rarely, if ever, is a motivating factor for colleagues. Power among peers in surgery is often more accurately described as influence. And working with and among colleagues, friends, and peers, we cannot influence them unless we first engage them.

Three Cs of leadership
Leading without a formal title can be summarized using the three Cs: conviction, communication, and collaboration.

Conviction
Conviction is the most important of the three. It is the unshakable belief of a leader that he or she is doing the right thing for an institution or individual. For me,
conviction has always involved valuing patient safety above all else within health care. In truth, I was not always so passionate about patient safety—until I left a surgical sponge in a patient. Very early in my career, I operated on a young man with a progressive neurologic disease. The operative plan of a routine diverting colostomy went horribly wrong, resulting in an extensive adhesiolysis with enterotomies and a bowel resection. I felt particularly bad for this patient because, despite his circumstances, he never showed any anger or bitterness. He was always cheerful and upbeat. I was troubled when he struggled postoperatively. I found the source of his misery several days after surgery, when I ordered and reviewed abdominal X rays. I saw the abnormal opacity on the films and was devastated. I was certain I would be sued for liability, that my reputation would suffer, and that I would lose referrals when the news spread throughout my small hospital. I was focused on all the negative consequences that would befall me when I should have been concentrating on my patient’s care. I felt even worse for being so selfish. My patient had competed in 10K runs in the past and was now wheelchair-bound, and I was worried about how his misfortune was affecting me. I went straight to his room and told him everything.

His wife and daughter were with him. I told them about the sponge, apologized to them for letting them down, and told them that another operation would be necessary to remove it. I told them I understood if they wanted to transfer his care to another surgeon. After taking all of this in, the patient said, “Doc, this is not a perfect world,” as he pointed to his wheelchair-bound, and I was worried about how his misfortune was affecting me. I went straight to his room and told him everything.

I learned from this experience was the importance of accountability. Leaders need to be accountable and take responsibility for their decisions and for the outcomes associated with those decisions—even the bad ones. I also learned how important it is for leaders to share lessons learned the hard way. We are trained to keep quiet about our complications, but this doesn’t help prevent our younger colleagues from making similar mistakes. I have shared this story with colleagues many times because I believe its lesson is beneficial. That is how we can demonstrate leadership, and we don’t need a title to do that.

Communication
With or without a title, communication is an important element of leadership. Strong leaders are usually great communicators, often understanding the hearts and minds of the people they lead. Great communication involves being an active listener rather than a talker, someone who can empathize with the concerns and passions of others. To know another’s passion is to know where they spend their time and their energy. Being attuned to the passions of colleagues helps leaders align those interests with organizational goals and allows administrators to communicate in a relatable manner. Often, a casual conversation can produce positive results.

I had a conversation with a colleague, during which I tried to find out why he was dismissive of participating in the surgical time out before each of his operations. Despite all the research in favor of it, this colleague said he didn’t think it contributed to patient safety. Knowing his passion for aviation as an amateur pilot, I asked him if he ever went out to the airport and simply jumped into his plane and took off without doing a pre-flight safety check. “Of course not,” he said. “That would definitely be unsafe. I could get myself killed!” (Personal communication with the author, September 30, 2014.) Seizing the opportunity and knowing I could push his buttons a bit, I asked him if his airplane was more important than his patients. I also asked if his operating room team, like the air traffic controller in the tower, would like to know his “flight plan” for each
Successful leaders who collaborate well can align goals and incentives for all. A friend who was on the rowing team in college calls this “pulling all the oars in the same direction.”

operation and whether any special equipment would be necessary for a smooth takeoff and landing. Understanding the parallels between aviation and surgery, he relented and agreed that he would begin to participate more actively in the surgical time out. He is now one of our most vocal supporters of this process—and no formal title was necessary to bring about this change.

Collaboration
Collaboration, another crucial component of leading without a title, speaks to working with colleagues to create a partnership related to introducing and achieving organizational goals. Collaborative leaders are skilled at conveying a sense of respect for the people whom they lead. They publicly recognize their colleagues as valuable members of the organization whose engagement and input is vital to the success of any initiative or project, and they reinforce the message that patients, physicians, and the organization are much stronger when the effort is collective. Successful leaders who collaborate well can align goals and incentives for all. A friend who was on the rowing team in college calls this “pulling all the oars in the same direction.”

Just over 18 months ago, St. Joseph Medical Center converted from a traditional call coverage model to an acute care surgery model. As chief of surgery, I was largely responsible for the development and implementation of the program, whereas the chief medical officer had decision-making authority for negotiating the compensation and contractual obligations of the surgeons. He and I could have worked out the details regarding the call schedule, the metrics, and the parameters for the program in a short period of time and could have presented the plan to the interested parties. However, we knew we would have better buy-in and more commitment if we involved those parties in the process. We included the surgeons participating in the program, the hospitalists with whom we share responsibility for many of these acute care patients, and the emergency department (ED) physicians who are often the first contacts with these patients. Working together, all the groups had input into the structure of the model. The spirit of camaraderie and collaboration was evident throughout the process, and the rollout was met with excitement and a belief that this new model would improve the patient experience as well as patient outcomes. In less than a year from its inception, the proof of its success was evidenced by marked improvement in the Press Ganey patient satisfaction surveys and in a dramatic reduction in the “leakage rate” from the ED. Hospital administration was as pleased as the clinicians with the level of success and acceptance on the part of both the patients and the nursing staff.

Successful leaders make a habit of tapping in to the passions of others as they relate to patient care. By keeping the patient at the center of the health care universe, leaders can motivate and inspire others to work toward a better and brighter future for both patients and physicians. Visionary leaders are being called upon to create a patient-centered culture. Referring back to the quote from Mother Teresa, much, if not all, of what we do creates a ripple effect on future generations of both patients and surgeons. And an optimistic perspective can and should be contagious for those future leaders in health care organizations. Leaders don’t need titles to lead, but they do need to inspire those around them to represent our profession in a positive way, ideally attracting the next generation to surgery. One never knows where the ripples from the casting out of a single stone will spread.

Inspiring others
In March 2015, shortly after the National Residency Match Day, I received a thank you note from a young man whom I had not seen in six years. He participated in a job shadow program that my partners and I maintain for undergraduate pre-med majors from Illinois Wesleyan University, Bloomington, a local liberal arts university. He reintroduced himself to me in the note, and then proceeded to explain the source of his gratitude. “I shadowed you in surgery about six years ago, and I have wanted to be a surgeon ever since then. Last Friday on Match Day, I was fortunate enough to match into the surgical residency that was my first choice,” he wrote. “I’m so excited to see what the future holds,
Leaders don’t need titles to lead, but they do need to inspire those around them to represent our profession in a positive way, ideally attracting the next generation to surgery. One never knows where the ripples from the casting out of a single stone will spread.

and I wanted to let you know what I have been up to, and that you fostered much of my early surgical interest.” As I read further, I could feel my chest swelling with pride, even though I struggled to remember any details of our encounter. He concluded, “Thank you for spending the time to make me feel comfortable and for inspiring me. I will certainly pay that forward in my future practice.”

I have kept his name confidential but have shared excerpts from his note with staff, colleagues, nurses, and hospital administrators. I use it as an example of leading without a title and of how actions that we take for granted—our daily routines of patient care—can be inspirational to others. I don’t remember what types of disease processes this young man saw or what procedures I performed while he shadowed me. I don’t remember what cases I did on the day the thank you note arrived in the mail. Because of its message, however, I am certain it was one of the best days I have had in more than 23 years of surgical practice.

Looking to the future
I believe there is much to be optimistic about in the future of our profession. And because I have been leading in my organization for many years without a formal title, a new title doesn’t define me or inspire me. But truthfully, if someone could come up with a catchy title that rolls off the tongue and is even modestly hip, I would definitely use it. If it were up to me, I would like to be called the chief of optimistic leadership, because it’s always hip to be “cool.” ♦

Note
This article is based on a presentation that Dr. Wieland gave at the American College of Surgeons National Surgical Quality Improvement Program 10th Annual National Conference, July 25–28, 2015, in Chicago, IL.

REFERENCES
As I was traveling home from Clinical Congress 2015 in Chicago, IL, having just been appointed Chair of the Young Fellow’s Association (YFA), I couldn’t help but reflect on how dramatically the American College of Surgeons (ACS) has changed over the years.

I have been privileged to be deeply engaged in ACS activities since my second year of residency in 2004. In the last 12 years, I have been honored to represent the College at meetings of the American Medical Association, to lead the Resident and Associate Society (RAS-ACS), to serve on several College committees, and now to chair the YFA. I have thus acquired a unique perspective on the work of the College and how it supports residents and young surgeons, which, due to the visionary leadership of numerous individuals, has recently become even more active.

This article highlights just a few of the ways in which our organization has focused its attention on becoming more sensitive to young surgeons’ needs, more responsive to our wishes and requests, and more inclusive of young surgeons in its programming and among its leadership ranks.
No longer a monolith

Although the College has always valued its young members and has been receptive to our input, the ACS and its leadership have occasionally been criticized for appearing to be monolithic and dominated by senior academic surgeons who may not be well attuned to the issues facing the typical surgeon. If there was any truth to that sentiment in the past, it certainly is not reflective of my experience.

In the last decade there has been a marked increase in the productivity of RAS and the YFA, which has been augmented by the support of the College’s leadership. I have seen firsthand how the investment of the College in resident and young surgeons has grown. Without question, these changes have led to a surge in enthusiasm and participation among young surgeons worldwide and will contribute to the College’s bright future as the premier organization representing surgeons around the world.

Clinical Congress 2015 was nothing short of revolutionary. Under the combined leadership of Patricia L. Turner, MD, FACS, Director, ACS Division of Member Services; Ajit K. Sachdeva, MD, FACS, FRCSC, Director, ACS Division of Education; and David B. Hoyt, MD, FACS, ACS Executive Director, several major initiatives and new programs were launched. These were all meant to inject a sense of fun into the meeting, promote collegiality, and encourage young surgeon interaction with senior surgeons and College leaders. Programs like the Selfie Scavenger Hunt, which resulted in more than 500 selfies with senior College leaders posted to Twitter; recognition badges for long-standing ACS Fellows; early morning yoga and Zumba sessions; giant comment boards that provided attendees a public platform to express their views regarding the meeting; and light-hearted photographs of the Board of Regents made for a much more spirited event while maintaining the scientific rigor for which the Clinical Congress is known. Importantly, these programs underscored the fact that the College leadership is accessible, responsive, and invested in its members.

A program that deserves specific mention is the YFA- and RAS-sponsored speed-mentoring session. Promoted by Rebecca C. Britt, MD, FACS, a YFA Member and President of the Virginia Chapter of the ACS, this was a tremendously successful event where medical students and residents were matched with potential mentors, ranging from RAS and YFA leaders to senior surgeons. A total of 12 groups, each with five mentors and five mentees, were created, based upon shared interests. In the span of an hour, each mentee had the rare opportunity to have five private conversations to discuss their goals.

In total, 300 encounters occurred during this innovative session, and the feedback from mentors and mentees was universally positive. As a participant, I can attest that the session was highly invigorating and inspiring. Hopefully, several of the pairings that were created during this session will evolve into long-lasting and mutually beneficial relationships.
Another notable addition to the Clinical Congress took place on the final evening of the meeting. During the Taste of the City event, conference attendees were treated to an extravaganza of live music, entertainment of various kinds, game booths, and food stations showcasing the diverse Chicago restaurant scene. With more than 1,000 attendees, this was the most notable example of the degree to which the College’s leadership is extending itself in order to remove barriers and promote interactions among its members.

YFA: More active than ever

Beyond the enhanced collegiality of the Congress, its content also was much more heavily influenced by Young Fellows than ever before. Under the leadership of Adnan Alseidi, MD, FACS, Chair of the YFA Education Workgroup, an electronic abstract and session submission system was created for interested YFA members. Using this innovative outreach program, a record-breaking 25 YFA-sponsored sessions were proposed for this year’s Congress, of which 12 were accepted. Some of these sessions covered broad themes related to a career in surgery, such as the joys, struggles, and rewards of a surgical career; managing stress and preventing burnout; the emotional impact of adverse events; and emotional intelligence. Others were more specific, including sessions such as changes in medical liability law, being an expert witness, becoming a successful principal investigator, and a session on functional ergonomics. These sessions were universally well-attended and well-received, paving the way for an even more productive year in 2016.

As I begin my term as Chair, it is heartening to note that the YFA has never been more productive, valued, and supported by the College. Today, Young Fellows are empowered to express their views by posting comments on our open ACS Community page, proposing panel session topics at Clinical Congress, and even applying for YFA seats on numerous College committees through our open call mechanisms (these positions are widely advertised on ACS media). At Clinical Congress, the College made every effort to create informal opportunities for Fellows to meet and directly communicate with our leadership. With so much effort put forth by the College to engage Young Fellows, it should come as no surprise that this year’s inductee class was one of the largest (1,679), continuing to improve upon previous records set in 2013 and again in 2014.

Future directions

It is a tremendous honor to follow in the footsteps of great Past-Chairs such as Michael Sutherland, MD, FACS; Rob Todd, MD, FACS; Laurel Soot, MD, FACS; and Mark Savarise, MD, FACS, upon whose shoulders the YFA stands today. As was the case for them, my overarching goal is to increase membership and Young Fellow participation in College activities. We will continue to formalize and expand our open application process for all committee appointments such that all interested surgeons have equal opportunity to be selected for positions when they become available.

Beyond engagement, I also have two specific goals for this year. First, the YFA is creating a manuscript outlining Young Fellows’ highly critical opinions of the recent nationwide surge in perioperative attire-related policies in response to a set of recommendations that were published by the Association of periOperative Nurses in early 2015. This is an example of how we intend to transform member opinions expressed in the ACS Communities forum into action, and we anticipate that this activity will inform the creation of a more comprehensive and appropriate set of recommendations led by the College.

In addition, spurred by interest in a Clinical Congress 2015 YFA-sponsored session, YFA members will be extensively featured in an issue of Current Problems in Surgery that will be dedicated to The Emotional Impact of Adverse Events in Surgery. In that issue, we will explore meaningful ways to prevent and mitigate burnout, as well as offer strategies to support colleagues who may be distressed over an adverse patient outcome or event.

It is an enormous privilege to serve alongside an outstanding Governing Council composed of dedicated volunteers who give tirelessly to the College. Together, and in continued collaboration with College leadership and the RAS, I look forward to working hard to help make this another banner year for the YFA.
The leadership of the American College of Surgeons (ACS) understands that our most junior members—namely, residents and young surgeons just entering practice—represent the future both of the profession and of this organization. To this end, the ACS has hired new staff to meet the needs of trainee surgeons and has developed programs and activities to meet the challenges of this group.

As a neurosurgeon in training, I’m often asked whether the College has offerings for those of us in the surgical subspecialties outside of general surgery. The answer is, “Yes.” The College does offer specific benefits to surgical trainees in specialties outside of general surgery, but we could use your help to better define which products, services, or educational offerings would be useful to you in your training and practice.

Invitation to get involved

As incoming Chair of the Resident and Associate Society of the ACS (RAS-ACS), I encourage all trainees (residents and fellows) as well as junior faculty to become active members of the RAS-ACS. This
year, the RAS-ACS has many exciting projects planned, and your involvement in these initiatives will make this organization work even better for our members.

The RAS-ACS has four standing committees: Education, Advocacy & Issues, Membership, and Communication. These committees meet by conference call on a rotating schedule every Wednesday at 8:00 pm. The phone number to dial in is 1-888-585-9008 and the passcode is 549-242-585. We encourage all interested residents, fellows, and junior faculty to participate in these calls. Listening in on one or two conference calls is one of the best ways to understand how to get involved in the RAS.

Each RAS-ACS standing committee has an ambitious agenda planned for the year. Serving on a standing committee is a tremendous leadership experience for any surgical resident, fellow, or junior faculty member—it helps participants understand the structure and functions of the College, and it provides networking opportunities with surgical peers across the country.

Communications Committee
Our Communications Committee, led by Erin Garvey, MD, will be working on several exciting programs in 2016. We are working to develop a journal club in partnership with the *Journal of the American College of Surgeons*, which will provide surgical trainees with the opportunity to publish scientific literature reviews, facilitating discussion and learning across institutions.

We are developing new channels for communicating key information to RAS-ACS members, particularly at the grassroots level. We are developing podcasts and using social media to promote educational resources for trainees. The Communications Committee also hosts an annual essay competition and coordinates the RAS-themed issue of the *Bulletin* each August.

Education Committee
Our Education Committee, under the leadership of Becky Hoffman, MD, has done a remarkable job of developing several engaging programs for RAS members. (If you are a young surgeon, particularly a junior faculty member, with an interest in resident, medical student, or lifelong education, you are urged to participate in this committee.)

Surgical Jeopardy is being piloted for use at several ACS chapter meetings and already is a big hit, receiving enthusiastic feedback. This question-and-answer competition tests trainees’ surgical knowledge, pitting two teams against each other for accolades and the thrill of victory. If you have an interest in crafting questions or you have suggestions on how to enhance this resource, the Education Committee would appreciate your input.

The committee also is developing a surgical skills competition for presentation at Clinical Congress. This program would be similar to the “Top Gun” competitions some specialty societies offer at their meetings.

Advocacy & Issues Committee
Our Advocacy & Issues Committee, led by Billy Ward, MD, is responsible for leading the RAS’ efforts to promote awareness about the legislative process, its effects on surgical training and practice, and information regarding state and federal advocacy issues. This
committee will be working closely with ACS staff in the Division of Member Services to develop more resources for RAS members serving in the military, with the goal of helping surgical trainees maintain their skills during deployment.

This committee also is seeking to raise awareness regarding the issue of drug shortages. Many common medications and generics, including normal saline, basic antibiotics like amoxicillin and bactrim, and other medications including diltiazem, chemotherapeutics, and atropine are in short supply in hospitals across the nation. This situation is having a detrimental effect on patient care, as patients are treated with other, less-than-ideal medication regimens or physicians are forced to delay treatment altogether until suitable medication is discovered. The surgical specialties, particularly the trainees, witness the impact of these shortages and the challenges that come with treating patients in these situations. For example, surgical trainees are unable to gain firsthand experience using a proper medication regimen because they must make do with whatever medication is available. The RAS plans to raise awareness among surgical trainees of this growing problem and to continue working closely with staff in the ACS Division of Advocacy and Health Policy to support meaningful legislative reforms intended to address the medication shortage crisis.

We also plan to work closely with Operation Giving Back (OGB), which supports surgeons serving across the globe and on U.S. soil. We believe that highlighting surgical access needs domestically is important and plan to work closely with OGB to seek ways that RAS members can participate in serving underserved regions within the U.S. Given the success of the Clinical Congress 2015 RAS Symposium, which focused on the role of social media in communication among health professionals, this committee intends to work closely with ACS leaders to develop guiding principles for how social media can be effectively and appropriately employed by surgeons and surgical trainees.

**Membership Committee**

Our Membership Committee, led by Priya Jadeja, MD, is an enthusiastic panel of physicians dedicated to improving the membership experience for RAS members. The committee has set ambitious goals to understand member attrition and to gain feedback from former ACS members regarding how the organization can improve its products and services, which include developing incentives for long-term members in an effort to recruit and retrain members of the ACS and RAS, as well as focusing more resources and attention on our subspecialty members in an effort to comprehend their needs and develop resources to improve their training experience. The Membership Committee also coordinates the annual International Exchange Program, which provides an all-expense paid trip to recipients with the opportunity to participate in another country’s primary surgical meeting; host nations include Australia/New Zealand, Italy, and Ireland.

**Liaison with ACS standing committees**

RAS-ACS members serve as liaisons to the 13 ACS Advisory Councils representing all surgical subspecialties. The RAS-ACS also appoints liaisons to serve on the College’s 26 standing committees, ranging from the Committee on Trauma to the Commission on Cancer. If a member is interested in getting involved in RAS-ACS activities, contact me at mayababu@gmail.com.

The Executive Committee of the RAS, including Nick Mouawad, MD, Vice-Chair, and Afif Kulaylat, MD, Secretary, are excited about the events and initiatives planned for 2016, and we look forward to meeting the leadership development needs of this generation and those to come. ♦
Preparing for MACRA implementation

by Matthew Coffron, MA, and Vinita Ollapally, JD

The initial excitement regarding the repeal of the sustainable growth rate (SGR) formula as a result of the passage of the Medicare Access and CHIP (Children’s Health Insurance Program) Reauthorization Act (MACRA) in early 2015 is now fading, and the Centers for Medicare & Medicaid Services (CMS) is beginning to plan for the implementation of new payment mechanisms established in the law. This column describes the reimbursement systems that will replace the SGR and explains what surgeons need to know to prepare for the transition.

What are the new payment mechanisms under MACRA?
MACRA creates a new Merit-based Incentive Payment System (MIPS) that will adjust physician payments up or down annually based on performance. MACRA also places new emphasis on alternative payment models (APMs) that will create a pathway for the development of physician-focused APMs. Physicians who provide a certain percent of their patient care in the APMs will be exempt from many MIPS requirements and will be offered additional incentives.

When do the new payment programs take effect?
The new MIPS payment update and incentives for APM participation will take effect in 2019. However, because of the significant lag between performance periods and payment years, physicians are likely to have their payments adjusted in 2019 based on their performance in 2017, so it is important to begin preparing early on for the changes in reimbursement policies.

How can surgeons prepare to succeed under MIPS?
To provide each physician with a composite score between one and 100, CMS will combine and streamline existing quality programs, discontinuing their associated penalties after 2018. These quality programs include the Physician Quality Reporting System (PQRS), the value-based payment modifier (VM), and the Electronic Health Record (EHR) Incentive Program. An additional category referred to as clinical practice improvement activities (CPIA) will be added to provide credit for expanding access to care, using clinical decision support tools, implementing surgical checklists, and participating in APMs and other efforts designed to improve patient care.

Because the new updates will be based largely on modified versions of existing programs, the best way to ensure success under the new program will be to make certain you are successfully participating in the PQRS, VM, and EHR Incentive Program. A number of American College of Surgeons (ACS)-developed resources are available to help Fellows become familiar with the current requirements of these programs, which are likely to be quite similar to the requirements in the MIPS program, at least in the early years.

How will payments be adjusted under MIPS?
Under the current payment policies, penalties for the PQRS, VM, and EHR Incentive Program will grow to as much as 10 percent in 2018, with very little potential for positive updates. Beginning in 2019, these penalties will be repealed. The maximum penalty under MIPS will be 4 percent, and providers will be

V101 No 2 BULLETIN American College of Surgeons
able to achieve up to 4 percent in positive adjustments—even higher if few physicians receive high composite scores. An additional incentive payment for the highest performers will be offered in 2019–2024. In other words, under MIPS the maximum penalty will be diminished, and surgeons could experience sizable positive updates based on performance. The maximum updates and penalties will grow over time, reaching 9 percent in 2022 and beyond. The maximum penalties under MIPS never grow as high as they will have been in 2018 under existing programs.

What are the benefits of participating in an APM?
MACRA calls for the creation of new physician-focused APMs and incentivizes APM participation in a number of ways. You do not need to see patients exclusively through an Accountable Care Organization or other model to see benefits. For practices that are unable to receive a high portion of their payments through these models, participation even at very low levels may provide credit in the CPIA portion of MIPS and could lead to higher updates. Those physicians who are able to receive 25 percent of payments through a qualified APM will receive a 5 percent lump sum incentive and will be exempt from many MIPS requirements. Surgeons who try to meet this threshold but fall short may be considered partially qualifying and will be exempt from MIPS without receiving the incentive. These targets grow to 50 percent, and eventually 75 percent, of payments. Finally, starting in 2026, the law institutes small annual payment increases with updates growing faster for qualified APM participants than for those providers participating in MIPS.

Where can I learn more about APMs for surgeons?
New APMs are likely to proliferate in the coming years in response both to MACRA and to a previously announced U.S. Department of Health and Human Services goal of tying 50 percent of Medicare payments to APMs by the end of 2018. While different types of models are in development, surgical services lend themselves well to bundled payment models due to their episodic nature.

Surgeons and Bundled Payment Models: A Primer for Understanding Alternative Physician Payment Approaches is a tool published by the ACS to help surgeons learn more about APMs (see sidebar, page 32).

What is the ACS doing to facilitate participation in MIPS and APMs?
The ACS will work with CMS to ensure that the agency implements the new payment systems in a way that makes sense for how surgeons deliver quality care and that minimizes administrative burdens. In November, the College sent a detailed response to a CMS request for information on MIPS, APMs, and a new technical assistance program for small and rural practices. CMS will use this response, along with the comments from other physician societies and interested parties, to inform a proposed rule that will provide greater detail into how the programs will be administered. The proposed rule is scheduled to be released in March, at which time the College will provide further comments to help CMS refine its plans. The final rule should be published in late fall.
ADDITIONAL RESOURCES

- Surgeons and Bundled Payment Models: A Primer for Understanding Alternative Physician Payment Approaches: facs.org/publications/primers
- Interactive tool: facs.org/advocacy/quality/medicare-programs

More information on some of the terms used in this article:

- PQRS: facs.org/advocacy/regulatory/pqrs
- VM: facs.org/advocacy/regulatory/vbm
- EHR Incentive Program: facs.org/advocacy/regulatory/ehr

The College intends to work closely with CMS to ensure that options are available for the greatest number of surgeons to participate in APMs if they so choose. To this end, ACS quality and regulatory staff will be examining opportunities to create and pilot new APMs with CMS and the Center for Medicare & Medicaid Innovation. In addition, ACS staff will keep Fellows informed about the requirements of the new program as they emerge, helping Fellows succeed in the new system.

How will MACRA impact payment for global codes?

MACRA requires that, starting in 2019, CMS improve the accuracy of the valuation of global surgical services. CMS has indicated it will do this by examining and revaluing the individual components of global codes. MACRA also requires that CMS develop a process to gather information needed to value surgical services from a representative sample of physicians and requires that data collection begin by January 1, 2017. These data must include the number and level of medical visits furnished during the global period and other items and services related to the operation as appropriate. These data could be extracted from claims at the end of the global period or in another manner that CMS determines. CMS has the authority to delay up to 5 percent of payment for the services that a physician is required to provide until the required information is reported. At this point, CMS has not indicated how it plans to collect the data needed to revalue global surgical services. ACS staff will meet with CMS to provide recommendations.
As surgeons and surgical oncologists interested in improving our field and in improving patient outcomes, it is important to us that practice-changing scientific research, clinical trials, and cancer guidelines be incorporated into clinical use in a timely fashion. However, estimates show that only 14 percent of original scientific research designed to improve patient care actually reaches the designated population of interest and takes more than 17 years to achieve even this impact.\(^1\)

Cancer clinical trial outcomes are a significant component of this research base. Although they require a marked investment of financial and human resources, these outcomes data are unable to help the larger population of cancer patients in a timely and effective manner.

Dissemination and implementation research
Dissemination and implementation research has its roots in effectiveness and efficiency research, which dates back to the 1970s. In the 1990s, dissemination and implementation research programs started to expand and involve the intended stakeholders (patients, providers, payors, and policymakers) with, for example, the development of the Agency for Healthcare Research and Quality (AHRQ). This research approach, however, is still in its infancy.

Dissemination is defined as the “targeted distribution of information and intervention materials to a specific public health or clinical practice audience,” while implementation is “the use of strategies to adopt and integrate evidence-based health interventions and change practice patterns within specific settings.”\(^2\) In short, the goal of dissemination and implementation processes is to package the created evidence, transmit it to the population of interest, and ensure it is received and adopted in its intended or appropriately modified form.

Dissemination strategies and implementation research programs include an array of qualitative research methods and designs that may not be immediately familiar to the practicing surgeon. However, several of the processes set forth by dissemination and implementation researchers include interventions that surgeons already use frequently, such as the multidisciplinary tumor board and community outreach programs.\(^3\) Each of these interventions is a component of the American College of Surgeons (ACS) Commission on Cancer (CoC) standards for accreditation.\(^4\)

Community surgeons who treat cancer are most likely to learn of clinical trial outcomes from reading journals and at national meetings, but it is at local tumor conferences that surgeons can discuss with their peers how to incorporate the information into clinical practice. Presenting a case in a multidisciplinary venue and discussing how the trial results should affect management of a particular patient is one existing mechanism for dissemination.

New committee
The ACS Clinical Research Program (ACS-CRP), a component of the Alliance for Clinical Trials in Oncology, is committed to improving the dissemination and implementation of cancer research into routine clinical practice. The ACS-CRP is dedicated to ensuring that surgeons and their patients benefit from the latest advances in cancer care.

by Lee G. Wilke, MD, FACS; Diana Dickson-Witmer, MD, FACS; and Judy C. Boughey, MD, FACS

FEB 2016 BULLETIN American College of Surgeons
...[T]he goal of dissemination and implementation processes is to package the created evidence, transmit it to the population of interest, and ensure it is received and adopted in its intended or appropriately modified form.

Clinical Trials in Oncology, has recently developed a Dissemination and Implementation Committee charged with developing strategies for disseminating key cancer clinical trial results as well as designing implementation research programs for novel cancer guidelines. Key collaborators with this new committee are members of the CoC and the ACS-CRP committees on Education, Cancer Care Delivery Research, and Cancer Care Standards Development. Crucial to the growth of this program will be methodologists with expertise in dissemination and implementation research, as well as patient and cancer community advocates with an interest in moving guidelines and trial results to the larger cancer patient population.

One project that the ACS-CRP Dissemination and Implementation Committee will explore is the dissemination of critical elements of the operation set forth in the recently published *Operative Standards for Cancer Surgery.*

How does the surgical cancer community ensure that each breast, pancreatic, colon, and lung operation follows the recommended operative steps detailed in this innovative manual? Will inclusion of each of these key practices improve cancer patient outcomes? These are the questions that the new committee intends to address.

Additionally and importantly, this group will be responsible for the dissemination of recent clinical trial results. In close association with the CoC, the ACS-CRP Dissemination and Implementation Committee seeks to ensure that each of the CoC-accredited hospitals can quickly incorporate clinical trial results and implement novel processes for making certain the community that would benefit from these trial results does so in a timely manner.

This new committee welcomes input from ACS Fellows, particularly your responses to the following types of questions: What are the things that most effectively give you the confidence and tools necessary to change your clinical practice in response to results of contemporary trials? How do you “operationalize” the new paradigms you read about or hear about at national meetings? The answers to these questions and the dissemination and implementation research associated with them will help the cancer community to shorten the 17-year gap from discovery to improved patient outcomes.

For more information on this committee, contact Lee G. Wilke, MD, FACS, at wilke@surgery.wisc.edu.

REFERENCES


SRGS and the COT trauma education programs: Keeping surgeons current on the provision of optimal patient care

by Lewis M. Flint, MD, FACS; Whitney Greer; Ronald M. Stewart, MD, FACS; Monique N. Drago, EdD; and Ryan M. Hieronymus, MBA

This month’s column highlights two educational resources unique to the American College of Surgeons (ACS). Selected Readings in General Surgery (SRGS), a critical resource for all practicing general surgeons, offers the latest information and research to help provide state-of-the-art care while earning continuing medical education (CME) credit. In addition to SRGS, the ACS Committee on Trauma (COT) provides a variety of courses to support today’s trauma surgeon and all the members of the trauma care team.

SRGS: All you need to know
For more than 40 years, SRGS has been the premier literature review for general surgeons who want up-to-date information on evidence-based medicine and to remain on the cutting edge of practice. SRGS was founded in 1974 by Robert N. McClelland, MD, FACS, professor of surgery, University of Texas Southwestern Medical Center, Dallas. The ACS took ownership of SRGS in 2007 when Dr. McClelland retired. “Selected Readings has taken its place as a vital component of the offerings of the American College of Surgeons and contributes to the value of these offerings in several areas, including the program for Maintenance of Certification in surgery,” Dr. McClelland said.* Today, Lewis M. Flint, MD, FACS, co-author of this article, is Editor-in-Chief of SRGS, and the publication remains dedicated to the same core values that are at the heart of the ACS mission: to improve the care of the surgical patient and to safeguard standards of care in an optimal and ethical practice environment.

The science behind SRGS
In 2014, approximately 14,000 peer-reviewed journal articles were published on topics related to general surgery, and, according to a recent American Board of Surgery report, surgeons perform, on average, nearly 400 operations a year.† Thus, it would be inordinately difficult for practicing surgeons to review every article that would be of value to them and their patients, which is why the SRGS is such an essential resource. SRGS is published eight times a year in the following months: February, March, May, July, August, September, October, and December. Each issue focuses on a specific topic and includes an overview of about 80 pages, written by Dr. Flint. These summaries provide insightful reviews of approximately 150 articles published in the world’s most prominent medical journals. Some subscription types also provide access to reprints of specific key articles cited in the overview, which Dr. Flint includes as recommended reading.

SRGS issues are published on a revolving cycle of the most relevant topics in general surgery, including liver disease, vascular surgery, general oncology, breast disease, pediatric surgery, rural surgery, and trauma. This wide range of topics ensures that readers

---

are exposed to a breadth of learning experiences to help them provide excellent patient care, as well as maintain their general surgery knowledge base, develop comparative and critical literature reading skills, and effectively prepare for recertification exams.

Variety of formats
No two surgeons have the exact same preferences. Some general surgeons prefer to read a print journal, while others are more interested in Web-based learning; still others prefer a mixed format. SRGS offers a range of subscription types to better meet the needs of its diverse surgical readership. Some of the most popular subscriptions are as follows:

• **SRGS print:** Subscribers receive a hard copy of SRGS eight times per year. The print version includes both the overview and the selected article reprints. Print subscriptions are available with or without CME, and special rates are available for surgery residents.

• **SRGS Premium and SRGS Practicing Surgeon:** Both SRGS Premium and SRGS Practicing Surgeon are online versions of the publication. The Premium version is identical to the print version, which means it includes the overview and the selected article reprints. The Practicing Surgeon version does not include the reprints.

• **SRGS Connect Plus Print:** Surgeons who don’t want to choose between the print and online versions of SRGS can take advantage of this subscription format, which is available with or without online access to article reprints. Subscribers also receive a hard copy of each issue and have access to the materials online.

All online versions of SRGS provide access to additional materials, including “What You Should Know,” a compilation of 10 monthly review articles written by surgeons, for surgeons; and “The Knowledgeable Surgeon,” an engaging monthly editorial review written by Bernard Jaffe, MD, FACS, former editor-in-chief of *Surgical Rounds* and professor of surgery at Tulane University School of Medicine, New Orleans, LA.

In addition, SRGS is launching a new feature—an audio companion to the overview, which will be available to all subscription types sometime this year.

National pulse check
Today, more than 45 million U.S. citizens are age 65 and older, accounting for 14 percent of the nation’s total population. According to a 2014 report published by the U.S. Census Bureau, the size of this demographic is projected to nearly double to 83.7 million by 2050. Additionally, for better and for worse, the entire health care policy arena is changing, with increasing demands for measurable care. As an example of how attuned SRGS is to the prevailing and critical issues that surgeons face today, SRGS will launch 2016 with an issue on geriatrics and palliative care, which will highlight surgical advancement in elderly care; and an issue on ethics, patient safety, and the business of medicine, which will examine some of the ways surgeons can remain viable in the changing health care frontier.

Furthermore, in response to the continuing emphasis on lifelong learning and Maintenance of Certification, SRGS offers subscribers the opportunity to earn 80 hours of CME credit every year (10 credits per issue). Each issue of SRGS contains 20 multiple-choice pre- and posttest questions. To earn credit, subscribers complete the pretest, read the issue, and then take the posttest. Progress on the pretest and posttest can

---

be saved and completed later. When completed, the correct answer for each question and score are provided, and CME credits are posted automatically to the ACS MyCME database, which stores all members’ CME credits in one location. Thus, subscribers may view their transcripts, print their certificates, and keep track of the documentation needed for credentialing, renewing state licenses, and recertifying with medical boards in a centralized location.

Contact Whitney Greer, Managing Editor, SRGS, at wgreer@facs.org, or Dr. Flint at lflint@facs.org with any questions or comments regarding SRGS.

**COT education and training: Meeting the needs of today’s trauma team**

The ACS COT develops and implements meaningful programs for trauma care in local, regional, national, and international arenas. The trauma education curriculum comprises six standalone courses: Advanced Trauma Life Support® (ATLS®); Trauma Evaluation and Management® (TEAM®); The Rural Trauma Team Development Course (RTTDC); Disaster Management and Emergency Preparedness (DMEP); Advanced Trauma Operative Management (ATOM®); and Advanced Surgical Skills for Exposure in Trauma (ASSET). Each course may be taken independently, but they each build upon the framework of ATLS, the largest and earliest course.

**ATLS**

The ATLS program provides a systematic, concise approach to the care of a trauma patient. The ACS COT developed ATLS and introduced the program in 1980. Since then, ATLS has been offered internationally, training more than 1 million providers in more than 70 countries. In the Provider Course, students learn how to treat the greatest threat to life first by using a systematic ABCDE (airway, breathing, circulation, disability, exposure) approach, which is both universal and easy to remember. ATLS participants learn safe and reliable methods for treating patients during the so-called “golden hour”—the first hour following a traumatic injury, during which there is the highest likelihood that medical treatment will prevent death.

Specific elements of the ATLS program are as follows:

- **Intended audience:** Physicians, physician extenders, dentists, nonphysicians (nurses, physician assistants, paramedics, ambulance personnel)

- **Topics/objectives addressed:**
  - How to assess a patient’s condition rapidly and systematically
  - Primary survey, ABCDE
  - Resuscitation and stabilization of patients according to priority

- **Course lengths:**
  - Student Course: Two days and 2.5 days
  - Instructor Course: One day, 1.5 days, and two days
  - Student Refresher Course: Half day and one day

**TEAM**

TEAM introduces the concepts of trauma assessment and management to medical students in their clinical years. The core content is adapted from the ATLS course and is an expanded version of the ATLS Initial Assessment and Management lecture. The TEAM format is flexible, with a 90-minute slide presentation and optional components. The program includes a three-segment initial assessment video demonstration, a series of clinical trauma case scenarios for small-group discussion, and skills sessions. The slide/lecture presentation, included in the faculty DVD, can be
easily adapted into a medical school’s curriculum. The TEAM program provides a standardized introductory course in the evaluation and management of trauma for medical students and multidisciplinary team members. The ATLS Committee strongly encourages the participation of ATLS instructors, as they are familiar with the philosophy, purpose, and content of the program.

Because TEAM is an abbreviated version of the ATLS course, it is not a replacement for ATLS participation. Medical students are encouraged to take the ATLS course in their final year of medical school or after graduation.

RTTDC
The RTTDC emphasizes a team approach to the initial evaluation and resuscitation of the trauma patient at a rural health care facility. More than 60 percent of U.S. trauma deaths occur in rural areas, and this course assists health care professionals in determining whether there is a need to transfer the patient to a higher level of care. The one-day course includes interactive lectures on medical procedures, communication strategies, and three team-performance scenarios.

Developed by the COT’s Rural Trauma Committee, RTTDC is based on the concept that in most situations, rural facilities can form a trauma team of at least three core members.

Specific elements of the RTTDC are as follows:

- **Intended audience:** Any health care professional who is part of the trauma care team
- **Topics/objectives addressed:**
  - Identify local resources and limitations
  - Initiate transfer process early
  - Establish a performance improvement process
  - Define a relationship between the rural trauma facility and the regional trauma system and ensure that communication is strong

- **Course length:** The course is offered in a single-day or modular format, which allows hospitals and trauma centers to tailor the course to their needs.

DMEP
The DMEP course teaches planning methods, preparedness, and medical management of trauma patients in mass casualty disaster situations. Through lecture and interactive scenarios, health care providers learn incident command terminology, principles of disaster triage, injury patterns, and availability of assets for support.

The COT recognizes that a mass casualty event is not just another busy night in an urban trauma center. Most physicians have little or no background or experience in such circumstances. The DMEP course teaches skills that apply to any kind of mass casualty event and helps institutions be better prepared to address the needs of patients who experience this type of trauma. The course is open to anyone who may be a first receiver of casualties following a disaster. DMEP participants learn both the skills and practical ways of thinking that lead to better performance in a range of disaster situations.

Specific elements of DMEP are as follows:

- **Intended audience:** Acute care providers (surgeons; anesthesiologists; emergency medicine physicians; emergency department, operating room, intensive care unit, and trauma nurses; and pre-hospital professionals), hospital administrators, public health personnel, and emergency managers

- **Topics/objectives addressed:**
  - Emphasizes an all-hazards approach

Developed by the COT’s Rural Trauma Committee.
| Planning, triage, incident command, injury patterns and pathophysiology, and consideration for special populations |
| Pitfalls and barriers in disaster planning |
| Epidemiology and history of disasters |

**Course length:**
- One-day didactic and interactive provider course

**e-DMEP:** The first trauma education e-course developed and is available on the ACS E-Store at [web4.facs.org/ebusiness/ProductCatalog/product.aspx?ID=542](http://web4.facs.org/ebusiness/ProductCatalog/product.aspx?ID=542)

### ATOM

The ATOM course is an effective method of increasing surgical competence and confidence in the operative management of penetrating injuries to the chest and abdomen. This course uses a hands-on approach to teaching the surgical skills needed to manage atypical and complex cases as well as the confidence that surgeons need to be able to treat these injuries. The student-to-instructor ratio for this course is one-on-one or two-on-one.

Specific elements of the ATOM course are as follows:

- **Intended audience:** Senior surgical residents, trauma fellows, military surgeons, and fully trained general surgeons who are not frequently called on to treat penetrating injuries

- **Topics/objectives addressed:**
  - The lecture portion teaches the management of penetrating injuries, including trauma laparotomy and spleen and diaphragm, liver, pancreas and duodenum, genitourinary, cardiac, and vascular injuries
  - The lab session presents students with scenarios in which they must identify and repair simulated injuries to the chest and abdomen

- **Course length:** One-day provider course (six 30-minute lectures followed by a three-hour lab session)

### ASSET

The ASSET course uses human cadavers to expose students to the anatomic structures that, when injured, may pose a threat to life or limb. Students use a course manual that provides an overview of surgical exposures in the following key areas: neck, chest, abdomen and pelvis, and upper and lower extremities. The one-day course covers each section, beginning with a case-based overview followed by a hands-on training. Students assess their ability to perform each procedure independently and are evaluated on knowledge and technical skills.

Specific elements of the ASSET course are as follows:

- **Intended audience:** Mid-level and senior surgical residents, trauma and acute care surgical fellows, and any surgeon who wants to review this anatomy

- **Topics/objectives addressed:**
  - Allows practice on techniques that are used rarely but are good to know in critical moments
  - 50 procedures, including fasciotomies, venous and arterial exposure, exposure and repair of organ tissue, as well as proper use of surgical instruments

- **Course length:** One day

For more information about the COT trauma education programs described here, go to [facs.org/quality-programs/trauma/education](http://facs.org/quality-programs/trauma/education). ♦
Credentialing and privileging: Five tips for ASCs

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

Over the last few years, the number of ambulatory surgery centers (ASCs) owned or managed by surgeons has substantially increased. Furthermore, some health care professionals and administrators now assert that certain operations that can be done in ambulatory centers should not be performed in hospitals. With that in mind, this column highlights key elements of the credentialing process for ASCs.

Understanding the credentialing process—defined as the process of obtaining, verifying, and assessing the qualifications of a practitioner to provide care or services in or for a health care organization—is essential to ensure that the properly credentialed and privileged practitioners are providing the best possible care to those patients who require outpatient surgery.

The following are five tips to better understand this process.

**Tip 1: Use the elements of performance as a guide**
The Joint Commission standard for the credentialing and privileging process for an accredited ASC is HR 02.01.03, which states that the facility “grants initial, renewed, or revised clinical privileges to individuals who are permitted by law and the [ASC] to practice independently.”*

The standard has 34 elements of performance (EPs), which include the following measurable actions:

- Review of the practitioner’s credentials, including evidence of current licensure
- Evaluation of relevant training and education specific to the requested privileges
- Evidence of competence or ability to perform the specific procedure requested (including the applicant’s written statement that no health problems exist that could affect his or her ability to perform the requested privileges, as stipulated by EP 10)
- Ability to comply with the ASC’s requirements for granting, renewing, revising, and denying privileges
- Verification of current license from primary source
- Primary source verification documenting training specific to the privileges requested
- Evaluation of challenges to licensure or registration
- Documentation of current evidence, including peer and/or faculty recommendations, of the individual’s ability to perform the privileges requested

**Tip 2: Obtain key verification**
One of the chief responsibilities of a freestanding ASC facility is to determine whether licensed, independent practitioners are capable and competent to provide high-quality and safe care to patients. Before a practitioner can be considered for this

---

Understanding the credentialing process...is essential to ensure that the properly credentialed and privileged practitioners are providing the best possible care to those patients who require outpatient surgery.

privilege, however, necessary credentialing must be verified. Key verification can come from the following sources:

- Primary source verification, which centers on the practitioner’s qualifications by an original source or approved agent of that source. This form of verification may include direct correspondence, telephone, or electronic communication

- Reports from credentials verification organizations that meet Joint Commission requirements

**Tip 3: Use peer reviews**
EP 8 of the standard states, in part, that before granting initial renewed or revised privileges to a licensed, independent practitioner, the organization should evaluate the results of any peer review of the individual’s clinical performance.†

Peer recommendations must come from practitioners who are in the same professional discipline. Peer review is important because it can meet requirements to review professional performance, judgment, and clinical or technical skills before granting initial, renewed, or revised privileges.

---

**Tip 4: Understand the risks of inaction, expectations of implementation**

Neglecting the credentialing and privileging process increases the risk of negatively affecting the following:

- Quality of care
- Patient safety
- Risk management
- Compliance with Joint Commission standards and the Centers for Medicare & Medicaid Services Conditions of Participation or Conditions of Coverage
- Public reputation
- Financial health

In addition, privileges should be site-specific to ensure the staff is competent in that area and the equipment and environment are appropriate for the requested operation.

---

**Tip 5: Ask for help if you need it**

Questions on credentialing and privileging, including requests for a conference call, should be directed to The Joint Commission’s Standards Interpretation Group at 630-792-5900. Questions also can be submitted via an online form at https://web.jointcommission.org/sigsubmission/sigsubmissionform.aspx. More information also is available at www.jointcommission.org/standards_information/jcfaq.aspx. ♦️

---

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

---

The 2015 Pediatric Report of the National Trauma Data Bank® (NTDB®) is an updated analysis of the largest aggregation of U.S./Canadian trauma registry data ever assembled. In total, the NTDB now contains more than 6 million records. The 2015 Pediatric Report is based on 143,996 records submitted by 745 facilities from admission year 2014. The NTDB classifies pediatric patients in this report as patients who are younger than 20 years of age.

The mission of the American College of Surgeons (ACS) Committee on Trauma (COT) is to develop and implement meaningful programs for trauma care. In keeping with this mission, the NTDB is committed to being the principal national repository for trauma center registry data. The purpose of this report is to inform the medical community, the public, and decision makers about a variety of issues that characterize the current state of care for injured pediatric patients in the U.S. It has implications for epidemiology, injury control, research, education, acute care, resource allocation, and other areas.

Four regions

The U.S. Census Bureau divides the U.S. into four regions. The Northeast comprises nine states, the Midwest 12 states, the West 13 states, and the South the remaining 16 states and the District of Columbia. Each region has its own population statistics, and the pediatric component (patients younger than 18 years old) is fairly well divided among the four regions—22.3 percent of pediatric trauma patients were in the Northeast, 24.1 percent were in the Midwest, 24.3 percent were in the South, and 24.9 percent were in the West. Figure 36 of the 2015 Pediatric Report indicates that the South accounts for more than 40 percent of the trauma incidents. (See Figure 1, page 43).

Many dedicated individuals on the ACS COT, including the Pediatric Surgery Subspecialty group, along with those individuals caring for pediatric patients at trauma centers...
Throughout the country, have contributed to the early development of the NTDB and its growth in recent years. Building on these achievements, the goals in the coming years include improving data quality, updating analytic methods, and developing data that enable more useful inter-hospital comparisons. These efforts will be reflected in future NTDB reports to participating hospitals as well as in annual pediatric reports.

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

The NTDB 2015 Pediatric Report is available on the ACS website as a PDF file at facs.org/quality-programs/trauma/ntdb/docpub.
Apps incorporating clinical photography offer the potential to improve care

We read with interest the insightful article “Sharing clinical photographs: Patient rights, professional ethics, and institutional responsibilities” published in the October 2015 Bulletin (Bull Am Coll Surg. 2015;100[10]:17-22). Our own research experience using clinical photography for postoperative assessment has revealed several practical challenges related to secure image transmission and storage, image quality, and incorporation of remote assessments into surgeon workflow.

We are active clinicians and surgical researchers at the University of Washington, Seattle; University of Wisconsin, Madison; and Vanderbilt University, Nashville, TN, and are developing and testing Web- and smartphone-based tools incorporating clinical photography to manage postoperative patients. We have found that both patients and surgeons accept online approaches to care, and these techniques can be tailored to meet the needs of diverse populations, including the elderly.

We also have observed that wound images generated by patients and even providers are of variable quality and may be difficult to interpret. Patients have different degrees of experience with digital photography and may have physical impairments, such as poor vision or tremor, which can impair their ability to capture a focused image suitable for clinical diagnosis.

Furthermore, a health care professional can only evaluate the portion of the patient that is included in the image, creating a risk for missing key findings. Issues of secure data transmission and storage also have come to light, as has the increase in volume of information to be managed. Current clinical processes and informatics systems may not have the capacity to handle this deluge of additional patient data.

Despite these challenges, mobile applications incorporating clinical photography offer the potential to increase access to patient-centered care and improve outcomes. As a surgical community, we recognize an opportunity to establish standards for the capture, transmission, assessment, and documentation of digital images that inevitably will be used to provide surgical care.

Kristy Kummerow Broman, MD, MPH
Nashville, TN

Benjamin Poulose, MD, MPH, FACS
Nashville, TN

Heather Evans, MD, MS, FACS
Seattle, WA

Sara Fernandes-Taylor, PhD
Madison, WI
To whom it may concern,

Dear sir or madam,

Time to change the general surgery MOC exam

I read with interest the article “The American Board of Surgery Maintenance of Certification Program: The first 10 years” in the July 2015 issue of the Bulletin (Bull Am Coll Surg. 2015;100[7]:15-19). The general surgery Maintenance of Certification (MOC) examination is offered annually and comprises approximately 200 multiple-choice questions designed to assess a surgeon’s cognitive knowledge and clinical judgment. The exam lasts five hours and is offered at testing facilities throughout the country. Surgeons must pass this examination every 10 years.

Most surgeons find the time and expense necessary to take these tests onerous. Some have argued that it has spawned a cottage industry that funnels profits into professional societies, test preparation book publishers, and testing companies.

A major argument in favor of board certification is that it maintains and improves the quality of care for patients. Two recent studies in the Journal of the American Medical Association sought to evaluate the role of MOC with respect to physician quality and medical costs, respectively.*† Physicians certified before the 1990 requirement for recertification were compared with those certified after 1990. Medical outcomes were no better, and overall costs were barely lower in the recertifying group. Both studies concluded that MOC is expensive, time-consuming, and has no effect on quality of care.

It’s time to change the MOC examination from one that tests the ability of surgeons to reproduce recently crammed material to one that helps them improve their knowledge. Open-book examinations with generous time allotments and access to current resources should replace the current exams. They should be offered online at a reasonable cost. The ability to find and retain accurate information is more valuable than the ability to shoehorn it into memory. These examinations could even be required more often than every 10 years, as their purpose would be educational rather than administrative.

In January 2014, when the American Board of Internal Medicine announced a series of new requirements for MOC that would have generated additional fees, several leading physicians formed a new recertification organization: the National Board of Physicians and Surgeons (NBPAS). The leaders of the American Board of Surgery should set an example for all medical specialties by changing the MOC requirements as outlined above or in accordance with the NBPAS requirements. The result will be more knowledgeable practitioners, many sighs of relief, and improvement in our health care system.

Steven G. Friedman, MD, FACS
New York, NY

Remembering Dr. McSwain

I have fond memories of Norman E. McSwain, MD, FACS, who died last summer and whose obituary was published in the October 2015 Bulletin (Bull Am Coll Surg. 2015;100[10]:56-58). The first time I met him was as a visiting professor at Tulane University Hospital, New Orleans, LA. He picked me up at the airport and we chatted on the way to the hospital. He was dressed

---

in a blue work shirt, wearing a bolo tie and black cowboy boots. I had grown up in eastern Washington, which was cattle country with many wheat fields. He reminded me of my childhood and being with people who were down to earth. After my talk the next morning, Norm invited me to come to his home in the French Quarter and spend the evening. His home was a true museum with mementoes of the Civil War and Native American culture. His clothing was a reflection of his personality. I don’t remember him wearing a regular tie but often a bolo tie, turquoise and other colors, was de rigueur. My wife Jane and I miss him and his compassion for his friends, family, and patients.

Donald D. Trunkey, MD, FACS
Portland, OR

Service members injured in combat should not have to seek volunteer care
I was surprised and angered by the article about Timothy A. Miller, MD, FACS, and Operation Mend, which was published in the December 2015 Bulletin (Bull Am Coll Surg. 2015;100[12]:28-30). Any service member injured in battle and requiring plastic and reconstructive surgery should not have to seek surgical care from a volunteer organization. This type of care should be available from the best plastic surgeons, such as Dr. Miller, and paid for in full by the federal government.

I’m sure Operation Mend is a wonderful organization and does surgery of the highest quality, but there should be no need for it. Men and women injured in battle deserve the best care possible and should not have to rely on a volunteer organization to provide their care.

W. Slocum Howland, Jr., MD, FACS
Highlands, NC

“My wife Jane and I miss [Dr. McSwain] and his compassion for his friends, family, and patients.”

–Dr. Trunkey

To whom it may concern,

Dear sir or madam,

To whom it may concern,

To whom it may concern,

To whom it may concern,

To whom it may concern,

To whom it may concern,

To whom it may concern,
ACS and AGS release geriatric perioperative recommendations

The American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP®) and the American Geriatrics Society (AGS) Geriatrics-for-Specialists Initiative, with support from the John A. Hartford Foundation, on January 4 released Optimal Perioperative Management of the Geriatric Patient: A Best Practices Guideline. The consensus-based national guideline addresses perioperative care for patients ages 65 and older as defined by Medicare regulations. This population continues to grow, with more than 40 million older adults now living in the U.S., a number that is expected to more than double to 89 million by 2050.*

The new guideline has been published on the Journal of the American College of Surgeons (JACS) website and will run later this year in the print version of JACS and the Journal of the American Geriatrics Society. In addition, the ACS and AGS posted a freestanding volume of this perioperative guideline at facs.org/quality-programs/acs-nsqip/geriatric-periop-guideline.

A framework for excellence
The guideline provides a framework for addressing the complex issues facing patients of advanced age, who are more likely to experience postoperative complications and prolonged recovery. The ACS/AGS Geriatric Surgery Task Force developed the guideline with an expert multidisciplinary panel, which evaluated current evidence and best practices in the medical literature to produce expert recommendations for surgeons, anesthesiologists, and allied health care professionals who work with older adults. This consensus-based guideline is “not a substitute for clinical judgment and experience,” the authors explain, but it can support tailored, comprehensive geriatric evaluations.

“It’s inspiring to see our collaboration achieve this next milestone. This new interdisciplinary guideline provides us with another meaningful tool for improving geriatric surgical care. We now have expert recommendations in place for older patients that range from preoperative assessment to perioperative management,” said guideline co-author Clifford Y. Ko, MD, MS, MSHS, FACS, Director of ACS NSQIP, and Principal Investigator of the Coalition for Quality in Geriatric Surgery (CQGS) Project.

“Representing more than 6,000 health professionals committed to high-quality, person-centered care for older adults, the AGS recognizes that expanding geriatrics expertise means ensuring that all health care professionals—not just geriatrics experts—know and can employ principles of excellence in elder care,” added Nancy E. Lundebjerg, MPA, chief executive officer of the AGS. “This collaboration builds on the legacy of our Geriatrics-for-Specialists Initiative, which itself underscores the unique importance of geriatrics awareness for surgeons and related medical specialists.”

“More than ever, 80-, 90-, and even 100-year olds are undergoing surgery,” said Terry Fulmer, PhD, RN, FAAN, president of The John A. Hartford Foundation. “Our exciting partnership with ACS and AGS has produced another tool that will result in safer care and better outcomes for the growing number of older surgical patients.”

“We searched the medical literature in developing this guideline to find the best available evidence and the most relevant peer-developed position statements,” said guideline co-author Ronnie Rosenthal, MD, MIPM.

The consensus-based national guideline addresses perioperative care for patients ages 65 and older as defined by Medicare regulations. This population continues to grow, with more than 40 million older adults now living in the U.S., a number that is expected to more than double to 89 million by 2050.

MS, FACS, Chair of the Geriatric Surgery Task Force; Co-Principal Investigator, CQGS Project; and chief of surgery at the Veterans Affairs Connecticut Healthcare System, West Haven. “We also included several appendices that provide examples of tools that can be used to assist the clinician in assessing risk factors and developing treatment plans and care models. In doing so, we feel that we’ve developed a fully comprehensive resource that is now readily accessible via the Web and can be used immediately by all clinicians and caregivers who treat and work with older surgical patients.”

“As a start, this guideline functions as an unprecedented educational resource, one that organizes all of the components of perioperative care of the older adult in one place,” concluded guideline co-author Sanjay Mohanty, MD, a general surgery resident at Henry Ford Hospital, Detroit, MI, and an ACS/AGS James C. Thompson Geriatrics Surgical Fellow. “Perhaps it will one day play an important role in informing us about process and providing us with insightful metrics on outcomes for geriatric surgical patients.”

Last chance to register for 2016 ACS-AEI Consortium Meeting

February 29 is the deadline to register for the ninth annual American College of Surgeons Accredited Education Institutes (ACS-AEI) Consortium Meeting, which will take place March 7–8 at the Swissôtel Chicago, IL. The ACS-AEI Consortium, sponsored by the ACS Division of Education, is a global network of 94 ACS-AEIs that use simulation-based technology to educate and train practicing surgeons, surgical residents, medical students, and members of the surgical team.

Meeting sessions will examine various aspects of simulation-based training, including emerging technologies in simulation. Two interactive debates will explore whether higher fidelity is better for learning and whether Maintenance of Certification (MOC) for simulation is ready to be launched on a national level. Participants will have access to interactive workshops, scientific paper presentations, posters, and networking opportunities. Graham T. McMahon, MD, MMSc, president and chief executive officer of the Accreditation Council for Continuing Medical Education, will deliver the keynote address, and a special panel will discuss simulation as a means of advancing continuing medical education.

Visit the ACS website at facs.org/education/accreditation/aei/consortium-meeting to view the agenda, register for the meeting, and reserve a hotel room.

For more information about the meeting or the AEI Program, contact Cathy Wojcik, Administrator, Program for Accreditation of Education Institutes, at cwojcik@facs.org.
Dr. Sachdeva delivers Distinguished Professor Lecture at USC

Ajit K. Sachdeva, MD, FACS, FRCSC, Director, American College of Surgeons Division of Education, delivered the Distinguished Professor Lecture at the University of Southern California’s (USC) Keck School of Medicine, Los Angeles. The acute care surgery division, department of surgery, sponsored the presentation. In his lecture, Preparation of Residents for Surgical Practice: Challenges, Opportunities, New Directions, Dr. Sachdeva highlighted the challenges of preparing residents for surgical practice, shared data regarding gaps in operative experiences and skills that have been identified, and proposed new strategies for training and verifying surgical residents’ knowledge and skills before graduation. Dr. Sachdeva also addressed issues regarding supervision decisions and transfer of appropriate autonomy to prepare residents for surgical practice.

Final month to apply for 12th annual Jacobson Promising Investigator Award

The Surgical Research Committee of the American College of Surgeons (ACS) is accepting applications for the 12th Joan L. and Julius H. Jacobson II Promising Investigator Award (JPIA), to be conferred in 2016. This award recognizes outstanding surgeons engaged in research who are advancing the art and science of surgery and demonstrating early promise of significant contribution to the practice of surgery and the safety of surgical patients. Applications must be submitted on or before February 26, 2016.

Surgeons who are at the “tipping point” of their research careers with a track record indicative of early promise and potential will receive special consideration for the award. Well-established surgeon-scientists are not eligible candidates.

For details on award criteria and nomination procedures, visit the JPIA website at facs.org/quality-programs/about/cqi/jacobson.
The American College of Surgeons (ACS), in association with Pfizer, Inc., is accepting nominations for the 2016 Surgical Volunteerism Award(s) and Surgical Humanitarian Award. All nominations must be received by February 29, 2016.

Volunteerism Awards
The ACS/Pfizer Surgical Volunteerism Award—offered in four potential categories—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 commitments, or for retired Fellows who have been involved in volunteerism in the course of active practice and into retirement. Resident Members and Associate Fellows of the College who have been involved in significant surgical volunteer activities as part of 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 as 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 dedicated 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.

The ACS Board of Governors’ Surgical Volunteerism and Humanitarian Awards Workgroup will evaluate the nominations and forward their selections to the Board of Governors’ Executive Committee for final approval.

Nominations
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

For the nominee to have a fair review, detailed
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.

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 career in surgery
- Completion of seven questions related to the nominee’s volunteerism or humanitarian work (2,500 characters maximum for each question) to include questions on the following: type of service provided, sustainability of programs, advocacy efforts, additional roles, and others

The nomination website will open January 4 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 the OGB at ogb@facs.org.

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

- Tie Tacs/Lapel Pin
  - #S1 Gold-Filled $60
  - #S2 Solid 14K Gold $350
- Cuff Links
  - #S3 Gold-Filled $200
  - #S4 Solid 14K Gold $1150
- Key (shown actual size of 3/4”)
  - #S5 Gold-Filled $100
  - #S6 Solid 14K Gold $565
- Miniature Key (Not Shown)
  - #S7 Gold-Filled $75
  - #S8 Solid 14K Gold $365
- Charm (Not Shown)
  - #S9 Gold-Filled $85
  - #S10 Solid 14K Gold $550
- Miniature Charm
  - #S11 Gold-Filled $60
  - #S12 Solid 14K Gold $350
  - #S13 Sterling Silver w/ 18” Sterling Silver Neckchain $65
  - #S14-1 Sterling Silver Charm $50
- Ring
  - #S14 Solid 14K Gold $1950
  - #S14.1 Solid 10K Gold $1450
  (Indicate finger size)
- Tie Bar
  - #S15 Gold-Filled Emblem $75
- Necktie
  - #S16A Dark Blue $35
  - #S16B Light Blue $35
  - #S17 Maroon $35
  Extra long add $5.00
- Diploma Plaques
  - #S18 Satin Gold Finish $360
  - #S19 Satin Silver Finish $360
  8-1/2” x 12” metal plaque on 11”x14-1/2” walnut. Specify name, day, month, year selected.
- Men’s Bow Tie (Untied) (Not Shown)
  - #S22 Dark Blue $35
  - #S23 Maroon $35
- Rollerball Pen - Chrome
  - #S25 Cross Townsend Medalist with 23/K Gold Plated Emblem $135
- Money Clip (Not Shown)
  - #S26 With Gold-Filled emblem $75
- Desk Set (Not Shown)
  - #S27 Solid Walnut with Cross Gold-Filled Pen & Pencil/Gold-Filled emblem; name and year elected a Fellow engraved on gold polished plate $325
- Wallet (Not Shown)
  - #S28 Black cowhide with Gold-Filled emblem $100
- Blazer Buttons (Not Shown)
  - #S29 Gold Electroplated (set of 9) $35
- Blazer Patch
  - #S30 Hand embroidered $35
- Shipping/Handling/Insurance
  - Domestic (48 contiguous states) $15
  - Alaska, Hawaii, Puerto Rico $32
  - Foreign $40

Jim Henry, Inc.
435 Thirty-Seventh Avenue
St. Charles, Illinois 60174
phone: 630 584 6500
toll-free: 630 584 3036
www.jimhenryinc.com
e-mail: kcredille@jimhenryinc.com

Designed expressly for the American College of Surgeons, these emblematic items are crafted to perfection in the Jim Henry tradition of excellence. The American College of Surgeons receives a royalty for allowing Jim Henry, Inc. the use of the American College of Surgeons marks and other intellectual property.

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

Form No. 912509-10/15

Excellence in Awards and Recognition Since 1938

FEB 2016 BULLETIN American College of Surgeons
**Chapter news**

by Donna Tieberg

---

**Three Florida chapters host reception at Clinical Congress**

A combined reception for members of the three American College of Surgeons (ACS) Florida chapters took place Monday, October 5, 2015, at the Hilton Chicago at Clinical Congress. The Florida Chapter organized the event, and two other chapters in the state—the South Florida Chapter and the Jacksonville Chapter of the ACS—cohosted. Other cohosts included the University of Florida, Gainesville; the University of Miami Miller School of Medicine; the University of South Florida Morsani College of Medicine; and the University of Florida College of Medicine–Jacksonville. In addition, all new ACS Initiates from Florida were invited to attend. The 125 attendees had the opportunity to network with other ACS members from the state, officers of the three chapters, and faculty from Florida’s academic institutions.

Also representing the state of Florida at Clinical Congress was Andrew Gratzon, MD, from the Orlando Health general surgery residency program. Dr. Gratzon was the 2015 winner of the Commission on Cancer (CoC) Resident Paper Competition held at the Florida Chapter meeting last May. He was subsequently...
invited to present his paper to an audience of 300 Clinical Congress attendees at the CoC Annual Meeting Sunday, October 4. The topic of Dr. Gratzon’s paper, for which he received an honorarium, was Vascularized Lymph Node Transfers for Treatment of Upper Extremity Lymphedema after Breast Cancer Therapy.

62nd annual Massachusetts Chapter meeting features resident skills competition
The Massachusetts Chapter of the College (MCACS) hosted its 62nd Annual Meeting December 5, 2015, at the Westin Copley Place in Boston. More than 150 medical professionals, including 81 residents, attended the meeting.

The meeting opened with a Breakfast at the Debates Symposium hosted by the Society for Surgery of the Alimentary Tract. Led by Karim Alavi, MD, a resident at the University of Massachusetts Memorial Medical Center, Worcester, the symposium included two debates: What is the Best Approach When Dissecting in the Lowest Part of the Pelvis and Why? and Is Robotic Surgery for Pancreatic Disease Appropriate?

Michael T. Jaklitsch, MD, FACS, Chapter President, offered opening remarks, and Andrew L. Warshaw, MD, FACS, Immediate Past-President of the ACS, spoke on Appropriate Care for the Surgical Patient. The chapter presented the third Basic Science Oral Presentation Award in memory of the late Joseph E. Murray, MD, FACS, who conducted the world’s first successful organ transplant and received the Nobel Prize in Physiology or Medicine in 1990.

The day-long Massachusetts meeting program also included a Poster Competition, Resident Paper Competition, and the chapter’s fifth annual Resident Top Gun Competition. In this contest, residents from general surgery programs in Massachusetts and invited guests from New Hampshire were timed and graded on their laparoscopic skills. Top Gun teams consisted of three residents from each of 10 participating institutions. Contestants showcased their abilities on intracorporeal knot tying, transfer of objects from one hand to another, and pattern cutting. The winning team included Nora Fullington, MD; Dan Hetherman, MD; and Josh Scurlock, MD, all residents at the University of Massachusetts Memorial Medical Center. The chapter’s Top Gun Competition trophy will be showcased at Memorial Medical Center for one year.

The MCACS looks forward to its 63rd Annual Meeting, December 3 at the Westin Copley Place. More details and a complete program of the 2015 Annual Meeting of the Massachusetts Chapter are available on the chapter archives pages at http://meeting.mcacs.org/archives/.

Traveling scholar tells of experiences in Tanzania at MSS Fall Conference
The Minnesota Surgical Society (MSS), a chapter of the ACS, hosted its Fall Conference October 23–24, 2015, at Fitger’s Inn in Duluth. In attendance at the meeting were 28 residents, research trainees, and medical students who shared their research in the areas of trauma, cancer, and general surgery. Other highlights of the meeting included
a presentation titled Tricks of the Trade: 1,000 Whipple Procedures and Still Counting with guest speaker Michael B. Farnell, MD, FACS, who shared a review of his career and insights gathered from caring for more than 1,000 patients who have undergone Whipple procedures.

Each year since 2009, the MSS has budgeted up to $2,000 for a Humanitarian Scholarship, awarded to those residents who are interested in participating in an international surgical elective in a resource-poor setting. Eligible participants must be general surgery residents or medical students on a surgical track and must be from Minnesota’s Hennepin County Medical Center, Minneapolis; the University of Minnesota; or the Mayo Clinic.

In 2015, the MSS awarded $1,500 to Arthur T. Johnson, MD, a postgraduate year-four (PGY-4) resident from Hennepin County Medical Center. Dr. Johnson said he returned home after finishing his residency in Tanzania with a greater appreciation for the resources and education available in the U.S. The 2016 MSS Humanitarian Scholarship will go to Sydne Muratore, a PGY-4 resident from the University of Minnesota, to support her travel to and residency at Holy Family Surgery Center (HFSC), El Rancho Santa Fe, Honduras. HFSC is an ambulatory surgery center on the grounds of the Nuestros Pequenos Hermonas Honduras Home.

Connecticut Chapter meeting offers special session on patient-centered care
The Connecticut Chapter of the American College of Surgeons Professional Association, Inc. hosted its annual meeting November 6, 2015, at the Marriot in Farmington, CT. The meeting was attended by 200 and had strong support from industry partners. The meeting agenda was revamped this year to include a morning session devoted entirely to attending physicians, with an afternoon session focused on residents and medical students.

The meeting began with two lectures on enhancing surgical quality. Alan K. Meinke, MD, FACS, a general surgeon in Westport, CT, presented CT Surgical Quality Collaborative: Driving Value for All Surgeons. This engaging session was developed to educate Fellows about the work of the Connecticut Surgical Quality Collaborative (CtSQC), an ACS National Surgical Quality Improvement Program-based collaborative, which recently rolled out statewide protocols for enhanced recovery after surgical procedures. Thomas Heleotis, MD, CPE, a thoracic surgeon from Long Beach, NJ, presented The Importance of Post-Operative Pain Management: Its Impact on Future Surgical

continued on page 56
**Virginia residents gather for Jeopardy competition**

Residents from all of the surgical training programs in Virginia participated in a Resident Jeopardy Competition at a combined meeting of the Virginia Chapter and the Metropolitan Washington, DC, Chapter last May at the Richmond Hilton, VA.

**New Mexico Chapter welcomes keynote speaker Dr. Mattox**

Special guest and keynote speaker Kenneth L. Mattox, MD, FACS, Past Second Vice-President of the ACS, is welcomed by chapter leaders at the 2015 New Mexico Chapter meeting September 19, 2015, at the Crown Plaza, Albuquerque.

Participants at the meeting included (from left, all MD, FACS): Anthony R. Vigil, former ACS Governor for New Mexico; Stephen W. Lu, Committee on Trauma State Liaison; Michael P. Keller, Chapter Councilor; Bridget N. Fahy, Chapter Councilor; Katherine T. Morris, Chapter Councilor; Melanie Yeats, Chapter President; Dr. Mattox; Albert Man-Chung Kwan, Chapter Secretary-Treasurer; Jean D. Remillard, Chapter Vice-President; and Ashwani Rajput, MD, FACS, CoC State Chair.
NEWS

Reimbursement. Dr. Helleotis spoke about the importance of managing pain, particularly using non-opioid strategies, and its impact on Medicare’s value-based purchasing equation. Following these sessions, the local Committee on Trauma and CoC and the chapter’s Young and Senior Surgeons Committees met.

The chapter recognized Kathleen A. LaVorgna, MD, FACS, with its Distinguished Service Award in honor of her contributions to surgical patient care and the art and science of medicine in Connecticut. Dr. LaVorgna is a Past-President of both the Connecticut Chapter of the ACS and the Connecticut State Medical Society. U.S. Rep. Rosa DeLauro (D-CT) was honored with the chapter’s Legislator of the Year Award for her commitment to the legislative concerns of surgeons in Connecticut.

In the James Foster Memorial Lecture, John Torello, the parent of an infant who was left severely disabled due to a medical error that led to untreated jaundice, offered a patient’s perspective on patient-centered care.

Mr. Torello’s inspiring and informative talk was followed by the chapter resident paper competitions, resident lectures on Choosing Your Fellowship, and the annual chapter Surgical Skills Competition. Once again, St. Mary’s Hospital of Waterbury, CT, took first place.

Keystone Chapter offers full spectrum of activities at annual meeting
The Keystone Chapter of the ACS (KCACS) hosted its Annual Scientific Meeting November 6 at The Commonwealth Medical College (TCMC) in Scranton, PA. President and dean of TCMC, Steven J. Scheinman, MD, welcomed attendees to a full day of educational sessions on issues ranging from pancreatic cancer treatment and robotic surgery to the aging surgeon. A chapter poster contest also was featured, and oral abstracts were presented throughout the day. A total of 75 surgeons and other health care professionals attended the meeting, along with 13 exhibitors.

The highlight of the event was the Annual Jeopardy Tournament. Teams representing seven different medical programs from around the chapter area vied for the chapter trophy. David R. Arbutina, MD, FACS, Past-President of the KCACS and Past-ACS Governor, served as master of ceremonies. Judges included KCACS Past-President and present ACS Governor for Pennsylvania Joseph P. Bannon, MD, FACS, and KCACS Past-President Christopher P. Coppola, MD, FACS. At the end of the competition, the 50 Cells of Grey team, including Naureen Iqbal, MB, BS, a PGY-5 resident, and Enobong Efiong, MD, a PGY-3 resident, from Geisinger Medical Center in Danville, PA, won the trophy, which will be displayed at Geisinger Medical Center for one year.

Metropolitan Philadelphia Chapter presents first Surgical Jeopardy Tournament
The Metropolitan Philadelphia Chapter hosted its first annual young surgeons Surgical Jeopardy Tournament November 12 at the Barbuzzo Restaurant in Philadelphia, PA. A total of 70 residents, faculty, and Metro Philadelphia Fellows participated.
in the event aimed at improving young surgeon engagement in chapter and College activities. The chapter received a Resident Surgical Jeopardy toolkit via the pilot program sponsored by the Resident and Associate Society (RAS-ACS) Education Committee. Metro Philadelphia Chapter Vice-President Jeffrey L. Butcher, MD, FACS, was master of ceremonies for the competition, and volunteer judges included chapter Council Members Sameer A. Patel, MD, FACS, and Jeffrey M. Farma, MD, FACS.

Resident participants from Drexel University displayed their incisive surgical knowledge during the proceedings and were awarded the Surgical Jeopardy Tournament trophy. Drexel will hold the trophy at their institution for the next year. Six other teams representing universities and hospitals in the Philadelphia area participated in the successful tournament. The chapter looks forward to hosting future Jeopardy tournaments. Additional photos of the event may be seen on the Metropolitan Philadelphia Chapter website at www.metrophilasurgeons.org.

**ACS Massachusetts Chapter joins ACS Italy Chapter annual meeting in Milan**

Representatives of the Massachusetts Chapter of the ACS were guests at the 29th Annual Italy Chapter meeting October 25, 2015, in Milan. Approximately one year ago, the two chapters created a partnership via the ACS Chapter Partner Program to collaborate and share ideas. Representatives of the Massachusetts Chapter in attendance included Michael T. Jaklitsch, MD, FACS, Chapter President; Terry Buchmiller, MD, FACS, Past-President of the chapter and present Governor for Massachusetts; Cristina R. Ferrone, MD, FACS, chapter member; P. Marco Fisichella, MD, FACS; and Beatrice Dionigi, MD, a PGY-4 resident at Brigham and Women’s Hospital, Boston. Ronald V. Maier, ACS First Vice-President, also attended. Each of these individuals delivered presentations at a special international session. Laura F. Goodman, MD, a PGY-4 general surgery resident at University of California-Davis, also participated in the proceedings via an ACS International Exchange Program award. Dr. Goodman spoke on global surgery.

For the first time, the Italy Chapter featured a Resident Surgical Jeopardy contest using the toolkit provided by the RAS-ACS. Residents from three surgical programs in Italy participated in the competition. Winning team members each received free subscriptions to minimally invasive surgery courses provided by the Advanced International Mini-Invasive Surgery Academy of Milan.

Also in attendance at the Italy Chapter meeting as a special guest was then-ACS Governor for Spain and former ACS Chair of the Governors’ Chapter Activities International Workgroup Miguel A. Cainzos, MD, FACS. Dr. Cainzo’s participation in the meeting was due in part to the organization of chapters into International Regions 14–17 via the International Workgroup. Chapters in the same region are encouraged to offer joint meetings or to participate in the meetings of other local chapters. Italy and Spain are both members of the International Workgroup’s Region 15. ♦
Spend Your Time Learning, Not Searching

Selected Readings in General Surgery (SRGS®) is the premier literature review for general surgeons.

• Explore an expert summary of the latest published research.
• Study a variety of topics, including specialty areas like pediatrics, breast, and vascular diseases.
• Earn a substantial number of self-assessment credits for MOC Part II.*
• Expand your knowledge when it’s convenient for you. Read SRGS on any platform at home, in the office, or while traveling.

* The American College of Surgeons (ACS) is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians. The ACS designates this enduring material for a maximum of 80 AMA PRA Category 1 Credits™ annually. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Subscribe today!
www.facs.org/publications/srgs
or call 800-631-0033
ACS awards Claude H. Organ, Jr., MD, FACS, Traveling Fellowship to Dr. Joseph

Kathie-Ann Joseph, MD, MPH, FACS, recently was selected to receive the American College of Surgeons (ACS) 2015 Claude H. Organ, Jr., MD, FACS, Traveling Fellowship. Dr. Joseph is chief, breast surgery, and associate professor of surgery, Bellevue Hospital Center, New York University Langone Medical Center, NY.

She will travel to Chicago, IL, to visit the Cook County Health and Hospitals System to observe how health care systems work in another major metropolitan area. She also will focus on the ways large hospitals systems manage care for underserved women. Dr. Joseph will attend the American Association for Cancer Research Conference on the Science of Cancer Health Disparities in Racial/Ethnic Minorities and the Medically Underserved. She will present her experiences to the ACS Scholarships Committee at Clinical Congress 2016.

The Claude H. Organ, Jr., MD, FACS, Traveling Fellowship was established in memory of Dr. Organ, a Past-President of the ACS. The $5,000 award makes it possible for an outstanding young surgeon to attend an educational meeting or to choose an institution for an extended visit, tailored to the surgeon’s research interests.

The annually awarded fellowship benefits young surgeons who are members of the Society of Black Academic Surgeons, the Association of Women Surgeons, or the Surgical Section of the National Medical Association.

The requirements for this award are posted at facs.org/member-services/scholarships/special/organ, where information regarding the 2016 Claude H. Organ, Jr., MD, FACS, Traveling Fellowship also is posted. ♦
## Calendar of events

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

### February

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Dates</th>
<th>Location</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Puerto Rico Chapter</td>
<td>February 18–20</td>
<td>San Juan, PR</td>
<td>Aixa Velez-Silva, <a href="mailto:acspuertoricochapter@gmail.com">acspuertoricochapter@gmail.com</a>, <a href="http://www.acspuertoricochapter.org">www.acspuertoricochapter.org</a></td>
</tr>
<tr>
<td>North Texas Chapter</td>
<td>February 19–20</td>
<td>Dallas, TX</td>
<td>Carrie Steffen, <a href="mailto:carrie@stettenmanagement.com">carrie@stettenmanagement.com</a>, <a href="http://www.ntexas.org">www.ntexas.org</a></td>
</tr>
<tr>
<td>South Texas Chapter</td>
<td>February 25–27</td>
<td>San Antonio, TX</td>
<td>Janna Pecquet, <a href="mailto:janna@southtexasacs.org">janna@southtexasacs.org</a>, <a href="http://www.southtexasacs.org">www.southtexasacs.org</a></td>
</tr>
</tbody>
</table>

### March

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Dates</th>
<th>Location</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alberta Chapter</td>
<td>March 15</td>
<td>Calgary, AB</td>
<td>John Barry Kortbeek, <a href="mailto:john.kortbeek@albertahealthservices.ca">john.kortbeek@albertahealthservices.ca</a></td>
</tr>
<tr>
<td>Northern California Chapter</td>
<td>April 29–30</td>
<td>Berkeley, CA</td>
<td>Christina McDevitt, <a href="mailto:nccacs@att.net">nccacs@att.net</a>, <a href="http://www.nccacs.org">www.nccacs.org</a></td>
</tr>
</tbody>
</table>

### April

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Dates</th>
<th>Location</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Japan Chapter</td>
<td>April 1</td>
<td>Osaka, Japan</td>
<td>Kazuhiko Yoshida, <a href="mailto:kaz-yoshida@jikei.ac.jp">kaz-yoshida@jikei.ac.jp</a></td>
</tr>
</tbody>
</table>

### May

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Dates</th>
<th>Location</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minnesota Surgical Society</td>
<td>May 5–7</td>
<td>Minneapolis, MN</td>
<td>Janna Pecquet, <a href="mailto:janna@mnsurgicalsociety.org">janna@mnsurgicalsociety.org</a>, <a href="http://www.mnsurgicalsociety.org">www.mnsurgicalsociety.org</a></td>
</tr>
</tbody>
</table>

### Future Clinical Congresses

<table>
<thead>
<tr>
<th>Year</th>
<th>Dates</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>October 16–20</td>
<td>Washington, DC</td>
</tr>
<tr>
<td>2017</td>
<td>October 22–26</td>
<td>San Diego, CA</td>
</tr>
<tr>
<td>2018</td>
<td>October 21–25</td>
<td>Boston, MA</td>
</tr>
</tbody>
</table>