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Calendar of events

CHUCK, AN ELMWOOD PARK, ILL., NATIVE, TOOK THOUSANDS OF PHOTOGRAPHS THROUGHOUT THE LAST 40 YEARS, DOCUMENTING THE COLLEGE’S CLINICAL CONGRESSES AND MANY OTHER EVENTS, INCLUDING COMMITTEE ON TRAUMA MEETINGS, THE ANNUAL JACOBSON DINNER, AND THE 2014 ERNEST A. CODMAN, MD, FACS, MEMORIAL CEREMONY.

ALWAYS ON THE MOVE, CHUCK WAS EASY TO SPOT, WITH HIS EVER-CHANGING HAIR COLOR AND EVER-PRESENT STEPLADDER, DARING THROUGH CROWDS WHILE HAULING HIS CART OF HEAVY PHOTOGRAPHY EQUIPMENT. HE WAS A PERFECTIONIST IN HIS WORK, EXPENDING GREAT ENERGY AND CARE ON EVERY ASSIGNMENT—STRAIGHTENING JACKETS, REMOVING BADGES, MOVING PEOPLE JUST AN INCH OR TWO, TEASING AND EXHORTING, “THIS IS THE LAST ONE...AND NOW, JUST ONE MORE!”—ALL IN THE PURSUIT OF EXCELLENCE.

HIS VIBRANT PERSONALITY MADE EVERYONE SMILE. BOTH ON AND OFF THE JOB HE JOKE WITH SURGEONS AND STAFF, RELATED STORIES ABOUT PAST ACS MEETINGS AND LEADERS, SHARED PHOTOS OF HIS CATS, DISCUSSED CAMERA EQUIPMENT WITH INTERESTED PASSERSBY, AND BEFRIENDED HOTEL STAFF, SHUTTLE BUS DRIVERS, BARISTAS, WAITERS...EVERYONE.

CHUCK STUDIED IN THE WELL-KNOWN PHOTOGRAPHY PROGRAM AT COLUMBIA COLLEGE IN CHICAGO, ILL. HE BEGAN HIS CAREER AS A STAFF PHOTOGRAPHER FOR OSCAR & ASSOCIATES, MOVED TO ATWOOD CONVENTION PUBLISHING, AND THEN Ran HIS OWN BUSINESS IN WASHINGTON, DC, AND ATLANTA, GA, BEFORE RETURNING TO ILLINOIS.

HE WAS PASSIONATE ABOUT ART AND MUSIC; HE PLAYED IN A ROCK BAND IN THE 1970S. ALWAYS GENEROUS WITH HIS TIME, HE VOLUNTEERED WITH A LOCAL CAT RESCUE AND SERVED AS A HANDYMAN AND COMPANION FOR ELDERLY FRIENDS.

IT’S DIFFICULT TO IMAGINE THAT SUCH A LIVELY CHARACTER IS NO LONGER WITH US, BUT WE ALL HAVE MANY, MANY MEMORIES OF CHUCK TO SHARE AND TREASURE. (FOR MORE PHOTOS OF CHUCK, SEE PAGE 35 OF THIS ISSUE.)

CONDOLENCES MAY BE SENT TO THE GIORNO FAMILY C/O TINA WOELKE AT THE ACS, 633 N. SAINT CLAIR ST., CHICAGO, ILL. 60611. DONATIONS TO HIS FAVORITE CAT RESCUE, WHERE HIS CATS NOW RESIDE, WOULD BE WELCOME: GYPSY CATS NFP INC., 1845 N. NATCHES AV., CHICAGO, ILL. 60707, OR WWW.GYPSYCATS.ORG.

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*continued on next page*
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Looking forward

by David B. Hoyt, MD, FACS

As I enter my seventh year as Executive Director of the American College of Surgeons (ACS), I have paused to reflect on how much the staff and volunteers of this organization have accomplished in this timeframe. This month, I share with you some of my observations about our accomplishments and how we will build on them in the coming months through our strategic planning process.

Quality improvement

A primary goal when I started at the ACS was to enhance the College’s databases so that health care institutions and professionals could benchmark their performance and determine what steps to take to improve the quality and safety of patient care. Since then, the ACS National Surgical Quality Improvement Program (ACS NSQIP®) has expanded and is now providing outcomes data to nearly 700 hospitals.

Furthermore, we have established a Trauma Quality Improvement Program and a Cancer Quality Improvement Program, which expand the capabilities of the ACS National Trauma Data Bank® and the ACS National Cancer Data Base, respectively. And, to assist surgeons in offering cancer patients the best treatment options, the College was active in the development of the Cancer Staging Manual and Cancer Staging Atlas offered through the American Joint Committee on Cancer. To make these databases more useful we are engaged in a software replacement effort. We anticipate that this project will lead to significant advances in the capabilities of the ACS quality databases.

We also have developed a broader range of verification and accreditation programs. The ACS has added two such programs—the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program and the National Accreditation Program for Breast Centers—and more recently launched the Children’s Surgery Verification program.

Later this year, we will tie all of these concepts together with the publication of the ACS quality manual. This guidebook is designed to assist...
Looking toward the future, the ACS is in the process of selecting a learning content management system, which will include a program for surgeons to manage CME and to maintain a log of their efforts to engage in lifelong learning.

surgeons who have been asked to serve as the surgical quality officers at their institutions.

Emerging quality issues of concern include the effects of performing concurrent operations and surgeon fatigue on patient care, public reporting of institutional and physician outcomes, and perioperative readiness. The College is partnering with other organizations that represent members of the operative team to address these concerns and develop best practices for resolving any underlying problems.

**Advocating for the surgical patient**

For more than a decade, repeal and replacement of the sustainable growth rate formula used to calculate Medicare physician payment was a key objective of the ACS. With enactment of the Medicare Access and CHIP (Children’s Health Insurance Program) Reauthorization Act (MACRA) in April 2015, this milestone was achieved.

Part of our success in this arena is attributable to the establishment of the Health Policy and Advocacy Group (HPAG). This committee is charged with identifying public policy issues that affect surgeons and our patients, establishing the ACS legislative and regulatory agenda, and recommending courses of action to the Board of Regents. HPAG and other College committees will likely play an important role in our strategic plans for ensuring that MACRA is implemented in a way that guarantees patient access to quality surgical care and to the type of information necessary to make informed health care decisions.

The ACS Inspiring Quality Tour, launched in 2011, greatly contributed to our ability to inform health policy decision makers and legislators about how the ACS Quality Programs can be used to improve the value of health care services. As MACRA is implemented, the College will continue to promote the use of clinical, rather than administrative, data for reimbursement and public reporting purposes. Specifically, we are advocating that the Centers for Medicare & Medicaid Services use data from qualified clinical data registries, ACS NSQIP, and the ACS Surgeon Specific Registry for its Physician Quality Reporting System, the Physician Compare website, and the development of the Merit-based Incentive Payment System defined in MACRA.

**Educational opportunities**

In 2010, the ACS sought to provide more electronic learning opportunities, developing focused curriculums and assessment techniques, enhancing skills training and validation, and assisting surgeons in achieving Maintenance of Certification.

A key development in this area has been growth of the ACS Accredited Education Institutes program to promote hands-on training through simulation. We also have expanded access to webcasts from the annual Clinical Congress and made other transformational changes in the Clinical Congress program, providing more opportunities to acquire the Continuing Medical Education (CME), Self-Assessment, and Patient Safety and Ethics credits surgeons need to meet the evolving demands of surgical and state licensing boards.

Furthermore, we are providing opportunities for young surgeons to develop their confidence and skills as independent health care professionals through the Transition to Practice Program. With this objective in mind, we also are promoting mentorship programs.

Looking toward the future, the ACS is in the process of selecting a learning content management system, which will include a program for surgeons to manage CME and to maintain a log of their efforts to engage in lifelong learning. In addition, the ACS clinical guidelines program, Evidence-Based Decisions in Surgery, was established in 2014 and is flourishing.
At present, we are surveying individuals who have dropped their ACS membership or have never been members to determine how we can better meet their needs. When those studies are completed, we will develop a strategic plan to address our perceived shortcomings.

__Reaching out to all surgeons__

We have sought to foster the growth of the ACS membership by offering the programs and services described previously, as well as through a young surgeon and specialty surgeon recruitment campaign and member engagement activities. Furthermore, we have used strategic planning to revitalize and restructure the ACS Board of Governors, and Advisory Councils are better positioned to represent the needs of their constituents. In addition, Member Services and the Division of Advocacy and Health Policy have combined forces to present the annual ACS Leadership & Advocacy Summit.

The ACS has been working to strengthen its domestic chapters, providing chapter leadership training programs and offering chapters opportunities to receive contracts for their administrative services through the College’s association management services.

In addition, the ACS has established a partnership with military health services, which is enabling the exchange of research findings and cross-educational opportunities. Likewise, we are seeking to expand our international reach by revitalizing the Operation Giving Back program and encouraging the establishment of ACS chapters in every nation. Surgeons in all parts of the world have much to learn from each other, and we would be derelict in our professional responsibilities if we failed to work together to provide quality care to all people.

Furthermore, the College is providing greater opportunities for our members to communicate with each other and with the ACS leadership. For too long, ACS Governors and Regents were isolated from the rank-and-file membership. We have sought to close that divide through various communications vehicles—including the online ACS Communities—and with more interactive activities at ACS programs.

At present, we are surveying individuals who have dropped their ACS membership or have never been members to determine how we can better meet their needs. When those studies are completed, we will develop a strategic plan to address our perceived shortcomings.

__World-class organization__

It is the staff of the College that is ultimately responsible for implementing the ACS strategic plan. We have expanded the number of staff significantly in recent years, recruiting and developing a world-class team. To ensure that ACS staff members have the skills, resources, and expertise needed to meet your changing needs, we are working with an architectural firm to determine how we can best use our properties to stimulate innovation and creative problem solving. We also have established a Go Positive training program, which focuses on encouraging our team to uphold our values of professionalism, excellence, innovation, introspection, and inclusion.

We have come a long way in developing programs and services that surgeons of all generations, specialties, and practice environments will find useful and relevant—all while maintaining the organization’s financial solvency. We intend to continue the strategic planning process each year to sustain this momentum.

If you have comments or suggestions about this or other issues, please send them to Dr. Hoyt at lookingforward@facs.org.
Provisions in the 2016 Medicare physician fee schedule that will affect surgical practice: An overview

by Neha Agrawal, MPH; Jill Sage, MPH; and Vinita Ollapally, JD
New payment policy and coding and reimbursement changes set forth in the 2016 Medicare physician fee schedule (MPFS) final rule took effect January 1. The MPFS, which the Centers for Medicare & Medicaid Services (CMS) updates annually, lists payment rates for Medicare Part B services and introduces and updates a number of other policies affecting physician reimbursement and quality measurement. On September 8, 2015, the American College of Surgeons (ACS) submitted comments related to the MPFS proposed rule. These comments provided feedback to CMS on a number of policies outlined in the final rule released October 30, 2015. Although the MPFS final rule introduces important payment and policy changes that affect all physicians, this article focuses on updates that are particularly relevant to general surgery and its related specialties.

Conversion factor and other payment updates

The conversion factor for 2016 is $35.8279—slightly less than the 2015 conversion factor of $35.9335. The 2016 conversion factor reflects a 0.5 percent upward adjustment specified under the Medicare Access and CHIP (Children’s Health Insurance Program) Reauthorization Act (MACRA), a budget-neutrality adjustment of –0.02 percent, and a –0.77 percent target recapture amount.

The target recapture amount was specified in the Protecting Access to Medicare Act of 2014, under which CMS established an annual target reduction in MPFS spending resulting from adjustments to misvalued American Medical Association (AMA) Current Procedural Terminology (CPT)* codes for 2017 to 2020. The Achieving a Better Life Experience Act of 2014 accelerated the application of the MPFS expenditure targets and set a 1 percent reduction target for 2016. Consequently, if the estimated net reductions in MPFS expenditures resulting from adjustments to misvalued CPT codes in 2016 fall short of the 1 percent target, then cuts equal to the shortfall amount must be made to all MPFS services. In the final rule, CMS adopted a methodology to implement this provision, including how net reductions in misvalued codes are calculated. Based on this methodology, CMS identified misvalued services that achieve a 0.23 percent in net reductions; because this drop does not meet the targeted 1 percent reduction, CMS is required to make a 0.77 percent reduction to all MPFS services in 2016.

*All specific references to CPT codes and descriptions are © 2015 American Medical Association. All rights reserved. CPT and CodeManager are registered trademarks of the American Medical Association.
Global codes
In 2014, CMS finalized a policy to transition all 10- and 90-day global codes to 0-day global codes; however, MACRA prohibited CMS from implementing that change. Nonetheless, MACRA does require that CMS collect data needed to value surgical services, such as the number and level of visits furnished during the global period, beginning January 1, 2017, and then use those data to revalue surgical services in 2019.

In its comments on the proposed rule, the ACS provided feedback to CMS about this policy, including recommendations on the types of data the agency could collect and how to acquire them, suggestions on how to value the individual components of the global surgical package, and other items and services omitted at present from the global surgical package but that could be added. CMS acknowledged the College’s suggestions, but the final rule provides no information regarding how the agency intends to collect data or revalue surgical services. The College will continue to work with CMS to encourage the agency to revise surgical codes in a way that is fair and accurate.

Lower gastrointestinal endoscopy services
In 2015, the AMA CPT Editorial Panel revised the lower gastrointestinal (GI) endoscopy code set, which required review of physician work values within the MPFS. The AMA/Specialty Society Relative Value Scale Update Committee (RUC) subsequently provided recommendations to CMS for valuing these services. For 2016, CMS finalized implementation of the new and revised CPT codes and finalized the RUC-recommended physician work relative value units (RVUs) for the base colonoscopy code (45378), resulting in a –9 percent change from 2015. CMS adjusted the value of the other colonoscopy codes using that RVU. (See related article, page 18.)

CMS considered the ACS’ comments and ultimately finalized payment rates more closely tied to the values that the RUC recommended. In its comments to CMS, the College opposed both the CMS-proposed RVU and RUC-recommended RVU for the base colonoscopy code. The ACS urged CMS to accept the RVU recommended by the specialties and then apply appropriate increments to the family codes. The College’s position was corroborated with a detailed discussion of colonoscopy as a lifesaving procedure and the subsequent effect of net savings for Medicare, the value of colonoscopy to patients and the health care system, and the importance of maintaining quality of care and Medicare beneficiary access to care.

Advance care planning
Beginning this year, CMS recognizes and makes a separate payment for advance care planning (ACP) services, specifically CPT code 99497 (ACP including the explanation and discussion of advance directives such as standard forms, by the physician or other qualified health professional; first 30 minutes, face-to-face with the patient, family members, and/or surrogate) and CPT code 99498 (ACP; each additional 30 minutes). CPT guidelines assert that ACP may be billed on the same day or a different day as other evaluation and management services, as well as within global surgery services. CPT guidelines prohibit reporting ACP on the same date as select critical care services. For more information on billing for ACP services, refer to CPT coding guidance in the CPT 2016 manual. It is important to note that ACP services are, by definition, voluntary, and Medicare beneficiaries may decline to receive them.

In its comments to CMS, the College supported separate payment for ACP services. The College noted that general surgeons typically engage in these types of discussions with patients before an operation and urged CMS to allow surgeons to use these codes in addition to the global surgical codes. CMS proposed and finalized the RUC-recommended values for these codes.

“Incident to” billing
To ensure that “incident to” services furnished to a Medicare beneficiary are consistent with the requirement that physicians personally furnish the services for which they are billing, CMS clarifies that physicians...
who bill for “incident to” services must also provide the care or directly supervise its delivery. For example, if the physician supervising the “incident to” service is someone other than the physician who is treating the patient more broadly, only the supervising physician may bill Medicare for “incident to” services.

“Incident to” services are services or supplies furnished to a patient as an integral, albeit incidental, part of a physician’s professional services in the course of diagnosis or treatment of an injury or illness. “Incident to” services can only be provided in the physician’s office and are billed with the physician’s National Provider Identifier.

Nonphysician practitioners (NPPs) often render care that is “incident to” procedures and services that surgeons provide. To bill for the NPP, the surgeon must have seen the patient first at a previous encounter and established the plan of care.

**Changes to the Stark Law**

CMS finalized two new exceptions to the physician self-referral statute (Stark Law). The first allows hospitals, federally qualified health centers, and rural health clinics to pay a physician to assist with the employment of an NPP. Without this exception, payments from these hospitals to a physician to assist with the employment of NPPs would violate the Stark Law. The exception applies to payments to physicians who employ NPPs to furnish only primary care services, not specialty care services. This new exception is intended to recognize the increasing role that NPPs play in meeting primary care needs and to expand access to primary care services, especially in rural areas.

In its comments on the proposed rule, the ACS advocated for extending this exception to arrangements in which hospitals compensate physicians who employ NPPs who provide specialty care (not just primary care). Because NPPs do not have a specialty designation, it is sometimes unclear whether they are providing primary care, specialty care, or primary care services related to physician-provided specialty care. Most importantly, however, the College said the physician self-referral statute should not be used to support one specialty over another. In the final rule, CMS responded that the agency finds no compelling need to include other specialties in this exception.

The second new Stark Law exception protects timeshare agreements, under which a hospital or local physician practice may, on a limited basis, ask a specialist from a neighboring community to provide specialty services in a space owned by the hospital or practice. Without this new exception, such arrangements violate the Stark Law. The ACS supported this exception.

**PQRS**

The Physician Quality Reporting System (PQRS) is a Medicare quality pay-for-reporting program that originally provided payment incentives to eligible professionals (EPs) who voluntarily reported data on quality measures for covered services furnished in a specified reporting period. In 2015, however, PQRS transitioned to a program that penalizes EPs for non-participation. Lack of participation in PQRS in 2016 will result in a 2 percent payment penalty that will be applied in 2018.

EPs can participate in the PQRS program by reporting on individual measures, or, alternatively, on measures groups. Similar to 2015, EPs can report measures for the program through claims, a traditional registry, electronic health records (EHRs), or a qualified clinical data registry (QCDR). CMS finalized several key changes for PQRS in 2016, described as follows.

**Individual measure reporting**

For individual measure reporting via the claims- and registry-based options, CMS continues to require the reporting of nine measures covering at least three National Quality Strategy (NQS) domains for 50 percent of the applicable Medicare Part B fee-for-service (FFS) patients in order to avoid a penalty. Of the measures reported, if the EP sees at least one Medicare
patient in a face-to-face encounter, the EP must also report on at least one measure contained in the cross-cutting measures set specified by CMS.† The EHR-based reporting mechanism remains unchanged from 2015, and EPs may continue to report nine measures covering three NQS domains. The ACS Surgeon Specific Registry (SSR) was approved for PQRS reporting under the individual measure reporting option for 2015 and will be available in 2016 pending CMS approval.

Measures group reporting
A PQRS measures group allows EPs to report on a set of related measures determined by CMS. Measures groups can only be reported through a CMS-approved traditional registry. The reporting requirement for the measures group option for 2016 remains the same as 2015. EPs must report one measures group for 20 patients—the majority (at least 11) of whom must be Medicare FFS patients. One PQRS measures group is relevant to general surgeons: the General Surgery Measures Group (see Table 1, this page).

The College website features a user-friendly interactive flowchart that provides an overview of the Medicare quality programs, available at facs.org/advocacy/quality/medicare-programs.

### TABLE 1.
2015 PQRS GENERAL SURGERY MEASURES GROUP

<table>
<thead>
<tr>
<th>Measure number (NQF/PQRS)</th>
<th>Measure title</th>
<th>NQS domain</th>
</tr>
</thead>
<tbody>
<tr>
<td>0419/130</td>
<td>Documentation of Current Medications in the Medical Record</td>
<td>Patient Safety</td>
</tr>
<tr>
<td>0028/226</td>
<td>Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention</td>
<td>Community/Population Health</td>
</tr>
<tr>
<td>N/A/354</td>
<td>Anastomotic Leak Intervention</td>
<td>Patient Safety</td>
</tr>
<tr>
<td>N/A/355</td>
<td>Unplanned Reoperation within the 30 Day Postoperative Period</td>
<td>Patient Safety</td>
</tr>
<tr>
<td>N/A/356</td>
<td>Unplanned Hospital Readmission within 30 Days of Principal Procedure</td>
<td>Effective Clinical Care</td>
</tr>
<tr>
<td>N/A/357</td>
<td>Surgical Site Infection</td>
<td>Effective Clinical Care</td>
</tr>
<tr>
<td>N/A/358</td>
<td>Patient-Centered Surgical Risk Assessment and Communication</td>
<td>Person and Caregiver-Centered Experience and Outcomes</td>
</tr>
</tbody>
</table>

†Cross-cutting measures are those that CMS considers to be broadly applicable to all physician specialties for those EPs who have at least one face-to-face Medicare encounter. For a list of the 2015 PQRS cross-cutting measures, visit www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment- Instruments/PQRS/Downloads/2015_PQRS_CrosscuttingMeasures_12172014.pdf. Four additional measures were finalized for 2016 and can be found on Table 29 of the Medicare Program, Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2016 Final Rule, www.federalregister.gov/articles/2015/11/16/2015-28005/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other-revisions.
QCDR

In addition to the claims, EHR, and registry-based reporting options, EPs may report to PQRS with the QCDR reporting option. A QCDR is a CMS-approved entity that collects medical and/or clinical data to track patients and diseases for purposes of improving quality of care. A QCDR differs from a traditional PQRS registry in several ways. This option was created to provide an opportunity for EPs to simultaneously use existing high-quality clinical registries for quality improvement to meet PQRS reporting requirements. QCDRs can offer more flexibility for participating in PQRS than other reporting options, allowing EPs to report on a variety of measure types, including those from the Consumer Assessment of Healthcare Providers and Systems Clinician and Group Survey (CG-CAHPS); measures endorsed by the National Quality Forum (NQF); current PQRS measures; measures used by medical boards or specialty societies; and measures used in regional quality collaboratives.

QCDRs must have the capacity to track outcomes, possess benchmarking capabilities, provide timely feedback reports at least four times a year, risk adjust when appropriate, and submit quality measures data on multiple payors (not just Medicare). QCDRs also are required to publicly report performance results, excluding measures in their first year of reporting. New for 2016, QCDRs will have the ability to submit quality measures for group practices as well as individual EPs.

For the 2016 QCDR reporting requirements, groups and individual EPs must report on nine measures selected by the QCDR, including at least two outcome measures that cover at least three NQS domains for 50 percent of applicable patients to which each measure applies (or, if two outcome measures are not available, report on at least one outcome measure and at least one of the following types of measures: resource use, patient experience of care, efficiency/appropriate use, or patient safety).

The Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) and the SSR (trauma measures) were both QCDRs in 2015 and will be available in 2016 pending CMS approval. QCDRs, MBSAQIP, and SSR participation give participants the option of reporting their data on quality measures to satisfy PQRS requirements.

Physician Compare

The Physician Compare website is designed to help patients locate and obtain information about Medicare-participating physicians. As previously finalized by CMS, the following information will be reported on Physician Compare this year: all group-level reporting mechanisms for groups of two or more; 2015 CAHPS measures for all groups of two or more who collect data via the CMS-specified certified CAHPS vendor; four 2015 PQRS measures reported by individual EPs in support of the Million Hearts Campaign; 2015 PQRS measures reported by individual EPs collected via registry, EHR, or claims; 2015 PQRS data and non-PQRS data collected from QCDRs; and all measures reported by the Medicare Shared Savings Program Accountable Care Organizations (ACOs).

CMS notes that it will only post measures that it determines to be statistically valid and reliable, have a minimum sample size of 20 patients, have undergone consumer testing, and have been in the PQRS program for more than a year.

CMS also finalized its proposal to post Value Modifier (VM) cost and quality tiering data, including a notation of the payment adjustment information, an indication if the EP or group was eligible but did not report measures, and utilization data in a downloadable file in 2017 based on 2016 data. CMS chose not to finalize posting a green check mark on Physician Compare profile pages to indicate who received an upward adjustment under the VM. Also finalized for 2017 based on 2016 data, CMS will assign a five-star rating based on PQRS performance rates.

In its comments on the proposed rule, the College expressed concern that the agency’s rapid timeline for releasing these data without adequate testing could mislead and confuse the public and even inappropriately harm the reputation of physicians. CMS responded that it is using an incremental approach.
and the policies finalized for 2016 are simply the next step.

**Value-based payment modifier**
The Affordable Care Act requires CMS to apply a value-based payment modifier to physician payments. The modifier started with physicians in groups of 100 or more in 2015 based on 2013 performance, groups of 10 or more in 2016 based on 2014 performance, and extends to all physicians and groups of two or more in 2017 based on 2015 performance. Application of the value-based payment modifier will result in Medicare payments to physicians that are differentially based on the cost and quality of care they provide.

**2018 payment adjustment**
In 2018, the value-based payment modifier will apply to all groups and individual physicians based on their quality and cost data from 2016. Similarly to previous years, in 2018 CMS will separate physicians into categories based on whether they successfully participate in PQRS. All physicians will be subject to quality tiering based on their performance with respect to quality and cost measures. Physicians in groups of two to nine EPs and solo practitioners have 2 percent of their payment at risk and could receive an upward, neutral, or downward adjustment under the quality tiering methodology. Physicians in groups of 10 or more EPs have 4 percent of their payment at risk and could receive an upward, neutral, or downward adjustment.

New for the 2018 adjustment, the value-based payment modifier will also apply to nonphysician EPs who bill under a group’s taxpayer identification number (TIN) based on the TIN performance. Nonphysician EPs have 2 percent of their payment at risk and could receive an upward or neutral adjustment but will be held harmless from a downward adjustment under the quality tiering methodology.‡

CMS increased the number of attributed episodes of the Medicare spending per beneficiary (MSPB) measure in the cost composite of the value-based payment modifier to increase its reliability. CMS proposed increasing the minimum number of episodes for inclusion of the MSPB measure in the cost composite of the value-based payment modifier from 20 to 100. However, as a result of public comments and additional testing, CMS decided that at least 125 attributed episodes will increase the reliability of the measure to be applied to the 2017 payment adjustment, based on 2015 data.

The ACS encourages surgeons to review their Quality and Resource Use Reports (QRURs), which are available for solo practitioners and group practices. QRURs provide information about the resources used and the quality of care given to Medicare FFS patients. More information about the 2014 QRUR, the most recent year available, can be found at [facs.org/advocacy/quality/qrur](http://facs.org/advocacy/quality/qrur). Instructions on how to obtain the report are available on the CMS website at [www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Obtain-2013-QRUR.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Obtain-2013-QRUR.html).

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‡Non-EPs who are subject to the VM include physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists.
2016 CPT coding changes and their effects

by Linda Barney, MD, FACS, and Mark T. Savarise, MD, FACS
Significant Current Procedural Terminology (CPT)* coding changes are being implemented in 2016. Notably, some of these changes reverse last year’s temporary coding for endoscopy procedures. This article provides reporting and payment information about the codes that are relevant to general surgery and its related specialties.

Lower GI endoscopy
The American Medical Association (AMA) CPT Editorial Panel revised the lower gastrointestinal (GI) endoscopy code set for 2015, which required a review of physician work values within the Medicare physician fee schedule (MPFS) final rule. As that change was under review in 2014, the American College of Surgeons, the American Society of Colon and Rectal Surgeons, the Society of American Gastroenterological Surgeons, and several gastrointestinal medical societies conducted AMA/Specialty Society Relative Value Scale Update Committee (RUC) surveys for physician work and offered their recommendations. However, the RUC as a whole disagreed with the specialty recommendations and proposed different values for some of the codes.

The RUC submitted its recommendations on the physician work relative value units (RVUs) for calendar year 2015 to the Centers for Medicare & Medicaid Services (CMS). However, CMS delayed implementing changes to the values for the lower GI codes, citing the new process for including proposed values for new, revised, and potentially misvalued codes in the proposed rule (instead of the final rule) as one reason for the delay. In concert with this decision, CMS implemented temporary Healthcare Common Procedure Coding System (HCPCS) G-codes for a number of the new lower GI endoscopy procedures.

For calendar year 2016, CMS has deleted the G-codes and accepted the CPT codes for reporting the newly defined procedures. CMS also has implemented new RVUs for the entire set of lower GI endoscopy codes using an incremental difference methodology that differs from the RUC and society recommendations for some of the codes. An incremental methodology uses a base code or other comparable code and considers what the difference should be between that code and another code by comparing the incremental differential.

Table 1 (pages 20–22) presents the lower GI endoscopy code set for 2016, along with a comparison of the 2015 and 2016 MPFS work RVUs. To read more about these coding and payment changes in the final MPFS rule, go to www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1612-FC.html.

The Colonoscopy Decision Tree (see Figure 1, page 23) is designed to assist with correct CPT code and modifier selection.

Soft-tissue localization
Two new Category I codes were established to report initial and additional lesion placement of soft-tissue localization device(s), including imaging guidance. If a more specific site descriptor than “soft tissue” is applicable (for example, breast), the site-specific code for marker placement at that site should be reported. In addition, the new codes should only be reported once per target, regardless of how many markers (that is, clips, wires, pellets, and radioactive seeds) are used to mark that target. These new codes may be used to report placement of localization device(s) for axillary lymph nodes following biopsy and include the following (∗ = new code for 2016, + = add-on code):

- ∗10035, Placement of soft tissue localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, including imaging guidance; first lesion
- +∗10036, each additional lesion (list separately in addition to code for primary procedure)

continued on page 22
### TABLE 1. 2015–2016 LOWER GI ENDOSCOPY CODING AND WORK RVU CHANGES

<table>
<thead>
<tr>
<th>CPT code</th>
<th>Descriptor</th>
<th>2015 work RVU</th>
<th>2016 work RVU</th>
<th>Percent change</th>
</tr>
</thead>
<tbody>
<tr>
<td>44380</td>
<td>Ileoscopy, through stoma; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)</td>
<td>1.05</td>
<td>0.97</td>
<td>−8%</td>
</tr>
<tr>
<td>44381</td>
<td>Ileoscopy, through stoma; with transendoscopic balloon dilation</td>
<td>0.00*</td>
<td>1.48</td>
<td>n/a</td>
</tr>
<tr>
<td>44382</td>
<td>Ileoscopy, through stoma; with biopsy, single or multiple</td>
<td>1.27</td>
<td>1.27</td>
<td>0</td>
</tr>
<tr>
<td>44384</td>
<td>Ileoscopy, through stoma; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)</td>
<td>2.94</td>
<td>2.95</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td><strong>Endoscopic evaluation of small intestinal pouch</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>44385</td>
<td>Endoscopic evaluation of small intestinal pouch (eg, Kock pouch, ileal reservoir [S or J]); diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)</td>
<td>1.82</td>
<td>1.30</td>
<td>−29</td>
</tr>
<tr>
<td>44386</td>
<td>Endoscopic evaluation of small intestinal pouch (eg, Kock pouch, ileal reservoir [S or J]); with biopsy, single or multiple</td>
<td>2.12</td>
<td>1.60</td>
<td>−25</td>
</tr>
<tr>
<td></td>
<td><strong>Colonoscopy through stoma</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>44388</td>
<td>Colonoscopy through stoma; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)</td>
<td>2.82</td>
<td>2.82</td>
<td>0</td>
</tr>
<tr>
<td>44388–53</td>
<td>Colonoscopy through stoma; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)</td>
<td>n/a</td>
<td>1.41</td>
<td>n/a</td>
</tr>
<tr>
<td>44389</td>
<td>Colonoscopy through stoma; with biopsy, single or multiple</td>
<td>3.13</td>
<td>3.12</td>
<td>0</td>
</tr>
<tr>
<td>44390</td>
<td>Colonoscopy through stoma; with removal of foreign body(s)</td>
<td>3.82</td>
<td>3.84</td>
<td>1</td>
</tr>
<tr>
<td>44391</td>
<td>Colonoscopy through stoma; with control of bleeding, any method</td>
<td>4.31</td>
<td>4.22</td>
<td>−2</td>
</tr>
<tr>
<td>44392</td>
<td>Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps</td>
<td>3.81</td>
<td>3.63</td>
<td>−5</td>
</tr>
<tr>
<td>44394</td>
<td>Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique</td>
<td>4.42</td>
<td>4.13</td>
<td>−7</td>
</tr>
<tr>
<td>44401</td>
<td>Colonoscopy through stoma; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)</td>
<td>4.83</td>
<td>4.44</td>
<td>−8</td>
</tr>
<tr>
<td>44402</td>
<td>Colonoscopy through stoma; with endoscopic stent placement (including pre- and post-dilation and guide wire passage, when performed)</td>
<td>4.70</td>
<td>4.80</td>
<td>2</td>
</tr>
<tr>
<td>44403</td>
<td>Colonoscopy through stoma; with endoscopic mucosal resection</td>
<td>0.00*</td>
<td>5.60</td>
<td>n/a</td>
</tr>
<tr>
<td>44404</td>
<td>Colonoscopy through stoma; with directed submucosal injection(s), any substance</td>
<td>0.00*</td>
<td>3.12</td>
<td>n/a</td>
</tr>
<tr>
<td>44405</td>
<td>Colonoscopy through stoma; with transendoscopic balloon dilation</td>
<td>0.00*</td>
<td>3.33</td>
<td>n/a</td>
</tr>
<tr>
<td>44406</td>
<td>Colonoscopy through stoma; with endoscopic ultrasound examination, limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures</td>
<td>0.00*</td>
<td>4.20</td>
<td>n/a</td>
</tr>
<tr>
<td>44407</td>
<td>Colonoscopy through stoma; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s), includes endoscopic ultrasound examination limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures</td>
<td>0.00*</td>
<td>5.06</td>
<td>n/a</td>
</tr>
<tr>
<td>44408</td>
<td>Colonoscopy through stoma; with decompression (for pathologic distention) (eg, volvulus, megacolon), including placement of decompression tube, when performed</td>
<td>0.00*</td>
<td>4.24</td>
<td>n/a</td>
</tr>
</tbody>
</table>

*Reported with unlisted code and carrier priced for 2015.

Continued on next page
<table>
<thead>
<tr>
<th>CPT code</th>
<th>Descriptor</th>
<th>2015 work RVU</th>
<th>2016 work RVU</th>
<th>Percent change</th>
</tr>
</thead>
<tbody>
<tr>
<td>45330</td>
<td>Sigmoidoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)</td>
<td>0.96</td>
<td>0.84</td>
<td>-13%</td>
</tr>
<tr>
<td>45331</td>
<td>Sigmoidoscopy, flexible; with biopsy, single or multiple</td>
<td>1.15</td>
<td>1.14</td>
<td>-1</td>
</tr>
<tr>
<td>45332</td>
<td>Sigmoidoscopy, flexible; with removal of foreign body(ies)</td>
<td>1.79</td>
<td>1.86</td>
<td>4</td>
</tr>
<tr>
<td>45333</td>
<td>Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps</td>
<td>1.79</td>
<td>1.65</td>
<td>-8</td>
</tr>
<tr>
<td>45334</td>
<td>Sigmoidoscopy, flexible; with control of bleeding, any method</td>
<td>2.73</td>
<td>2.10</td>
<td>-23</td>
</tr>
<tr>
<td>45335</td>
<td>Sigmoidoscopy, flexible; with directed submucosal injection(s), any substance</td>
<td>1.46</td>
<td>1.14</td>
<td>-22</td>
</tr>
<tr>
<td>45337</td>
<td>Sigmoidoscopy, flexible; with decompression (for pathologic distention) (eg, volvulus, megacolon), including placement of decompression tube, when performed</td>
<td>2.36</td>
<td>2.20</td>
<td>-7</td>
</tr>
<tr>
<td>45338</td>
<td>Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique</td>
<td>2.34</td>
<td>2.15</td>
<td>-8</td>
</tr>
<tr>
<td>45340</td>
<td>Sigmoidoscopy, flexible; with transendoscopic balloon dilation</td>
<td>1.89</td>
<td>1.35</td>
<td>-29</td>
</tr>
<tr>
<td>45341</td>
<td>Sigmoidoscopy, flexible; with endoscopic ultrasound examination</td>
<td>2.60</td>
<td>2.22</td>
<td>-15</td>
</tr>
<tr>
<td>45342</td>
<td>Sigmoidoscopy, flexible; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(ies)</td>
<td>4.05</td>
<td>3.08</td>
<td>-24</td>
</tr>
<tr>
<td>45346</td>
<td>Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)</td>
<td>3.14</td>
<td>2.91</td>
<td>-7</td>
</tr>
<tr>
<td>45347</td>
<td>Sigmoidoscopy, flexible; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)</td>
<td>2.92</td>
<td>2.82</td>
<td>-3</td>
</tr>
<tr>
<td>45349</td>
<td>Sigmoidoscopy, flexible; with endoscopic mucosal resection</td>
<td>0.00*</td>
<td>3.62</td>
<td>n/a</td>
</tr>
<tr>
<td>45350</td>
<td>Sigmoidoscopy, flexible; with band ligation(s) (eg, hemorrhoids)</td>
<td>0.00*</td>
<td>1.78</td>
<td>n/a</td>
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</tbody>
</table>

 Colonoscopy, flexible

<table>
<thead>
<tr>
<th>CPT code</th>
<th>Descriptor</th>
<th>2015 work RVU</th>
<th>2016 work RVU</th>
<th>Percent change</th>
</tr>
</thead>
<tbody>
<tr>
<td>45378</td>
<td>Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)</td>
<td>3.69</td>
<td>3.36</td>
<td>-9</td>
</tr>
<tr>
<td>45378–53</td>
<td>Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)</td>
<td>0.96</td>
<td>1.68</td>
<td>75</td>
</tr>
<tr>
<td>45379</td>
<td>Colonoscopy, flexible; with removal of foreign body(s)</td>
<td>4.68</td>
<td>4.38</td>
<td>-6</td>
</tr>
<tr>
<td>45380</td>
<td>Colonoscopy, flexible; with biopsy, single or multiple</td>
<td>4.43</td>
<td>3.66</td>
<td>-17</td>
</tr>
<tr>
<td>45381</td>
<td>Colonoscopy, flexible; with directed submucosal injection(s), any substance</td>
<td>4.19</td>
<td>3.66</td>
<td>-13</td>
</tr>
<tr>
<td>45382</td>
<td>Colonoscopy, flexible; with control of bleeding, any method</td>
<td>5.68</td>
<td>4.76</td>
<td>-16</td>
</tr>
<tr>
<td>45384</td>
<td>Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps</td>
<td>4.69</td>
<td>4.17</td>
<td>-11</td>
</tr>
<tr>
<td>45385</td>
<td>Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique</td>
<td>5.30</td>
<td>4.67</td>
<td>-12</td>
</tr>
<tr>
<td>45386</td>
<td>Colonoscopy, flexible; with transendoscopic balloon dilation</td>
<td>4.57</td>
<td>3.87</td>
<td>-15</td>
</tr>
<tr>
<td>45388</td>
<td>Colonoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)</td>
<td>5.86</td>
<td>4.98</td>
<td>-15</td>
</tr>
</tbody>
</table>

*Reported with unlisted code and carrier priced for 2015.

continued on next page
Open treatment of rib fracture without fixation

Code 21805, Open treatment of rib fracture without fixation, each, was deleted from the 2016 CPT code set and determined to be obsolete and reportable with other CPT codes. In current practice, an injured rib when treated in an open fashion is either resected (eg, 21600) or treated with some form of internal fixation (eg, codes 21811–21813). For more information on treatment of rib fractures code sets, refer to the January 2015 issue of the Bulletin.*

Intravascular ultrasound

Two new Category I “add-on” codes were established to report noncoronary intravascular ultrasound (IVUS) during diagnostic evaluation and/or therapeutic intervention. In addition, codes 37250 and 37251 and related radiological supervision and interpretation codes 75945 and 75946 were deleted. All transducer manipulations and repositioning within the specific vessel examined during a diagnostic procedure or before, during, and/or after therapeutic intervention (such as stent or stent graft placement, angioplasty, atherectomy, embolization, thrombolysis, and transcatheter biopsy) is bundled into the IVUS codes and may not be reported separately. However, non-selective and/or selective vascular catheterization may be separately reportable (for example, codes 36005–36248). The two new IVUS Category I add-on codes include the following:


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**TABLE 1. 2015–2016 LOWER GI ENDOSCOPY CODING AND WORK RVU CHANGES (CONTINUED)**

<table>
<thead>
<tr>
<th>CPT code</th>
<th>Descriptor</th>
<th>2015 work RVU</th>
<th>2016 work RVU</th>
<th>Percent change</th>
</tr>
</thead>
<tbody>
<tr>
<td>45389</td>
<td>Colonoscopy, flexible; with endoscopic stent placement (includes pre- and post-dilation and guide wire passage, when performed)</td>
<td>5.90</td>
<td>5.34</td>
<td>–9%</td>
</tr>
<tr>
<td>45390</td>
<td>Colonoscopy, flexible; with endoscopic mucosal resection</td>
<td>0.00*</td>
<td>6.14</td>
<td>n/a</td>
</tr>
<tr>
<td>45391</td>
<td>Colonoscopy, flexible; with endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures</td>
<td>5.09</td>
<td>4.74</td>
<td>–7</td>
</tr>
<tr>
<td>45392</td>
<td>Colonoscopy, flexible; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s), includes endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures</td>
<td>6.54</td>
<td>5.60</td>
<td>–14</td>
</tr>
<tr>
<td>45393</td>
<td>Colonoscopy, flexible; with decompression (for pathologic distention) (eg, volvulus, megacolon), including placement of decompression tube, when performed</td>
<td>0.00*</td>
<td>4.78</td>
<td>n/a</td>
</tr>
<tr>
<td>45398</td>
<td>Colonoscopy, flexible; with band ligation(s) (eg, hemorrhoids)</td>
<td>0.00*</td>
<td>4.30</td>
<td>n/a</td>
</tr>
</tbody>
</table>

*Reported with unlisted code and carrier priced for 2015.

Screening endoscopy

| G0104 | Colorectal cancer screening; flexible sigmoidoscopy | 0.96 | 0.84 | –13 |
| G0105 | Colorectal cancer screening; colonoscopy on individual at high risk | 3.36 | 3.36 | 0   |
| G0105–53 | Colorectal cancer screening; colonoscopy on individual at high risk | 0.96 | 1.68 | 75  |
| G0121 | Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk | 3.36 | 3.36 | 0   |
| G0121-53 | Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk | 0.96 | 1.68 | 75  |
initial noncoronary vessel (List separately in addition to code for primary procedure)

+ • 37253 each additional noncoronary vessel (List separately in addition to code for primary procedure)

Mediastinoscopy with biopsy
Two new CPT Category I codes (39401 and 39402) were established to replace code 39400, Mediastinoscopy, includes biopsy(ies), when performed. The new codes differentiate mediastinoscopy for biopsy of a mediastinal mass from lymph node biopsy(ies). Over the last 10 years, the number of mediastinoscopies performed has steadily declined. This decrease is attributable to the development and refinement of noninvasive lung cancer staging modalities such as computed tomography (CT) and positron emission tomography (PET). Additionally, pathologic staging of lung cancer can now be done using the less invasive technique of endoscopic bronchoscopic ultrasound (EBUS)-guided biopsy. Mediastinoscopy is most commonly performed for the staging of lung cancer and is used only when the previously mentioned modalities are inconclusive. It also is performed in patients deemed to be high risk for lung surgery (such as patients with chronic obstructive pulmonary disease). While the proper staging of lung cancer, which may involve the systematic biopsying of designated lymph node stations, is critical for determining appropriate treatment, mediastinoscopy can also be used to establish a diagnosis in patients with a large mediastinal mass. These are distinctly different patient populations. The two new codes allow for more accurate reporting of the different procedures and patient populations. These two new mediastinoscopy with biopsy codes include the following:
• 39401, Mediastinoscopy; includes biopsy(ies) of mediastinal mass (eg, lymphoma), when performed

• 39402, with lymph node biopsy(ies) (eg, lung cancer staging)

**Heterotopic liver transplantation**

Code 47136, Liver allotransplantation; heterotopic, partial or whole, from cadaver or living donor, any age was deleted from the 2016 CPT code set. This procedure (also known as auxiliary liver transplantation) involved leaving the recipient organ in place while transplanting a donor liver in a different (ectopic) location. When introduced, heterotopic liver allotransplantation was believed to be useful for reversible liver disease whereby the transplanted liver could be removed once the native liver recovered. However, this technique has been associated with increased surgical complications and is unsuitable for liver diseases where the native liver is at risk of further disease. The procedure is rarely performed in the U.S. and therefore was deleted. A reference was added to use 47399, Unlisted procedure, liver to report this procedure.

**Esophageal sphincter augmentation**

Two new Category III codes were established to report insertion and removal of a magnetic bead band on the esophageal sphincter for treatment of gastroesophageal reflux disease. Note that code 0392T reporting is restricted to placement of a magnetic band. In addition, placement of an esophageal sphincter augmentation device should not be reported at the same time as any other fundoplication procedure. The new codes include the following:

• 0392T, Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement of sphincter augmentation device (ie, magnetic band)

• 0393T, Removal of esophageal sphincter augmentation device

**Note**

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

**Laparoscopic transhepatic cholangiography**

Codes 47560, Laparoscopy, surgical; with guided transhepatic cholangiography, without biopsy and 47561, Laparoscopy, surgical; with guided transhepatic cholangiography with biopsy were deleted from the 2016 CPT code set. These codes were developed prior to 1990 to report cholangiography using a laparoscope in jaundiced patients with diagnoses that remained obscure despite complete clinical, laboratory, and X ray evaluation. In the absence of laparoscopic examination, the next logical step in the diagnostic workup would have been laparotomy. With advances in imaging (including magnetic resonance imaging and CT) and technology (including percutaneous transhepatic cholangiography), laparoscopic transhepatic cholangiography is no longer standard practice.
Highlights of Clinical Congress 2015

Scenes from Clinical Congress 2015. Right: The exhibit floor. • Upper left: Convocation. • Middle left: Attendees at the Young Fellows Association annual meeting. • Bottom: ACS Past-Presidents and other ACS leaders gathered for the New Century Presidents’ Dinner and sent a greeting to ACS President J. David Richardson, MD, FACS, who was absent due to illness. Front row, from left (all MD, FACS, with titles at the time of the photo): W. Gerald Austen, LaMar S. McGinnis, Jr., A. Brent Eastman, Carlos A. Pellegrini, Frank C. Spencer, Kathryn D. Anderson, ACS President Andrew L. Warshaw, and Gerald B. Healy. Back row: Seymour I. Schwartz, L. D. Britt, ACS Executive Director David B. Hoyt, and First Vice-President-Elect Ronald V. Maier.
The American College of Surgeons (ACS) Clinical Congress 2015 in Chicago, IL, provided surgeons, medical students, surgical residents, and other members of the operating room team with the opportunity to participate in myriad educational experiences and to interact with their peers. Total registration for the meeting was 13,481, including 8,801 physicians; the remaining attendees were exhibitors, guests, spouses, and convention personnel.

**Convocation**

J. David Richardson, MD, FACS, professor of surgery and vice-chairman, department of surgery, University of Louisville School of Medicine, KY, was installed as 96th President of the ACS at the 2015 Convocation October 4. Dr. Richardson was unable to attend the Clinical Congress; in his stead, David B. Hoyt, MD, FACS, Executive Director of the ACS, delivered Dr. Richardson’s Presidential Address, Challenges for the Second Century, to those of the College’s 1,679 Initiates in attendance and other audience members.

Two Vice-Presidents also assumed office at the Convocation: Ronald V. Maier, MD, FACS, as First Vice-President; and Walter J. Pories, MD, FACS, as Second Vice-President. Dr. Maier is the Jane and Donald D. Trunkey Professor of Trauma Surgery and vice-chair, department of surgery, University of Washington Medicine, Seattle, and is director and surgeon-in-chief, Harborview Medical Center, the regional Level I trauma center based in Seattle. Dr. Pories is founding chair, department of surgery; professor of surgery, biochemistry, and kinesiology; and director, bariatric surgery research group, East Carolina University, Greenville, NC.

In addition, Honorary Fellowship was conferred on six international surgeons: Emmanuel Quaye Archampong,
MB, BS, FRSCEd, FRCSEng, Accra, Ghana; William B. Coman, MD, MB, BS, FACS, FRCSEd, FRCSEng, FRACS, Brisbane, Australia; Mahesh R. Desai, MB, BS, MS, FRCSEd, FRCSEng, Nadiad, India; Abraham Fingerhut, MD, FACS, FRCSP(g), FRCSEng, Poissy, France; Eduardo de Santibañes, MD, PhD, Buenos Aires, Argentina; and Sir Errol Ricardo Walrond, MB, BS, BSc(Hon), FACS, FRCSEng, FCCS, Cave Hill, Barbados.

Named Lectures
Clinical Congress featured several Named Lectures, starting with the Martin Memorial Lecture, presented immediately after the Opening Ceremony on October 5. Paul E. Farmer, MD, PhD, chief strategist and co-founder, Partners in Health; the Kolokotrones University Professor and chair, department of global health and social medicine, Harvard Medical School; and chief, division of global health equity, Brigham and Women’s Hospital, Boston, MA, delivered the well-received lecture, Addressing Unmet Surgical Need: The Role of Academic Surgery.

Other Named Lectures presented at the Clinical Congress 2015 were as follows:

- Major General Brian C. Lein, MD, FACS, commanding general, U.S. Army Medical Research and Materiel Command, presented the Charles G. Drake History of Surgery Lecture: Lessons Learned from 15 Years of Armed Conflict: Implications for Further Military and Civilian Surgical Collaboration.
- Melvin J. Silverstein, MD, FACS, medical director, breast center, and the Gross Family Foundation Endowed Chair in Oncoplastic Breast Surgery, Hoag Memorial Hospital Presbyterian, Newport Beach, CA; and clinical professor, surgery, University of Southern California Keck School of Medicine, Los Angeles, presented the I. S. Ravdin Lecture in the Basic and Surgical Sciences: Radical Mastectomy to Radical Breast Conservation: Revolutionary.
- H. Randolph Bailey, MD, FACS, professor of surgery and emeritus director, residency training program for colon and rectal surgery, University of Texas Medical School; and clinical professor of surgery, Baylor College of Medicine, Houston, presented the Herand
Abcarian Lecture: Surgical Mentorship, More Than Just Teaching.

- **Monica Morrow, MD, FACS**, chief, breast surgical service, and Annie Burnett Windfohr Chair of Clinical Oncology, Memorial Sloan Kettering Cancer Center; and professor of surgery, Weill Medical College of Cornell University, New York, NY, presented the Excelsior Surgical Society/Edward D. Churchill Lecture: Redefining the Local Therapy of Breast Cancer in the Multimodality Era.

- **J. Wayne Meredith, MD, FACS**, Richard T. Myers Professor of Surgery and chairman, general surgery, Wake Forest Medical Center; director, general surgery residency program, and chief, surgery, Wake Forest University Baptist Medical Center; and founder and medical advisor, Childress Institute for Pediatric Trauma, Winston-Salem, NC, presented the Scudder Oration on Trauma: If Charles L. Scudder Could See Us Now.

- **Julie A. Freischlag, MD, FACS**, vice-chancellor, human health sciences; dean, school of medicine; and professor and chair, surgery, University of California-Davis Health System, presented the Olga M. Jonasson Lecture: Resilience.

- **Koffi Herve Yangni-Angate, MD**, professor of surgery, and consultant and head, cardiovascular and thoracic surgery department, Bouake University Teaching Hospital, and professor and chairman, cardiovascular and thoracic diseases department, Bouake University, Côte d’Ivoire, presented the Distinguished Lecture of the International Society of Surgery: Challenges in Open Heart Surgery in Africa: Côte d’Ivoire Experience.
Notable events
The revitalized Excelsior Surgical Society, composed of military surgeons and dedicated to their unique needs and issues, held its inaugural meeting October 4. A highlight of the meeting was the presentation of the first U.S. Army Major John P. Pryor Lecture by C. William Schwab, MD, FACS, FRCS, professor of surgery, University of Pennsylvania; director, University of Pennsylvania Trauma Network; and director, fellowship program in trauma surgery and critical care, University of Pennsylvania, Philadelphia. The lecture, Training of a Combat Surgeon and TEAM, focused on how to properly prepare surgeons to provide care in combat situations. The lecture also set the stage for much of the remainder of the meeting, which centered on the need for coordinated training between all branches of the military and civilian trauma centers. M. Margaret “Peggy” Knudson, MD, FACS, ACS Medical Director of the Military Health System Strategic Partnership with the ACS, gave an update on the program established at last year’s Clinical Congress. Several new member engagement activities took place at Clinical Congress 2015. The ACS Taste of the City offered Fellows, families, staff, and guests the opportunity to experience Chicago’s diverse dining and cultural scene and to network with other ACS members and leaders. The ACS Selfie Scavenger Hunt challenged Clinical Congress attendees to snap photos of themselves with various ACS leaders and members at various conference events and to post the photos on Twitter. Also new this year was the Chapter Speed Networking event, which allowed chapter council members, staff/administrators, and ACS Governors a chance to interact and listen to 15-minute table talks on a range of chapter-related topics.

Awards and honors
Several surgeons were honored for their contributions to the ACS. John A. Weigelt, MD, DVM, FACS, the Milt & Lidy Lunda/Charles Aprahamian Professor of Trauma Surgery, professor and chief, division of trauma and critical care, associate dean for quality, Medical College of Wisconsin, Milwaukee; and a general surgeon and medical director, clinical quality, Froedtert Memorial Lutheran Hospital, received the ACS Distinguished Service Award, the College’s highest honor, at the Convocation. The Board of Regents
presented the award to Dr. Weigelt “in appreciation of his continuous and devoted service as a Fellow of the American College of Surgeons” and “in recognition of his superb skills in synthesizing and applying surgical knowledge and conveying effectively critical concepts to learners that have positively impacted the practices of numerous surgeons.”

The Fellows Leadership Society (FLS) of the ACS Foundation presented the 2015 Distinguished Philanthropist Award to Paula and Danny R. Robinette, MD, FACS. The award was announced at the 26th annual FLS Benefactor Recognition Luncheon and recognizes Mrs. and Dr. Robinette’s philanthropic contributions and service to the international and surgical communities.

In addition to the Distinguished Philanthropist Award, this year the ACS Foundation Board of Directors presented the first Distinguished Organization Award to the Norman M. Rich Department of Surgery at Uniformed Services University of the Health Sciences, Bethesda, MD, in honor of its generous philanthropic partnership with the College.

Dr. Maier received the National Safety Council Surgeons’ Award for Safety at the annual ACS Committee on Trauma (COT) Dinner. The award citation points to Dr. Maier’s “distinguished career and visionary leadership dedicated to prevention of injuries, regionalization of trauma care, innovative trauma research, and lifelong commitment to the care of trauma patients.”

Dan Poenaru, MD, FACS, a pediatric surgeon from Montreal, QC, received the 2015 ACS/Pfizer Surgical Humanitarian Award for starting East Africa’s first pediatric surgical fellowship and for educating and training pediatric surgeons in Africa. Additionally, three surgeons received the ACS/Pfizer Surgical Volunteerism Awards. Susan Miller Briggs, MD, MPH, FACS, a trauma and general surgeon at Massachusetts General Hospital, Boston, received the International Surgical Volunteerism Award for working with not-for-profit organizations and the U.S. National Disaster Medical System to provide surgical care during humanitarian emergencies throughout the world. Rifat Latifi, MD, FACS, a trauma and general surgeon from Tucson, AZ, received the International Surgical Volunteerism Award for helping to establish telemedicine and e-health programs in underdeveloped countries, especially those nations recovering from conflict and in need of major rebuilding of their health care systems. Shilpa Shree Murthy, MD, MPH, a fourth-year general surgery resident at Indiana University, Bloomington, received the Surgical Resident Volunteerism Award for developing the Clinical Breast Exam Simulation Training Course to provide care and education in Rwanda.

The 2015 Scientific Forum abstract supplement was dedicated to Michael T. Longaker, MD, MBA, FACS, the Deane P. and Louise Mitchell Professor, Stanford University School of Medicine, CA, and professor of bioengineering and of materials science.
and engineering; director, Program in Regenerative Medicine; co-director, Institute for Stem Cell Biology and Regenerative Medicine; and director, Children’s Surgical Research, Stanford University. Dr. Longaker was honored in recognition of his exemplary leadership and mentorship of surgery residents.

Practicing surgeons, residents, and medical students were recognized for their contributions to advancing the art and science of surgery. Recipients honored with the Scientific Forum Excellence in Research Awards included the following: Julia Greene, MD; Mark H. Hanna, MD; Evren Dilektasli, MD; Yue-Yung Hu, MD, MPH; Jordan D. Bohnen, MD, MBA; Zeinab Alawadi, MD; Sanjay Mohanty, MD; Andre Valentin; Brian Blackwood, MD; Ruth Tevlin, MB, BCh, BAO, MRCSI; Christopher Scally, MD; Andrew P. Loehrer, MD; Ian R. Flindall, MB, BS, BSc(Hon), MSc, MRCS; Jonathan W. Scott, MD; Kumar Jayant, MD; and Kenneth W. Howell, MD.

Benjamin Levi, MD, assistant professor of surgery, divisions of burn and plastic and reconstructive surgery, and director of the burn/wound and regenerative medicine laboratory, University of Michigan, Ann Arbor, received the 11th Joan L. and Julius H. Jacobson II Promising Investigator Award. The award honors outstanding surgeons who engage in research, advance the art and science of surgery, and
demonstrate early promise of making significant contributions to the practice of surgery.

The 13th annual ACS Resident Award for Exemplary Teaching was presented to Brian C. George, MD, a fifth-year general surgery resident at Massachusetts General Hospital. The award recognizes excellence in teaching by a resident and highlights the importance of teaching in residents’ daily lives. Dr. George was selected by an independent review panel of the Committee on Resident Education.

The third annual Jameson L. Chassin, MD, FACS, Award for Professionalism in General Surgery was presented to Anji E. Wall, MD, PhD, a chief resident in general surgery at Vanderbilt University Medical Center, Nashville, TN. The award recognizes a chief resident in general surgery who exemplifies the values of compassion, technical skill, and devotion to science and learning. The ACS established the award with gifts from the Chassin family, colleagues, and friends of the late Dr. Chassin, who was a skilled surgeon, teacher, and scholar in New York, NY. Dr. Wall was selected by an independent review panel of the Committee on Resident Education.

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The following medical students were honored for their Basic Science Research posters:

- **First place:** Michaela C. Bamdad, Yale University School of Medicine, New Haven, CT: Serotonin Reuptake Inhibitors Protect the Intestinal Mucosa from the Effects of Chemotherapy

- **Second place:** Daniel Walden, Medical College of Wisconsin, Milwaukee: Xanthohumol, a Hop Plant Extract, Decreases NOTCH1 and Mediates Cellular Anti-Carcinogenic Pathways in Cholangiocarcinoma Cell Lines

- **Third place:** Jacob C. Young, University of Chicago, IL: Generation and Characterization of an IL13Rα2-Tropic Modified Adenovirus for the Personalized Treatment of Glioblastoma

The following medical students were recognized for their Clinical and Educational Research posters:
First place: Michaela C. Bambad, Yale University School of Medicine: Antibiotic Standardization Decreases Antibiotic-Associated Costs in Pediatric Patients with Appendicitis

Second place: Adam C. Fields, Icahn School of Medicine at Mount Sinai, New York, NY: Risk Factors for Unplanned Readmission Following Cholecystectomy: A NSQIP Analysis of 27,125 Patients

Third place: Tania Hassanzadeh, University of Arizona, Tucson: Defining Non-Surgical Head Bleeds; When Do You Need a Neurosurgeon?

The International Relations Committee (IRC) on October 6 welcomed the International Guest Scholars (IGS) for 2015 and other guests, including the following: Ramzi Alami, MD, International Surgical Education Scholar (ISES); Olufemi B. Bankole, MD, BCh, IGS; Abebe Bekele, MD, Dr. Abdol and Mrs. Joan Islami Scholar II; Faustin Yali bin Ramazani, MD, Baxiram S. and Kankuben B. Gelot Community Surgeon Travel Awardee; Yin Kai Chao, MD, IGS; Kenneth Siu Ho Chok, MB, BS, MRSCEdin, FRCSEng, FCSHK, FHKAM, Carlos Pellegrini Traveling Fellow; Sabine Irtan, MD, Dr. Abdol and Mrs. Joan Islami Scholar I; Tracey Elizabeth Irvine, MB, BS, Murray F. Brennan Scholar; Taiwo Akeem Lawal, MB, BS, MD, IGS; Jane E. Mendez, MD, FACS, IRC Scholarship Subcommittee Co-Chair; Nikolaus V. Michalopoulos, MD, MSc, PhD, IGS; Anand Kumar Mishra, MCh, IGS; Juan José Cossa Morchio, MD, Elias Hanna Scholar; Giuseppe Nigri, MD, PhD, FACS, FRCS, FASCRS, IRC Scholarships Subcommittee Co-Chair; Jennifer Mary O’Connor, MD, FACS, Community Scholar Awardedee; Daniel K. Ojuka, MB, BS, MMed, ISES; David Parés, MD, IGS; Edgar B. Rodas, MD, IGS; Anita R. Skandarajah, MB, BS, FRACS, Australia-New Zealand Exchange Fellow; Stavros Ioannis Tyritzis, MD, Stavros Niar- chos Foundation Scholar; and Nikolaos Vassos, MD, PhD, Germany Exchange Fellow.

The Commission on Cancer (CoC) presented the State Chair Outstanding Performance Award to Paul Hansen, MD, FACS, Oregon, and Wade Dosch, MD, FACS, South Dakota.

Alexander J. Poole, MD, FACS, FRCSC, a general surgeon in Whitehorse, YT, attended Clinical Congress as the recipient of the 2015 Nizar N. Oweida, MD, FACS, Scholarship. In addition, Catherine J. Hunter, MD, FACS, a pediatric surgeon at the Ann & Robert H. Lurie Children’s Hospital, Chicago, recipient of the 2014 Claude H. Organ, MD, FACS, Traveling Fellowship, gave a presentation before the ACS Scholarships Committee.

Lastly, the winners of the 2015 Resident and Associate Society (RAS) of the ACS essay contest spoke at the RAS Symposium. The theme of the essay contest was Social Media: Threat to Professionalism and Privacy or Essential for Current Surgical Practice? Johanna N. Riesel, MD, a third-year resident, department of surgery, Massachusetts General Hospital,
and Nakul P. Raykar, MD, MPH, a senior general surgery resident, department of general surgery, Beth Israel Deaconess Medical Center, Boston, were the first-place winners on the “essential” side. Lisa M. Kodadek, MD, a senior general surgery resident, Johns Hopkins University School of Medicine, Baltimore, MD, was the first-place winner on the “threat” side.

Annual Business Meeting
The ACS Annual Business Meeting of Members convened October 7 with Dr. Maier presiding in Dr. Richardson’s stead and the following officials presenting reports: Mark C. Weissler, MD, FACS, Chair of the Board of Regents; Michael J. Sutherland, MD, FACS, Chair of the ACS Professional Association political action committee (ACSPA-SurgeonsPAC) Board of Directors; Fabrizio Michelassi, MD, FACS, Chair of the Board of Governors (B/G); and Dr. Hoyt.

The election of the ACS President-Elect, Vice-Presidents-Elect, Regents, and Governors also took place at the Annual Business Meeting. Courtney M. Townsend, Jr., MD, FACS, the Robertson-Poth Distinguished Chair in General Surgery, department of surgery, University of Texas Medical Branch, Galveston, was elected President-Elect. Hilary Sanfey, MB, BCh, BAO, MCh, MA, MHPE, FACS, FRCSI, FRCS, professor of surgery and vice-chair for educational affairs, department of surgery; and associate director, Academy for Scholarship and Education, Southern Illinois School of Medicine, Springfield, was elected First Vice-President. Mary C. McCarthy, MD, FACS, Elizabeth Berry Gray Chair and Professor, department of surgery, Boonshoft School of Medicine, and adjunct graduate faculty, School of Engineering, Wright State University; and an acute care surgeon at Miami Valley Hospital, Dayton, OH, was elected Second Vice-President.

The B/G elected Valerie W. Rusch, MD, FACS, a cardiothoracic surgeon, New York, NY, Chair of the Board of Regents. Michael J. Zinner, MD, FACS, a general surgeon, Boston, was elected Vice-Chair of the Board of Regents.

The B/G also elected four new Regents: James C. Denneny III, MD, FACS, FAAOA, an otolaryngologist, Alexandria, VA; Timothy J. Eberlein, MD, FACS, a general surgeon, St. Louis, MO; Linda G. Phillips, MD, FACS, a plastic and reconstructive surgeon, Galveston; and Anton N. Sidawy, MD, MPH, FACS, a vascular surgeon, Washington, DC.

The following Regents were reelected to serve a second term: John L. D. Atkinson, MD, FACS, a neurologic surgeon, Rochester, MN; Henri R. Ford, MD, FACS, a pediatric surgeon, Los Angeles, CA; Enrique Hernandez, MD, FACS, a gynecologic oncologic surgeon, Philadelphia, PA; L. Scott Levin, MD, FACS, a plastic and reconstructive surgeon, Philadelphia; Beth H. Sutton, MD, FACS, a general surgeon, Wichita Falls, TX; and Steven D. Wexner, MD, FACS, a colorectal surgeon,
The completed photo. ACS Distinguished Service Award recipients, front row, from left (all MD, FACS): F. Dean Griffen, Amilu S. Stewart, John A. Weigelt, Barbara L. Bass, and Josef E. Fischer. Back row: Dr. Hoyt; Mary H. McGrath, Richard B. Reiling; Patricia J. Numann; and LaMar S. McGinnis, Jr.

PORTRAIT OF A PHOTOGRAPHER

Chuck Giorno (left), ACS event photographer, passed away at the close of this year’s Clinical Congress (see dedication, page 3). These photos capture Chuck at work, as he prepared the ACS Distinguished Service Award recipients for their annual photo.
Fort Lauderdale, FL. The following Regents were reelected to serve a third term: Leigh A. Neumayer, MD, FACS, a general surgeon, Tucson, AZ; and Marshall Z. Schwartz, MD, FACS, a pediatric surgeon, Philadelphia.

The B/G reelected Dr. Michelassi, a general surgeon, New York, NY, as Chair of its Executive Committee; Diana L. Farmer, MD, FACS, a pediatric surgeon, Sacramento, CA, was elected Vice-Chair; and Steven C. Stain, MD, FACS, a general surgeon, Albany, NY, was elected Secretary. Newly elected to the B/G Executive Committee for an initial one-year term were Daniel L. Dent, MD, FACS, a general surgeon, San Antonio, TX; and James W. Fleshman, Jr., MD, FACS, FASCRS, a colorectal surgeon, Dallas, TX; Susan K. Mosier, MD, MBA, FACS, an ophthalmic surgeon, Lawrence, KS; and Francis D. Ferdinand, MD, FACS, FRCSEd, a cardiothoracic surgeon, Wynnewood, PA, were both elected to serve initial two-year terms on the B/G Executive Committee.

More information about the Officers, Officers-Elect, Regents, and B/G Executive Committee is available on page 39.

**Clinical Congress 2016**

Be sure to attend the Clinical Congress 2016, October 16–20, in Washington, DC. Details regarding the educational program, registration, housing, and transportation will be posted at facs.org.

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**FOR MORE INFORMATION**

This article contains information that is discussed in greater depth in previous issues of the Bulletin. Following is a list of where some of these articles can be found.

**September 2015**
- John A. Weigelt, MD, DVM, FACS, chosen as 2015 Distinguished Service Award recipient, page 35
- Fellows honored for volunteerism, page 39
- Renewed Excelsior Surgical Society hosts first meeting at 2015 ACS Clinical Congress, page 48

**November 2015**
- RAS-ACS Symposium essays, page 17
- J. David Richardson, MD, FACS, installed as President of the ACS, page 51
- Six outstanding surgeons conferred Honorary Fellowship in the ACS, page 54

**December 2015**
- Courtney M. Townsend, Jr., MD, FACS, next ACS President-Elect, page 57
- New Regents, B/G Executive Committee Members elected, page 60

All articles can be viewed online at bulletin.facs.org.
To be a surgeon, one spends countless hours studying for tests, writing papers, doing research, and learning surgical techniques firsthand in the operating room (OR). But is that enough? Bestselling author Malcolm Gladwell suggests that a college graduate with enough training hours could perform cardiothoracic surgery.* However, surgeons disagree with this statement because learning to manage non-operative care or dealing with complications and unusual circumstances takes years of experience to master. Beyond the tangible aspects of surgical training lies “the hidden curriculum in surgery.”

This year, the Resident and Associate Society of the American College of Surgeons (RAS-ACS) Communications Committee invited residents to submit essays describing what they learned during or after residency training outside of the lectures, textbooks, ORs, and patient wards, hoping to capture life-changing experiences or personal lessons learned. Essays were judged by a panel of RAS-ACS members from all four standing committees: Advocacy and Issues, Communications, Education, and Membership. The author receives a $500 prize, and the winning essay is published in the Bulletin.

We are pleased to select “The things I carry,” by Krista Terracina, MD, a third-year resident at Virginia Commonwealth University, Richmond, as the 2015 RAS-ACS Communications Committee essay contest winner. Dr. Terracina’s piece exemplifies heartfelt experiences that will forever change her career path as a surgeon. I anticipate that as you take the time to read her essay, you will empathize and gain further insight into what is not formally taught in surgical training. ♦

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When I was an intern, I wanted to be prepared for anything that could happen. The pockets on my white coat bulged outward, overstuffed with things I thought I might need. Alongside the obvious necessities like a pen, a stethoscope, and my pager, I carried a sterile disposable scalpel, a few wound-care supplies, scissors, cards with Advanced Cardiac Life Support algorithms, a portable text, and printed reference materials.

As I have matured as a resident, I have stopped carrying so many supplies and reference materials in my white coat pockets, and yet I find that what I carry now is much heavier than it was then. I no longer carry any books or pocket cards; instead, I carry the lessons I have learned.

Lessons from patients and mentors
I carry what I have learned from my patients. I remember the grandmother who complained of several days of abdominal pain with a benign exam but with a computed tomography scan from a referring facility showing widespread pneumatosis and portal venous gas. After emerging from her operation, in which nothing was resected because it all would have needed to be resected, she took the news of her situation with quiet grace and passed away in the arms of her family that night. I carry her whenever I go see a consult in our emergency room, and I remember that appearances can be deceiving. Every patient begins to us as a mystery waiting to be solved.

I carry what I have learned from my mentors; the memory of the interaction between my attending and his patient after the pathologist informed us that the distal gastrectomy margins still were diseased. My attending was honest, straightforward, and humble; his patient was accepting, understanding, and happy to accept the course of action we set before her. I carry that lesson with me and remember that it is ultimately the quality of the relationships that we build with our patients that make us truly great surgeons.

Making a difference
I carry the moments that taught me to hope, like the young mother with severe blunt trauma from a motor vehicle collision. She was in the intensive care unit for months. Her wound care required at least a two-hour commitment from her physicians and nurses daily, and many of us questioned whether she would ever leave the hospital. I remember when I saw this patient and her husband on the trauma floor ready to move to rehab, and there was a smile on both of their faces. Today, she is home with her family, thankful for all that her care team did for her. I remember her, and I remember that when we do our duty with diligence and commitment, we can make a difference in people’s lives.

The most important things I carry when I walk into the hospital are not in my pockets. They are the names and faces of the many patients I have been privileged to interact with, each with a lesson for me, each with something important to say.

Acknowledgement
The author would like to acknowledge Rahul J. Anand, MD, FACS, associate professor, Virginia Commonwealth University, Richmond, for his encouragement and advice.
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The average age of the practicing surgeon is rising along with that of the American population. Approximately one-third of all practicing surgeons are older than age 55. For the more than 100 years since its founding, the ACS has emphasized the importance of high-quality and safe surgical care. To address concerns that advanced age may influence competency and occupational performance, the ACS has developed the following guidelines:

- The ACS maintains that it is in the best interests of the surgeon to adhere to a lifestyle that promotes wellness. As such, the ACS stresses the importance of a lifelong approach to physical, mental, and emotional wellness for personal and professional well-being.
- Surgeons are not immune to age-related decline in physical and cognitive skills. Even so, the ACS does not favor a mandatory retirement age because the onset and rate of age-related decline in clinical performance varies among individuals. Furthermore, a mandatory retirement age may have a deleterious impact on access to experienced surgical care, particularly in rural and underserved areas. Objective assessment of fitness should supplant consideration of a mandatory retirement age.
- Surgeons may not, on their own, recognize deterioration of their physical and cognitive function and clinical skills with age. Colleagues and coworkers are an important resource for identifying the surgeon who displays initial signs of professional deterioration. Potential warning signs may include forgetfulness, unusual tardiness, evidence of poor clinical judgment, major changes in referral patterns, unexplained absences, confusion, change in personality, disruptiveness, drastic change in appearance, and unusually late and incoherent documentation.
- Although age-related deterioration varies from individual to individual, gradual decline in overall health, physical dexterity, and cognition generally occurs after the age of 65. For this reason, it is recommended that, starting at age 65 to 70, surgeons undergo voluntary and confidential baseline physical examination and visual testing by their personal physician for overall health assessment. Regular interval reevaluation thereafter is prudent for those without identifiable issues on the index examination. Surgeons are encouraged to also voluntarily assess their neurocognitive function using confidential online tools. As a part of one’s professional obligation, voluntary self-disclosure of any concerning and validated findings is encouraged, and limitation of activities may be appropriate.
- Colleagues and staff must be able to bring forward and freely express legitimate concerns about a surgeon’s performance and apparent age-related decline to group practice, departmental and medical staff, or hospital leadership without fear of retribution. In addition, the surgeon’s quality and outcomes of patient care is the ultimate measure of ongoing competence and safety for surgeons of all ages. As such, peer-reviewed methods, including ongoing professional practice evaluation, should be performed commonly as part of recredentialing. If a potential issue is identified, additional methods of evaluation may include chart reviews, peer review of clinical decision making, 360-degree reviews and patient feedback, observation or video review of operating room cases, and proctoring. In these cases, once the initial potential issue has been addressed, more detailed and frequent reviews, such as focused professional practice evaluation, may be indicated.
- Occasionally, the surgeon will need to be referred to a comprehensive evaluation program. These examinations currently are being conducted at a number
Surgeons are not immune to age-related decline in physical and cognitive skills. Even so, the ACS does not favor a mandatory retirement age because the onset and rate of age-related decline in clinical performance varies among individuals.

of specialized centers where a battery of tests for neuropsychological assessment (see sidebar, this page). The costs of such testing should be borne by the hospital or medical staff, not the surgeon. These results cannot be used in isolation to determine continuation or withholding of hospital and surgical privilege but should be incorporated as an additional piece of information as part of an overall evaluation as described earlier in this statement. Further research is required to develop accurate and reliable screening tests to help identify surgeons who are potentially experiencing age-related decline in cognition and surgical skills.

• Decisions regarding hospital and operating room privileges should be made at the medical staff and/or hospital level only after careful evaluation of all evidence available. Medical staff bylaws and due process must be followed. Strict confidentiality is essential. As always, the best interests of the patient remain the first priority, while at the same time the confidentiality, dignity, and contributions of the surgeon must be respected.

• Senior surgeons play a vital role in their hospitals and communities, and their knowledge and years of experience can be valuable resources. Surgeons relinquishing clinical roles can contribute significantly to teaching, surgical assisting, research, or administration. If their abilities permit, and if they are willing, they should be given opportunities to contribute to these areas.

• All hospitals and facilities that deliver surgical care are encouraged to develop policies as appropriate for their institution in compliance with state and federal regulations. It also is expected that there will be local variations that cannot be covered or predicted with this statement.

COMPREHENSIVE NEUROPSYCHOLOGICAL ASSESSMENT currently based on the Halstead-Reitan Neuropsychological Test Battery

The battery consists of seven subtests with the following purposes:

• Category: Measure of abstracting ability
• Tactual performance: Measures memory and localization
• Rhythm: Task is to discriminate between like and unlike pairs of musical beats
• Speech sounds perception: Task is to discriminate spoken syllables
• Finger tapping: Measure of manual dexterity
• Time sense: Task of reproducing movement from sight as well as ability to estimate time span
• Trail making tests, Parts A and B: Measures psychomotor speed and flexibility

The administration of this test battery requires a highly trained examiner, typically a neuropsychologist, and requires a full day to complete. Interpretation requires the skills and knowledge of a trained neuropsychologist. This is the standard due to a high degree of clinical and psychometric reliability for most of the tests in the battery.
The following statement was developed by the American College of Surgeons (ACS) Subcommittee on Trauma Subcommittee on Injury Prevention and Control to educate surgeons and other medical professionals about the significance of older adult burns and evidence-based prevention activities. The ACS Board of Regents reviewed and approved the statement at its October 2015 meeting in Chicago, IL.

Statement on older adult burn prevention

The ACS recognizes the following facts:

• Changes occur to the skin of the elderly that increase their risk for burns. These changes include the following:
  – Intrinsic skin changes — those changes due solely to aging and which include loss of hair follicles and thinning and looseness of skin — increase the risk of deep burn and difficulty healing
  – Extrinsic skin changes, such as exposure to ultraviolet light and smoking, which accelerate aging effects

• Metabolic changes in the elderly that increase mortality after burns, including the following:
  – The lethal dose 50 or LD50 (total body surface area [TBSA] burn leading to 50 percent mortality) decreases markedly with age (LD50 value for a teenager is approximately 85 percent TBSA; for an 80 year old, it is approximately 10 percent TBSA).
  – The elderly have slower reflexes, resulting in an inability to react quickly in dangerous situations.

• Diseases associated with aging predispose the elderly to higher risk for burns, including the following:
  – Neurologic diseases:
    * Tremors, seizures, and syncope may lead to spills and flame and hot liquid exposure can result in deep burns.

      • Dementia is associated with poor choices that increase burn risk.
      • Diabetes mellitus increases burn risk and poor burn healing in three ways:
        * Higher risk for peripheral vascular disease, which leads to poor healing
        * Neuropathy, which leads to an inability to sense heat related to hot water, hot pavement, and heaters
        * Impaired resistance to infection, placing patients at increased risk for amputation

  – Pulmonary diseases:
    * Smoking while on oxygen may lead to face and inhalation burns.

Supported by the evidence, the ACS champions efforts to promote, enact, and sustain policies and legislation that encourage the following:

• Health care provider and public education regarding increased mortality of burns in geriatric patients compared with younger populations

• Public and health care provider education and prevention programs targeted to specific burns that are unique to the elderly population

Prevention programs to reduce burns in the elderly should include the following:
Metabolic changes in the elderly that increase mortality after burns include...that the elderly have slower reflexes, resulting in an inability to react quickly in dangerous situations.

• Physicians educating elderly patients using material that highlights the increased risk for burns and how minor burns can lead to death

• Education about appropriate water heater temperature of 120-degrees Fahrenheit

• Caution when handling hot liquids

• Use of alternate forms of accelerant other than gasoline

• Recommendation to use electric rather than flame candles

• Promotion of safe cooking practices without the use of flame (gas)

• Public education about the risk of burn and death when smoking while on oxygen

• Education on safe cooking and bathing practices for people with seizures, syncope, and history of falls

• Reminders for people with diabetes mellitus or any cause of decreased sensation to keep in mind the following:
  
  – Never walk barefoot on hot days

  – Never warm their feet in hot water or with heaters

  – Report even minor burns or injuries to their physician ♦

BIBLIOGRAPHY


The ACS recognizes that injuries are the leading cause of death and disability in children, despite the fact that the means to prevent these injuries are readily available. In particular, the following data pertain to children who are injured by motor vehicles when they are left unattended in or around cars:

- The not-in-traffic surveillance (NiTS) data show that in the four-year period spanning 2008 to 2011, non-traffic motor vehicle crashes killed an estimated 1,043 children ages 14 and younger. Additionally, an estimated 30,000 children of this age group were injured in these crashes.

- In 2013, at least 180 children died in non-traffic vehicle-related incidents because adults left them unattended in or around a vehicle.

- Approximately 24 percent of the deaths that occur in this situation result from children overheating while left in a car in hot weather.

- More than 50 percent of the deaths are caused by a child being run over by a motor vehicle in the driveway or while the vehicle is backing up. In these incidents, the driver is usually a parent.

The NiTS data show that in the four-year period spanning 2008 to 2011, non-traffic motor vehicle crashes killed an estimated 1,043 children ages 14 and younger.
More than 50 percent of the deaths are caused by a child being run over by a motor vehicle in the driveway or while the vehicle is backing up. In these incidents, the driver is usually a parent.

- Most rollover/back-over injuries are due to larger, high-profile vehicles (such as trucks and sports utility vehicles) with increased morbidity and mortality.

- In 10 percent of driveway fatalities, a child puts the car in motion.

  In addition to educating parents about the dangers of leaving their children unattended in and around motor vehicles, the ACS endorses the following prevention activities:

  - Support of legislation that impose fines on parents/caregivers who leave children unattended inside vehicles

  - Furthering of research, development, and installation of “back-over prevention devices” and rearview cameras in trucks, minivans, and other large vehicles

  - Studies on the effectiveness of sensing devices that would sound an alarm when a child is left in a car seat and the key has been removed from the ignition

  - Further research on the effectiveness of devices that would prevent children from being able to start a vehicle

**BIBLIOGRAPHY**


More than 5.6 million U.S. motor vehicle crashes occurred in 2012, resulting in 1.63 million injuries and 30,000 deaths. More than 52 percent of fatal injuries occurred in unrestrained occupants, and 79 percent of unrestrained occupants who were completely ejected from the vehicle died. Safety belts have been shown to significantly reduce morbidity, mortality, and the risk for occupant ejection in motor vehicle crashes. Jurisdictions that have primary seat belt laws continue to have high seat belt use. In the U.S., 33 states and the District of Columbia have primary seat belt laws and use is 85 percent. Safety belt use is approximately 62 percent in tribal reservations, and those with primary seat belt laws have the highest use. All Canadian provinces have primary seat belt laws, with 95 percent use.

Regarding the use of safety belts in motor vehicles, the ACS recognizes the following:

• Safety belts are the most effective safety device in preventing serious injury and death in motor vehicle crashes.

• Appropriate safety belt use reduces the possibility of ejection and the risk of death in vehicular crashes.

• Safety belt use varies significantly by age, gender, ethnicity, and time of day. Youth, males, Native Americans, and rural area occupants are among the lowest safety belt users and the highest mortality rate populations.

• Safety belt use reduces the risk of fatal injury for front seat passengers by 45 percent and the risk of moderate to severe injury by 50 percent.

BIBLIOGRAPHY


Safety belts have been shown to significantly reduce morbidity, mortality, and the risk for occupant ejection in motor vehicle crashes. Jurisdictions that have primary seat belt laws continue to have high seat belt use.

• Primary safety belt laws allow a citation to be issued whenever a law enforcement officer observes unrestrained vehicle occupants. Secondary safety belt laws require law enforcement to stop a violator for another traffic infraction before a safety belt citation may be issued.

• Primary safety belt laws have been shown to decrease mortality by 8 percent and increase safety belt use by 14 percent compared with secondary law states.

• Strong legislation and effective enforcement are crucially important to the success of safety belt laws.

Therefore, the ACS supports legislation enacting primary safety belt laws for all occupants and their effective enforcement.

**BIBLIOGRAPHY (CONTINUED)**


The one-year grace period for correct use of ICD-10 codes

by Cynthia Reyes, MD, FACS

Many surgeons welcomed the Centers for Medicare & Medicaid Services’ (CMS) decision to give health care professionals a one-year grace period to precisely comply with the 10th revision of the International Classification of Diseases (ICD-10) documentation requirements. Throughout this grace period, which ends October 1, 2016, CMS will remit payment to physicians if the ICD-10 code is at least in the appropriate family of codes.

The current roll out of ICD-10 may have left some surgeons feeling disoriented. Although precise ICD-10 documentation is not required for professional billing during the grace period, accurate ICD-10 coding is necessary to support hospital services and for quality reporting. Compliance with ICD-10 not only will benefit hospitals, for which compliance is required in year one, it will also benefit physicians through correct documentation of their patient’s clinical condition. Moreover, precise data are necessary to achieve high reliability in health care for our patients in the future. This column addresses some questions and concerns regarding ICD-10 coding that many surgeons share.

Why should surgeons be concerned about precise ICD-10 coding?

This grace period is a far cry from a free pass for the many health care professionals, especially surgeons, whose practices are often intertwined with the hospitals at which they deliver care. Contrary to the obligations for health care professionals, hospitals still are required to submit accurate ICD-10 diagnosis codes generated from physicians’ documentation. If the patient’s health care record is missing information necessary for proper ICD-10 coding, the hospital will have to ask physicians to provide more detailed information to avoid use of nonspecific codes that may result in the denial of the hospital’s Part A claims.

Does ICD-10 coding affect my participation in any reporting and payment programs?

ICD-10’s increased granularity provides a more accurate depiction of the patient’s severity of illness and should help physicians avoid undeserved penalties and poor ratings on publicly distributed provider report cards. Proper use of ICD-10 terminology may be useful to surgeons who are seeking to successfully participate in the Physician Quality Reporting System (PQRS) and the Medicare Value-Based Payment Modifier Program. With greater detail and increased ability to accommodate new technologies, ICD-10 has the potential to provide better data for evaluating and improving the quality of patient care. The data captured by the updated code set may be used to more meaningfully understand complications and track patient outcomes. Furthermore, ICD-10’s increased granularity could prove useful in clinical research and public health investigations.

What is the surgeon’s role in ICD-10 coding when a hospital and practice have billing and coding staff?

ICD-10 compliance does not mean surgeons have to become coders. The role of the clinician is to document the nature of the patient’s condition and services rendered to maintain or improve those conditions as accurately as possible, whereas the job of the coding professional is to ensure that the coding is consistent with the documentation. Lack of appropriate documentation is bad for payors, providers, and patients. The surgeon’s focus should be on the language and/or wording that will document
greater detail and specificity of the coded data for a given diagnosis, condition, disease, and/or surgical procedure.

What tips would you offer to surgeons who are trying to accurately document their cases using ICD-10?

Understanding the basics of ICD-10 documentation may help make ICD-10 coding less opaque. Clinical documentation of a patient encounter should include the following information, all of which typically is easy to provide:

- **Episode of care** (initial, subsequent, sequella)
- **Acuity of disease** (mild, moderate, severe, acute, chronic, acute on chronic)
- **Laterality** (right, left, bilateral)
- **Type and cause of a condition, disease, or disorder** (for example, expected acute blood loss anemia after surgery for a gunshot wound to the liver)
- **Underlying condition** (such as essential hypertension, uncontrolled type 1 diabetes)
- **Manifestation of disease** (such as sepsis due to perforated appendicitis)
- **Linking of diagnosis** (for example, diabetic nephropathy, peripheral vascular disease due to smoking, renal calculi due to hypercalcemia from primary hyperparathyroidism, and so on)
- **Causal organism** (identification of the infectious organism)
- **Relationship of drug, tobacco, alcohol to disease and documentation of use, abuse, or dependence**
- **Support medical necessity** with physical findings, labs, or radiologic findings (for example, as indicated by a mass seen in the right upper lobe on computed tomography scan, a thoracotomy and right lung resection will be performed)

Isn’t ICD-10 coding more of an issue for hospitals?

Isn’t Current Procedural Terminology (CPT) coding more relevant to billing for physician services?

Although CPT codes will still be accepted for billing for professional fees and outpatient procedures, nonspecific CPT codes may result in denial of payment for newer procedures.2 Furthermore, hospitals will be required to use ICD-10 procedure codes for all inpatient procedures. ICD-10 requires the following information in the description of procedures:

- **Specific anatomic site or region and body part** (such as right upper lobe of lung, upper inner quadrant right breast)
- **Laterality** (right, left, bilateral)
- **Root operation** (such as biopsy, excision, repair, resection)
- **Approach** (including percutaneous, endoscopic, open)
- **Devices used** (such as biologic (skin graft), synthetic (mesh), mechanical materials (cardiac pacemaker))
- **Qualifiers** are specific to the procedure (diagnostic procedure)

Because physicians are responsible for providing the documentation for these descriptors, we must be able to comply with ICD-10 requirements. Furthermore, CMS is monitoring postoperative outcomes outlined by the Agency for Healthcare Research and Quality (AHRQ). To avoid inaccurate designation of poor postoperative outcomes, it is important to document the following conditions as...
present on admission or before an operation when applicable:

- Systemic inflammatory response syndrome/sepsis
- Urinary tract infection (urosepsis)
- Veno-thromboembolism events
- Decubitus pressure ulcer
- Respiratory insufficiency/failure (including chronic obstructive pulmonary disease [COPD])
- Renal insufficiency/failure
- Coagulopathy
- Bleeding condition/anemia (such as gastrointestinal bleed)
- Hip fracture
- Wound dehiscence or other complications after another surgeon’s operation

What other tips would you offer for complying with ICD-10 documentation requirements?

Some other documentation tips for successful ICD-10 compliance are as follows:

- Eliminate the phrase “postoperative” condition from your documentation vernacular because it will imply a complication; for example, instead of using “post-op ileus,” document “expected ileus after intestinal resection.”
- State when expected medical conditions emerge after surgery are due to primary disease processes (for example, expected respiratory insufficiency after surgery requiring ventilator support due to COPD).
- Document if a condition is a result of the primary disease (for example, septic shock due to a tubo-ovarian abscess).
- Document when subsequent operations are anticipated (such as second-look surgery being planned to evaluate for progressive intestinal ischemia).
- For professional fee coding, list symptoms in medical terms when the diagnosis is not yet known. Only hospitals are allowed to use terms such as “suspect,” “probable,” or “rule out” in their coding.
- For reimbursement of services provided, diagnoses must be linked with treatment in plain English (for example, a bronchoscopy will be performed to investigate hemoptysis and a lung mass seen on chest X ray).

What is an example of steps an institution has taken to comply with ICD-10, and what have been the benefits?

In January 2014, hospital health information experts, hired consultants, and clinical documentation surgeon champions developed and implemented a clinical document improvement and ICD-10 training curriculum for the department of surgery at the University of New Mexico, Albuquerque. The curriculum began with mandatory lectures that addressed current documentation deficiencies and new ICD-10 documentation requirements for each surgical specialty. A clinical documentation surgeon champion assigned to each surgical specialty reviewed cases at division conferences and highlighted opportunities for better clinical documentation. Surgical health care professionals were given access to ICD-10 Internet and mobile apps. ICD-10 documentation tip sheets created for each surgical specialty were distributed to providers via hard copies attached to workstations and electronic versions made public on the hospital Intranet ICD-10 website. Providers and documentation
hat surgeons should know about... specialists reviewed clinical documentation queries during one-on-one sessions. Severity of illness and risk of mortality levels, case mix illness scores, provider query response rate, documentation delinquency, AHRQ quality measurements, and hospital charges for surgery patients are monitored for each surgery division and shared with providers.

These changes resulted in a 40 percent increase in the surgery department’s case mix index and a $300,000 per month increase in hospital charges.

**Are there any resources to consult to aid in implementing a similar program?**

Additional ICD-10 educational resources are available at the following links:


- CMS ICD-10 Ombudsman, reachable at: icd10_ombudsman@cms.hhs.gov.

**REFERENCES**


The benefits of attending a 2016 ACS Surgical Coding Workshop

by Sarah Kurusz

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

The workshops are beneficial for surgeons, administrators, managers, coders, and reimbursement staff. Team attendance is strongly encouraged to ensure accurate, consistent, and complete coding. If the physician is an ACS member, team members or practice employees may attend the workshop at the ACS member rate. The College also recommends attending a workshop once a year because the AMA updates the CPT code set annually. Moreover, improvements in coding constructs, additions of new technology, and changes to coding and reimbursement rules and payment policies make it beneficial to attend regularly.

Advantages of attending

When accurate coding is aligned with a clear understanding of payment policies, practices tend to improve their profit margins. Attending an ACS coding workshop increases participants’ knowledge of coding principles and helps them to decrease coding errors and reduce the risk of an audit. The workshop also comprises information regarding the new codes for the year and audit trends, allowing participants to practice accurate coding.

Furthermore, attendees have the opportunity to share their different coding and practice management ideas, knowledge, experiences, and backgrounds with the group. Attendees can learn how their colleagues are handling coding, billing, and practice management issues. Because the code set is updated annually, the topics discussed at ACS coding workshops change from year to year. In 2016, the first day of the workshop focuses on correct coding. Topics for discussion include reviewing the accuracy of your evaluation and management (E/M) coding against Centers for Medicare & Medicaid Services benchmarks, assessing the built-in coding features of your electronic health record system for risks, using the 10th revision of the International Classification of Diseases codes to enhance payment, monitoring and
managing your online reputation, addressing deficiencies in practice accounts receivable management, and sharpening your ability to review financial reports.

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

Other topics discussed include the following:

• The difference between CPT rules and Medicare rules and how this variance affects coding and billing

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

• How modifiers are used and their effects on reimbursement

• How to report and get paid for unlisted procedures

• Coding for excisional breast biopsy or partial mastectomy

• How to initiate a successful appeal when receiving incorrect payment

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

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<th>Hotel contact information</th>
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<td>February 11–12</td>
<td>Encore at Wynn Las Vegas</td>
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<td>Hyatt Chicago Magnificent Mile</td>
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The difference between returning a patient to the operating room to treat a surgical complication and a staged procedure.

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

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

Dates and locations of 2016 ACS Surgical Coding Workshops
The workshops will take place on the following dates:

- February 11–12, Las Vegas, NV
- March 17–18, Washington, DC
- April 28–29, Chicago, IL
- May 19–20, New York, NY
- August 11–12, Nashville, TN
- September 15–16, Dallas, TX
- November 10–11, Chicago, IL

Registration information
Register for the two-day workshop online at www.karenzupko.com/workshops/americancollegeofsurgeons/index.html or call 312-642-8310. The College offers a special rate for members and their coding staff, but ACS membership is not a requirement for attendance. The member price is $650 per course or $995 for both days. The nonmember price is $750 per day or $1,095 for both days. ACS Fellows and their staff should have their ACS member number available and enter it for each individual registering.

For hotel reservations, contact the hotel that is hosting the workshop and indicate that you are attending the ACS Surgical Coding Workshop for special pricing (see Table 1, page 55).

The College also offers airfare discounts on United Airlines. Contact an ACS travel counselor at 800-456-4147 or ACSTravel@facs.org, or contact United Airlines by phone at 800-521-4041 or online at www.united.com. When booking individual travel, be sure to indicate the name of the meeting and refer to the ACS file numbers provided for any applicable discounts. The ACS file numbers are Agreement Code: 973454; ZCode: ZTEZ.

More information about the workshops is available on the College website at facs.org/advocacy/practmanagement/workshops.

Additional ACS coding resources
To assist surgeons in their efforts to address coding questions, the ACS offers the following resources:

- The Coding Hotline (800-227-7911), 9:00 am–6:00 pm Eastern Time. The Coding Hotline staff will answer five free coding questions per year for each Fellow. For additional information on the ACS Coding Hotline, visit the ACS website.

- “Coding and practice management corner,” a column in the Bulletin, is published regularly and provides tips on a range of reimbursement-related issues. These and other articles are available on the ACS website.
To support and promote rural surgery, the American College of Surgeons (ACS) Board of Regents established the ACS Advisory Council for Rural Surgery (ACRS) at its June 2012 meeting. On creating the ACRS, the Regents said:

The mission of the ACRS is to identify, investigate, and rectify the challenges associated with rural surgical practice. To address these complex issues, the ACRS will work to develop broad-based training through rural residency tracks and to improve recruitment, retention, mentoring, and post-residency education for rural surgeons. All of the council’s efforts reflect the College’s commitment to ensuring that the nation’s 60 million rural patients have access to high-quality surgical care and to addressing the challenges facing rural surgeons.1

ACRS members have been actively working to fulfill the goals set forth by the Regents. This column describes the current activities of the ACRS.

**Development of rural surgery training programs**

ACRS members have identified and promoted general surgery residency training programs that emphasize specific training for rural surgeons or have a rural surgery track in their program.2 Furthermore, the ACRS has encouraged the development of a rural surgery track within current general surgery residency programs.3,4

For example, ACRS member and Past-Chair, ACS Board of Governors Executive Committee, Gary Timmerman, MD, FACS, a general surgeon at University of South Dakota Sanford School of Medicine and Sanford Medical Center, Vermillion, helped create an entirely new general surgery residency program at that institution. This training program places primary emphasis on graduating rural and community general surgeons. Unique to the program is that no other competing surgical specialty programs or fellowships are in place.

Furthermore, the ACRS has been an active supporter of the ACS Transition to Practice in General Surgery (TTP) program for residents who have completed their general surgery training. R. Phillip Burns, MD, FACS, a Past First-Vice-President of the ACS and Past Vice-Chair of the ACRS, has been instrumental in the development of the TTP program.5 Several of the hospitals that are participating in the TTP program have a strong rural focus in their training programs.

**Spreading the word**

To help better inform the surgical community about the issues facing rural surgeons, ACRS members have given presentations at ACS chapter meetings, Clinical Congress, and at large regional meetings.

In addition, the ACRS has been working with the Rural Surgeons Film Project, which produced the video *The Calling of Rural Surgery.*
Many members of the ACRS and rural surgical community have arranged regular rotations with medical students and residents, exposing them to a rural surgical practice.

This six-and-a-half-minute video showcases the great need for rural surgeons in the U.S. and clearly depicts the satisfaction that rural surgeons find in their work. The video was previewed at Clinical Congress 2015 and can be accessed at www.ruralsurgeon.info.

**Educating medical students and residents**

Many members of the ACRS and rural surgical community have arranged regular rotations with medical students and residents, exposing them to a rural surgical practice. In addition, Lauren Smithson, MD, FACS, a former ACRS member and a rural surgeon in St. Anthony, Newfoundland, developed the Society for Young Rural Surgeons (SYRUS). SYRUS, an international community of rural and global physicians, aims to promote interest in rural surgery among medical students, residents, and young practitioners. (For more information on SYRUS, visit www.youngruralsurgeons.com.)

**Advocacy activities**

Members of the ACRS have been actively working with the ACS Division of Advocacy and Health Policy, the American Medical Association, the American Hospital Association, the National Rural Healthcare Association, and representatives from the Centers for Medicare & Medicaid Services (CMS) to address concerns regarding the pending 96-hour rule legislation. The 96-hour rule, which concerns payment to critical access hospitals (CAHs) for Medicare patients, is of crucial importance for the financial viability for these facilities. ACRS members have been involved in conversations with CMS administrators on the subject and have advised members of Congress who serve on key committees regarding alternatives to the current rules and proposed legislation.

CMS recently indicated it would begin enforcing a long-forgotten rule requiring that physicians who admit patients to CAHs certify that each patient can reasonably be expected to be discharged or transferred within 96 hours. Previously, CAHs had been operating under a similar but separate condition of participation that required patient stays to be less than 96 hours on average. The recent action by CMS will result in surgeons without the ability to admit patients for procedures routinely performed in CAHs, and inpatients will be forced to go further from home for treatment.

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

ACRS members also have been actively working with the ACS Division of Advocacy and Health Policy regarding changes in reimbursement for colonoscopies and have responded to CMS’ request for information regarding the Medicare Access and CHIP (Children’s Health Insurance Program) Reauthorization Act that was enacted in April 2015. Specifically, the ACRS addressed CMS’ questions regarding technical assistance to small practices and practices in Health Professional Shortage Areas as they face implementation of the new law. Furthermore, ACRS members have worked with the ACS Division of Advocacy and Health Policy staff to provide comments on the meaningful use of electronic health records and the specific challenges facing small practices.

**Publications regarding rural surgery**

A monthly column, “The Rural Surgeon,” is published in ACS Surgery News and addresses issues in rural surgery. In addition, this column, “Dispatches from rural surgeons,” is published quarterly in the Bulletin. Both of these publications highlight the great support the ACRS
has consistently received from the ACS leadership in solving problems related to rural surgery. Furthermore, several ACRS members have published articles or editorial/opinion pieces in various journals and in the lay press. Furthermore, several ACRS members have published articles or editorial/opinion pieces in various journals and in the lay press.7

ACRS members Amy L. Halverson, MD, FACS, and David C. Borgstrom, MD, FACS, have written a book, Advanced Surgical Techniques for Rural Surgeons, published in November 2014, which provides content covering topics relevant to surgical care in rural areas, with a focus on the surgical diseases that are often treated by surgical subspecialists in the urban setting.

In addition to these publications, ACRS members are currently active in writing the rural surgery topic for Selected Readings in General Surgery, which will be published in 2016.

Clinical Congress activities
Since its inception, the ACRS has sponsored or cosponsored various Clinical Congress Panel Sessions, open forums, and Town Hall Meetings related to rural surgery issues, including an Advanced Skills Training for Rural Surgeons Postgraduate Course. These courses always have been well-received and well-attended. In 2015, an Advanced Skills Training for Rural Surgeons course was offered at the ACS North Dakota/South Dakota Chapter meeting. Consideration is being given by the ACS and the ACRS is considering holding Advanced Skills Training for Rural Surgeons courses at other chapter meetings.

In addition, rural surgery has been designated as a dedicated track at Clinical Congress, and Dr. Borgstrom has served as the Clinical Congress Program Liaison for the ACRS. He is now a member of the Clinical Congress Program Committee.

Five ACRS-cosponsored panel sessions have been accepted for the Clinical Congress 2016.

Another educational program that the ACRS has in development is the Rural Surgery Symposium, a biennial meeting devoted to rural surgical issues.

Lastly, the ACRS has sponsored a Rural Surgeon’s Dinner at Clinical Congress since 2012. Averaging more than 100 attendees, these dinners have provided a great opportunity for rural surgeons to network.

Development of standards
The ACRS is working with the ACS to develop a set of standards for use in establishing the infrastructure and practices required to optimize rural surgical care across the nation. These standards could also serve as a template for other nations to consider.

On call/locum tenens issues
ACRS member Robert P. Sticca, MD, FACS, chairman and program director, department of surgery, University of North Dakota School of Medicine and Health Sciences, Grand Forks, has developed the North Dakota Rural Surgery Support Program, which provides a general surgeon for locum tenens coverage at local rural hospitals.9

Members of the ACRS are working with the ACS to develop a system for locum tenens coverage for rural hospitals on a national basis.
Members of the ACRS are working with the ACS to develop a system for locum tenens coverage for rural hospitals on a national basis.

**Cancer patient care**

One of the authors of this article, ACRS member Michael D. Sarap, MD, FACS, a surgeon in Cambridge, OH, has been working with leadership of the Commission on Cancer and the National Accreditation Program for Breast Care. This effort is aimed at making it easier for lower volume rural hospitals that provide quality care to attain Commission on Cancer accreditation, or at least recognition, as well as to develop methods for these hospitals to measure their quality.10

**International activities**

ACRS members have been engaged in several efforts to coordinate international rural surgery activities. Examples are as follows:

- ACRS member Nadine Caron, MD, FACS, a surgeon at the University of Northern British Columbia, Prince George, has been involved in numerous programs in Canada to improve the care of native populations.

- Dr. Hughes, as the ACRS Chair, has traveled to New Zealand and Scotland to participate in rural surgery conferences.

- In 2016, Drs. Hughes and Timmerman will participate in the Royal Australasian College of Surgeons annual meeting in Brisbane, Australia. They will discuss the subject of rural practice in Australasia in an effort to learn how each area of the world responds to the challenges of rural surgery.

  - The ACRS will support *The Lancet* Commission on Global Surgery as that project continues to move forward.

  Many members of the rural surgical community across the country have expressed great appreciation for the College’s commitment to support and promote rural surgery. Members of the ACRS will continue to strive to fulfill its mission to identify, investigate, and meet the challenges associated with rural surgical practice.

**REFERENCES**


5. Richardson JD. ACS Transition to Practice Program offers residents additional opportunities to hone skills. *Bull Am Coll Surg.* 2013;98(9):23-27.


California voters in November 2014 overwhelmingly rejected statewide ballot measure Proposition 46 (Prop 46), which sought to weaken the state’s Medical Injury Compensation Reform Act (MICRA) by raising the cap on noneconomic damages in medical liability lawsuits to $1.1 million from $250,000. The Northern California, Southern California, and San Diego Chapters of the American College of Surgeons (ACS) joined in a statewide effort with the support of the ACS to empower surgeons to advocate with their patients, colleagues, and other health care professionals to defeat the ballot measure. Because of MICRA, liability insurance premiums have risen more slowly in California than elsewhere in the U.S. Surgeons in other states with lawsuit reform laws may benefit from the valuable lessons learned in the defeat of this ballot initiative as they work to catalyze efforts in medical liability reform in their states.

MICRA
Originally signed into law by Gov. Jerry Brown (D) in 1976, MICRA was enacted to preserve patient access to care and deter frivolous lawsuits against health care professionals and hospitals. It has served as the gold standard for medical liability reform since its enactment. The $250,000 cap on noneconomic damages discourages attorneys from filing non-meritorious lawsuits and has helped to contain health care costs, improve patient access to care, and stabilize medical liability premiums so that rates are lower than in other states without similar reforms. A report from the California legislature’s nonpartisan fiscal and policy advisor concluded that if Prop 46 had passed, the costs for California taxpayers would have increased by hundreds of millions of dollars annually. In the 40 years since MICRA was enacted, multiple legislative efforts and court challenges (involving both the California State Supreme Court and the U.S. Supreme Court) have been aimed at raising the cap. Prop 46 was the first effort at the ballot box. The measure was filed with the attorney general and moved into the signature-gathering phase after efforts to negotiate a legislative compromise, such as by raising the cap to $350,000, were unsuccessful.

United effort
A key proponent of Prop 46 was Consumer Watchdog, an organization that advocates for taxpayer and consumer interests, and, according to media reports, likely receives extensive financial backing from trial lawyers. In 1988, Consumer Watchdog was involved in the passage of California’s Proposition 103, which allows organizations to collect intervenor fees for challenging premium increases in auto, home, and property-casualty insurance. According to the California Department of Insurance, Consumer Watchdog has collected more than $14 million in intervenor fees since Proposition 103’s inception. U.S. Sen. Barbara Boxer (D-CA) and well-known consumer advocate Erin Brockovich also championed Prop 46.

A coalition opposed to the initiative also was assembled. The California chapters of the ACS and other medical, civic, government, and labor organizations united to preserve patient access to quality care. The
A coalition opposed to the [Prop 46] initiative also was assembled. The California ACS chapters and other medical, civic, government, and labor organizations united to preserve patient access to quality care.

The campaign was led by many of the health care associations, physicians, and allied health care professionals organized as Californians Allied for Patient Protection. The broad-based, bipartisan coalition included the California Medical Association (CMA), the California Dental Association, the National Association for the Advancement of Colored People, the California Hospital Association, Planned Parenthood, the American Civil Liberties Union, the California Chamber of Commerce, and the Service Employees International Union. California surgeons played an important role in the campaign. The leadership of the California ACS chapters applied for a 2014 ACS Lobby Day Grant as an initial step in the statewide effort to defeat Prop 46. ACS leaders worked with CMA leadership, testifying before the University of California Board of Regents, writing letters to the editors of newspapers across the state, and speaking at medical staff meetings and Democratic Club meetings. An October 2014 Bulletin article highlighting the likely challenges in patient access to care and increases in health care costs that would emerge if Prop 46 passed was provided as additional information at the conclusion of meetings with legislators.5

California voters rejected Prop 46 by a margin of 33 percent to 67 percent, sending it to defeat in every county. Several elements were essential to this victory and are key to future efforts:

• Carefully craft messages to the media: In a conversation with the Los Angeles Times, Jamie Court, president of Consumer Watchdog, told reporter Michael Hiltzik that the mandatory drug testing of physicians was added to Prop 46 as the “ultimate sweetener.” This comment likely adversely impacted public opinion, and, ultimately, nearly every major newspaper in California came out in opposition to Prop 46. Physician advocates need to be cautious in their comments to the media to avoid similar unfavorable consequences.

• Open communication with disparate groups: Physicians and medical students attended the state Democratic Party Convention in their white coats to urge delegates to vote no on Prop 46. While it appeared initially that the statewide Democratic Party would join the Republican Party in opposing Prop 46, a last-minute negotiation moved the party to a neutral position. This would later prove a key to victory, however, as each of the county Democratic chapters and clubs could individually oppose the proposal. Ultimately, several key Democrat elected officials also formally opposed the measure.

• Educate members about the issue and encourage them to actively engage in grassroots advocacy: The College mailed informational materials to all ACS members in California, encouraging them to raise awareness among their patients and colleagues of the challenges to access of care that passage of the measure would create. California surgeons also were urged to visit the official “No on 46” Web page, sign up as a supporter of the campaign and share messaging on social media, prepare letters to the editor of their local newspaper, and distribute “No on 46” campaign materials in patient waiting rooms.
The fight continues

Although Prop 46 was defeated, the fight isn’t over. Surgeons are moving forward with the next steps to protect MICRA, which include the following:

• California ACS chapters intend to educate state lawmakers about the need to maintain medical liability protections and to begin considering passage of other meaningful reforms and alternatives to the tort system for resolving liability claims, such as development of health courts, enterprise liability, safe harbors, and “disclose and offer” programs.

• It is likely that the proponents of Prop 46 will continue to try to enact measures that reflect the intent of this ballot initiative. Members of the coalition that opposed Prop 46 are closely monitoring whether a repeat ballot measure will be filed. Prop 46 used physician drug testing as a hook to draw public support. Since it polls well with voters, this tactic could be used again in a future initiative.

• A secondary intent of Prop 46 sought to require California physicians to use the state’s Controlled Substance Utilization Review and Evaluation System (CURES) database that is still under development before prescribing narcotics to patients. Proponents of Prop 46 used the story of Troy and Alana Pack, children who were struck and killed by an automobile driver addicted to alcohol and prescription pain medications, to gain support. The driver had not disclosed to her treating physicians that she had sought multiple narcotic prescription refills from different providers. In 2015, Governor Brown signed legislation to extend the deadline for health care providers to register to use the CURES database, as issues related to adequacy of funding and ensuring patient confidentiality for the database continue to be evaluated. The coalition against Prop 46 will explore alternate ways of fulfilling this provision in the initiative.

Ultimately, the defeat of Prop 46 was a team effort and is a testament to the importance and value of physician and surgeon advocacy. Perhaps the most constructive next step is to work legislatively and at the negotiating table to better meet the needs of society by reforming the medical liability system.

REFERENCES


Rectal cancer resection: Laparoscopic or open— which way forward?

by James W. Fleshman, MD, FACS; Judy C. Boughey, MD, FACS; and Y. Nancy You, MD, MHSc, FACS

After the Clinical Outcomes of Surgical Therapy (COST) trial demonstrated that laparoscopic resection was an acceptable alternative to open resection for colon cancer, the next issue for oncologic surgeons was determining the role of laparoscopic surgery in treating rectal cancer. Since the results of the COST trial could not be extrapolated to rectal surgery, the American College of Surgeons Oncology Group (ACOSOG) conducted the Z6051 randomized controlled non-inferiority trial comparing laparoscopic and open resection of rectal cancer.

The Z6051 trial
The results of the Z6051 trial were recently published in the *Journal of the American Medical Association*.[2] This study enrolled 486 patients with rectal cancer from 46 credentialed surgeons working at 35 institutions. The primary outcome was a composite success of the operation involving completeness of the total mesorectal excision (TME), negative circumferential resection margin (CRM), and negative distal margin (DM). The composite operative success rate was 81.7 percent for the laparoscopic group and 86.9 percent in the open group. This difference did not support the primary hypothesis that laparoscopic resection of the rectum was non-inferior to open resection for stage II and III rectal cancer within 12 cm of the anal verge and treated with neoadjuvant therapy in patients with a body mass index of less than 35.

The surgeons involved in the study are considered experts in laparoscopic surgery based on their participation in the COST trial or their submission of operative reports and videos of laparoscopic colectomies for central review. All of the participating surgeons were credentialed for laparoscopic and open rectal resection before participating in the trial with the submission and review of videos from participants’ operations. Reviewers were looking for the following:

- High ligation of the inferior mesenteric artery
- Mobilization of the splenic flexure, high ligation of the inferior mesenteric vein
- Dissection in the pelvis in the areolar tissue plane just outside the mesenteric envelope of the rectum that contains the lymphatics and fat of the rectum
- Transection of the rectum at a level to provide a clear distal margin in a right angle direction across the mesenteric fat

The pathology specimen was assessed in a standardized manner after the pathologists met to agree on methodology in order to provide CRM distance from the closest tumor invasion, completeness of the TME specimen based on the intactness of the mesenteric envelope, and DM negativity. Photo documentation of the TME specimen and video audit of the procedure served as quality control mechanisms throughout the study (see photo, page 65). The laparoscopic group showed TME complete or near complete, negative CRM and negative DM in 92.1 percent, 87.9 percent, and 98 percent, respectively, versus the open group rates of 95.1 percent, 92.3 percent, and 98 percent, respectively. The local recurrence and survival rates are still pending.
It may be necessary to rethink the appropriate candidate for laparoscopic rectal surgery. Use of this procedure may need to be limited to the upper rectal lesions and the smallest tumors in the widest pelvis to ensure perfect excision of the mesorectum.

Implications for the future
What do these findings mean for minimally invasive treatment of rectal cancer in the future? There are several key points to consider in discussing this question.

First, the participants were all motivated, expert surgeons functioning in a well-monitored and quality-controlled trial, using standardized operative techniques within their individual practice technique, treating the most difficult rectal cancer patients (curable, irradiated cancers within 12 cm of the anal verge, 50 percent in the low rectum), and applying a strict definition of laparoscopy (dissection in the pelvis by instrumentation under pneumoperitoneum). If these individuals could not achieve non-inferior results on the pathologic oncology outcomes compared with open surgery, it is unlikely that anyone else could.

It may be necessary to rethink the appropriate candidate for laparoscopic rectal surgery. Use of this procedure may need to be limited to the upper rectal lesions and the smallest tumors in the widest pelvis to ensure perfect excision of the mesorectum. It is important to remember that incomplete TME and positive CRM increase the risk of local recurrence of rectal cancer. It may be more appropriate to use the hybrid laparoscopic technique to achieve high ligation of the vessels and mobilization of the splenic flexure and limit the size of the lower abdominal incision to perform the pelvic dissection. This combines the minimally invasive benefits in the upper abdomen and the standard open approach to the pelvic dissection.

Another possibility is to use the robotic approach for the pelvic dissection since in-line, wristed instruments should improve the access to the low pelvis and reduce the chances of an incomplete TME. Only 34 patients in the study were operated on using a robot, so the conclusions regarding the robotic capabilities are limited by a small sample size. Preliminary data from other studies comparing robotic with laparoscopic approaches suggest equivalence between the two modalities. But do these data indicate that the robot can compensate for the laparoscopic deficiencies, or is it still putting the patient at risk?

It also is possible that a combined transanal TME and laparoscopic anterior resection as mentioned earlier for the hybrid open/laparoscopic approach may be able to overcome the difficulty with distal resection in the low pelvis. The transanal approach can be performed using transanal endoscopic microdissection, transanal minimally invasive surgery,
[The CoC Rectal Cancer Program] audit will provide a ready-made registry that will allow us, as concerned surgeons, to document our true success rate in the management of rectal cancer regardless of the approach used.

or standard transanal excision techniques. The learning curve and generalizability for these two approaches—robotic and combined minimally invasive/transanal—are as yet unknown.

Furthermore, as the ACS rolls out the new Rectal Cancer Program through the Commission on Cancer (CoC), the use of strict audit through the multidisciplinary team approach will become mandatory in institutions seeking CoC accreditation. This audit will provide a ready-made registry that will allow us, as concerned surgeons, to document our true success rate in the management of rectal cancer regardless of the approach used. It is anticipated that these ACS Rectal Program institutions will be reviewed in conjunction with the routine CoC accreditation survey. This process clearly has implications for which institutions will be performing rectal cancer in the future, and this study has raised the bar for surgeons to perform self-audit as we move forward.

**Conclusion**

The Z6051 trial has introduced several new concepts into the surgical trial arena including the following:

• Credentialing of surgeons based on video review and prior participation in surgical trials

• Use of pathologic oncology outcomes (TME, CRM, and DM) combined in a composite to determine operative success

• Use of a pathologic oncology outcome as a surrogate for long-term indicators of success (survival and recurrence)

• Use of photodocumentation of the surgical specimen as a means of quality control for the surgeons in the study

• Standardization of pathologic evaluation and surgical technique

• Definition of the rectum as 12 cm above the anal verge

• Distribution of the protocol to the Australian GI Trials Group for the Australasian Laparoscopic Cancer of the Rectum (ALaCaRT) study1 and the Comparison of Open versus laparoscopic surgery for mid or low REctal cancer After Neoadjuvant chemoradiotherapy (COREAN) study trial group2 to enable meta-analysis of the results in the future

The participants in this trial, both patients and surgeons, are to be congratulated for their contributions to the successful completion of this major study, which has led investigators to ask even more questions.

**REFERENCES**


Dr. Charles McBurney: A pioneer in the surgical treatment of appendicitis

by Robert R. Nesbit, Jr., MD, FACS

The name McBurney (Charles McBurney, MD) is probably second only to that of Cushing (Harvey Cushing, MD, FACS) as a recognized name in American surgery. Dr. McBurney was born in Roxbury, MA; educated at Harvard College, Cambridge, MA, where he rowed crew; and received his medical degree from the College of Physicians and Surgeons (P&S) in New York, NY, in 1870. He trained at Bellevue Hospital, New York City, for 18 months and furthered his medical training in Europe, spending time with Christian Albert Theodor Billroth, MD, in Vienna, Austria. He returned to New York in 1873 and was a busy private practitioner until his retirement in 1905.

Dr. McBurney joined the faculty at P&S, taught anatomy and operative surgery, and became professor of surgery at age 44, though he stepped down five years later due to the demands of his practice. In 1888, he became surgeon-in-chief at the Roosevelt Hospital, New York, NY, where he said he had "the entire surgical service from one end of the year to the other" and "the number of operations is about twelve hundred annually." He was noted for his clinical judgment, his teaching skills, and his expertise in trauma. In terms of technical operating skill, it was said that, "He was not a rapid performer with the scalpel, but exact, progressing without hesitation.... As a result, the patient’s final sutures were placed and the dressings applied in as short a time as those of one who appeared to work much faster." Dr. McBurney was an early proponent of aseptic technique, and among his visiting observers was a young William W. Mayo, MD.

McBurney’s tender point
In 1938, the journal Medical Classics cited 114 publications by Dr. McBurney, including case reports presented at meetings of the New York Surgical Society; but, of course, he is best known for his classic paper, “Experience with early operative interference in cases of disease of the vermiform appendix,” published in the New York Medical Journal. This paper was published just three years after Reginald Fitz, MD, described and named appendicitis and recommended operation for perforation.

Dr. McBurney described the early clinical course of the disease, including tenderness at a point “almost exactly two inches from the anterior iliac spine, on a line drawn from the process through the umbilicus.” Sir William Osler, MD, noted the importance of “McBurney’s tender point” in the first edition of his text in 1893. Dr. McBurney advised that appendectomy was not necessarily easy to perform and stated his "strong feeling that it is well worthwhile for anyone who may have to do this operation to see it done at least once first." Five years later, he described the muscle-splitting incision that bears his name.

Consummate general surgeon
Dr. McBurney was a true general surgeon. In addition to his contributions to appendectomy, one of his most notable achievements was his description of a technique for repairing fracture dislocations of the shoulder (often a complication of attempts to reduce a dislocation). In 1898...

FROM THE ARCHIVES
he described sphincterotomy for impacted gallstones, and in 1901, Dr. McBurney was called to Buffalo, NY, to evaluate the postoperative condition of President William McKinley and was subsequently unfairly criticized for stating an overly optimistic prognosis.

Charles McBurney was an astute observer, master surgeon, and role model for surgeons of all generations.

REFERENCES
2. Cutler CW, Martin AT, Peightal TC, eds. The Roosevelt Hospital, 1871–1957. Roosevelt Hospital, NY; 1957:113.
In my view, the future of the general surgeon, the future of surgery itself, and the future of the College are linked inseparably.

—Dr. M. J. Jurkiewicz, MD, FACS, 1989 American College of Surgeons (ACS) Presidential address*

M.J. “Josh” Jurkiewicz, MD, FACS, the 70th President of the College (1989–1990), died in May 2011, leaving behind a distinctive legacy. His extraordinary contributions to the field of surgery, to the education of surgical residents, and to the welfare of surgical patients are but a few hallmarks of his remarkable career and life. The ACS Foundation is honored to highlight Dr. Jurkiewicz, and his wife, the late deForest “de” Freeman Jurkiewicz, as Mayne Heritage Society members. The Mayne Heritage Society recognizes Fellows who have provided a bequest or other “planned” gift of any size to the College through their estate plan.

Rapid rise
Dr. Jurkiewicz was born September 24, 1923, and raised in Bellows Falls, VT. His parents, who ran the local general store, put him on a train bound for Baltimore, MD, to attend the University of Maryland School of Medicine.

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Dentistry at the age of 17. He graduated magna cum laude in 1946 and received his medical degree from Harvard Medical School, Boston, MA, in 1952. He and deForest married in 1951, and in their 57-year union had two children, Beth Jurkiewicz Wilson of Berkeley Lake, GA (co-author of this column), and Chris Jurkiewicz of Fairfield, CT, and two grandchildren, Colin Josh Wilson and Lucy deForest Jurkiewicz.

Beginning his pioneering career as a surgeon with a residency in plastic and reconstructive surgery and general surgery at Barnes Hospital, Washington University, St. Louis, MO, Dr. Jurkiewicz achieved the position of chief of plastic surgery at both University of Florida and the Veterans Affairs Medical Center in Gainesville. He then found a longtime home as the chief of plastic and reconstructive surgery at Emory University, Atlanta, for more than 20 years.

Role model
One of Dr. Jurkiewicz’s notable accomplishments at Emory was educating some 100 residents and fellows, who called him “Dr. J.” After retirement, he held the title of professor of surgery emeritus at Emory and continued to play an active role in the education of medical students, interns, and associates until his death. Dr. Jurkiewicz also acted as a plastic surgeon consultant at Walter Reed Army Medical Center in Washington, DC, from 1971 to 1991 and to the Shriners Hospitals for Children from 1995 to 2000.

In acknowledgment of his excellence as a mentor, his residents and fellows created the Jurkiewicz Society, noting their subsequent contributions to surgery and plastic surgery are a testament to Dr. Jurkiewicz’s legacy. Jurkiewicz Society member Grant Carlson, MD, FACS, said, “Dr. Jurkiewicz, in my mind, is the most influential plastic surgeon in the last 50 years. ‘Dr. J.’ has been the driving influence on my academic career. He was the consummate teacher, and so he will be remembered, and so he lives on.”

Another of Dr. Jurkiewicz’s residents and fellows, Albert Losken, MD, FACS, gave the eulogy at Dr. Jurkiewicz’s funeral, at which he said, “I often asked myself, ‘How did he get people to excel like that? How did he get us to want to do the right thing, and want to make him proud? I don’t know, but everyone did it. Perhaps it was that he was one of the most powerful surgeons in America, or was it the fact that he drove a rusted [Volkswagen] Rabbit? We all wanted to make him proud.”

In his remarks at an Emory University memorial, LaMar S. McGinnis, Jr., MD, FACS, ACS Past-President, eloquently summarized Dr. Jurkiewicz’s impact:

Today, Dr. Jurkiewicz’ associates, former students and residents, in aggregate, make up the most distinguished cohort of practitioners to the discipline of reconstructive and plastic surgery in the world, in my humble opinion. The influence of that collective of careful innovative thought evolved through research into surgical technique and surgical practice and has reached out to impact the field of medicine beyond reconstructive and plastic surgery; broadly including oncologic surgery, vascular surgery, radiation oncology, pediatric surgery, thoracic, orthopaedic, urologic surgery, and on and on. The history of surgical progress will long echo the influence of the man we honor today.
Dr. Jurkiewicz was, of course, more than a surgeon, educator, and mentor. He was a husband, father, friend, world traveler, gardener, and baker. Dr. and Mrs. Jurkiewicz traveled the world together with fellow plastic and reconstructive surgeons in a travel club called The Academic Plastic Surgery Forum, which began in 1969 with an initial 10 academic surgeons, including Paul Weeks, MD, FACS. “Our travel club recognized and appreciated Josh’s leadership and innovative skills early on; he was a ‘regular guy’ with inordinate skills,” remarked Dr. Weeks (personal communication with co-author Sarah Klein, November 12, 2015). Dr. and Mrs. Jurkiewicz also shared their love of travel with their family, who felt spending time with them was the real treasure. His daughter, Beth, said, “I joined him on the trip of a lifetime to Antarctica in 1998, but a road trip to Vermont was just as grand.”

**ACS loyalist**

Extremely loyal to the College, Dr. Jurkiewicz’s service culminated in 1989 when he was elected to serve as the 70th President of the ACS. He was honored to be the first—and to this date the only—plastic surgeon to serve as ACS President. He was known to often wear his presidential blazer with the College seal. Many College stalwarts were personal friends, including Dr. McGinnis; the late Oliver “Ollie” Beahrs, MD, FACS, ACS Past-President; and C. Rollins “Rollo” Hanlon, MD, FACS, ACS Past-Director.

At the closing of his ACS Presidential Address, Dr. Jurkiewicz said, “Crucial to the success of this enterprise is foundation support, as well as broad support by the Fellows. A greatly expanded educational role of the College will require nothing less.”

He wasn’t just paying lip service to his support for educational programs; he led by example, donating regularly to a number of educational institutions, including the ACS Foundation. The Jurkiewiczes also left a portion of their estate to the College. For their generosity to the College and other nonprofit institutions, the ACS Foundation Board of Directors named Dr. and Mrs. Jurkiewicz the 2006 ACS Distinguished Philanthropists.

It is clear that the Jurkiewiczes had a love of the surgical profession, patients, surgeons-in-training, and the ACS. The estate gift was but one indication of their dedication, and the ACS Foundation is grateful for the enduring mark that they left on the future of surgery. As members of the Mayne Heritage Society, Dr. and Mrs. Jurkiewicz will be listed prominently in honor rolls in both the Foundation Annual Report and other publications.

The leaders of the ACS Foundation encourage you to follow the Jurkiewicz’s example and to consider a bequest through your estate plan. Dr. and Mrs. Jurkiewicz believed that the future of surgery and of the ACS are intertwined. With their bequest, they are helping the next generation of surgeons continue their lifelong learning and surgical education to provide optimal patient care.

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**New MHS members**

The Mayne Heritage Society proudly welcomes new members Ruth L. Bush, MD, FACS, and William A. Fife, IV; Patricia J. Numann, MD, FACS; and Mark T. Savarise, MD, FACS, and Dr. Yvonne Savarise.
Antibiotic resistance causing issues for surgical patients

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

While looking over a patient’s lab results, Lisa Waldowski, MS, APRN, CIC, noticed that the patient had methicillin-resistant staphylococcus aureus. It was obvious to Ms. Waldowski, an infection preventionist in a hospital at the time, that the standard antibiotic wouldn’t work for the patient, who was being prepped in the operation room (OR). She immediately called the OR and told the operating team not to administer the antibiotic as ordered but to obtain one that would be effective for the specific organisms that this patient had. “When you have a drug-resistant organism, using a broad-spectrum antibiotic that the organism is not sensitive to is like throwing water at it. You’re not treating anything,” according to Ms. Waldowski, who now serves as The Joint Commission’s infection control specialist. In this role, Ms. Waldowski advises Joint Commission surveyors with interpretations of and education in infection control findings; she also responds to challenging questions, complaints, and potential threats to life/patient safety infection control-related events.

Inappropriate use
The Centers for Disease Control and Prevention (CDC) cites studies indicating that 30 percent to 50 percent of prescribed antibiotics in hospitals are administered in settings where an antibiotic is unnecessary or is ineffective against the pathogenic organisms. Increased and inappropriate antibiotic use leads to increased risks of antibiotic resistance, as well as contributing to clostridium difficile (C. difficile) infections. The CDC estimates that antibiotic-resistant bacteria cause 23,000 deaths and 2 million illnesses annually in the U.S.¹

According to a report from the Infectious Diseases Society of America and the Society for Healthcare Epidemiology, antibiotics were prescribed incorrectly in 50 percent of the cases studied—whether because other treatment options would have been more effective or the prescribed dosing or duration was improper.² In particular, prolonged surgical prophylaxis leads to excessive antibiotic use with its attendant complications. Most research shows that preoperative prophylaxis reduces surgical site infections by 50 percent or more, but continuing the antibiotic after the operation is over does not improve efficacy and actually increases antibiotic complications.³ Similarly, recent research shows that for intra-abdominal infections in which an effective source control has been achieved either by the surgeon or an interventional radiologist a short course of antibiotics (four to five days) is as effective as eight to 10 day dosages.⁴

Efforts to improve patient safety
The practice of safely and judiciously prescribing antibiotics has become a patient safety issue—one for which President Barack Obama’s Administration has created a national action plan. The goals of the proposal include the following:

• Slow the growth of resistant bacteria and the spread of resistant infections

The practice of safely and judiciously prescribing antibiotics has become a patient safety issue—one for which President Barack Obama’s Administration has created a national action plan.

- Advance development and use of diagnostic tests to identify and characterize resistant bacteria
- Develop new antibiotics or other vaccines

“When you have patients who have already been on antibiotics, or who have been using antibiotics inappropriately, there is a potential for development of multiple drug-resistant organisms and severe diarrheal infections that include *C. difficile*,” Ms. Waldowski says. “This happens because you aren’t just wiping out what you’re intending to, but also unfortunately wiping out normal flora that is needed and present in the gut and within parts of our bodies. You can cause harm when you’re not using antibiotics appropriately.”

In a surgical setting, Waldowski suggests following evidence-based guidelines when prescribing antibiotic prophylaxis and confirming that the right patient is being given the right antibiotic, at the right dose, and for the right amount of time. In addition, staff in hospitals and ambulatory surgery centers can help to improve antibiotic use and protect their surgical patients by sharing necessary antibiotic information when there is a transfer of care and implementing antimicrobial stewardship programs to provide focus for each person’s role in the appropriate administration of an antibiotic.

Providers have a resource to help with educating patients about antibiotics. The Joint Commission’s Speak Up campaign focuses on the do’s and don’ts of antibiotics, including a table that lists the illnesses that may require an antibiotic. These materials are available at www.jointcommission.org/topics/speakup_antibiotics.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.

**REFERENCES**

The 2015 Annual Report of the National Trauma Data Bank® (NTDB®) is an updated analysis of the largest aggregation of U.S. and Canadian trauma registry data ever assembled. The NTDB contains more than 6 million records. The 2015 Annual Report is based on 860,964 records with valid trauma diagnoses from the single admission year of 2014. The data were submitted by 746 facilities, including 237 Level I trauma centers, 259 Level II trauma centers, 189 Level III or IV trauma centers; as well as 36 Level I or Level II pediatric-only centers.

The U.S. Census Bureau divides the U.S. into four regions (see Figure 1, page 75, which illustrates the number of incidents by region). The Northeast Region has nine states, the Midwest has 12 states, the West has 13 states, and the South has the remaining 16 states, along with the District of Columbia. Each region has its own population statistics, with the South having slightly more than 37 percent of the U.S. population.

The leading trauma registry
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 objective, the NTDB is committed to being the principal national repository for trauma center data. The purpose of the Annual Report is to inform the medical community, the public, and policymakers about the various issues that characterize the current state of care for injured persons. The report has implications for many areas, including epidemiology, injury control, research, education, acute care, and resource allocation.

Many dedicated individuals on the ACS COT, as well as at trauma centers throughout the U.S., contributed to the early development of the NTDB and its rapid growth in recent years. To build on these achievements, the goals in the coming years include improving data quality, updating analytic methods, and
enabling more useful outcomes data comparisons between hospitals. These efforts will be reflected in future NTDB reports to participating hospitals, as well as in the annual reports.

Throughout the year, we will be highlighting these data through brief reports published monthly in the Bulletin. The NTDB Annual Report 2015 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 Annual Report 2015 is available on the ACS website as a PDF file at facs.org/quality-programs/trauma/ntdb/docpub.
The American College of Surgeons (ACS) is now accepting applications for the 2017–2019 Clinical Scholars in Residence positions. The ACS Clinical Scholars in Residence Program is a two-year on-site fellowship in surgical outcomes research, health services research, and health care policy. The program launched in 2005 for the purposes of advancing the College’s quality improvement initiatives and providing opportunities for residents to work on ACS Quality Programs. More specifically, ACS Clinical Scholars in Residence perform research relevant to ongoing projects in the ACS Division of Research and Optimal Patient Care.

About the program
The primary objective of the program is to address issues in health care quality, health policy, and patient safety, with the goal of helping the ACS Clinical Scholar in Residence prepare for a research career in academic surgery. The ACS Clinical Scholars in Residence have worked on projects and research involving data culled from the ACS’ National Surgical Quality Improvement Program, National Cancer Data Base, National Trauma Data Bank®, Surgeon Specific Registry, and Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program. The ACS Clinical Scholars have used their findings to develop practice guidelines and accreditation standards. Scholars are assigned to the appropriate group within the ACS based on their interests and the College’s needs.

In addition, participants earn a master’s degree in health services and outcomes research or health care quality and patient safety during their two years at ACS headquarters in Chicago, IL. The goal of this aspect of the program is to educate clinicians to become effective health services and outcomes researchers. The health curriculum focuses on these issues within institutional and health care delivery systems, as well as in the external environment that shapes policies related to quality and patient safety issues. All coursework is done at Northwestern University’s downtown Chicago campus, one block from ACS headquarters. The ACS also offers a variety of educational programs that may benefit Clinical Scholars, including the Outcomes Research Course and the Clinical Trials Course.

The ACS assigns internal mentors to meet regularly with each ACS Clinical Scholar in Residence. Scholars also have opportunities to interact with various surgeons who are affiliated with the ACS and the Division of Research and Optimal Patient Care. Whereas mentorship is one of the most important aspects of this fellowship, having guidance from and interaction with multiple individuals from diverse backgrounds will provide the best opportunity for success. In addition, a corps of ACS staff statisticians and project analysts serve as invaluable resources to the ACS Clinical Scholars in Residence.

Past successes
Since its inception, surgical residents throughout the U.S., including those from California, Connecticut, Colorado, Illinois, Kansas, Louisiana, Michigan, and Ohio, have participated in the ACS Clinical Scholars in Residence program. These individuals say that they have had excellent, productive experiences that have been useful in launching their careers in the field of academic surgery. With eight scholars already having completed the program and six scholars currently participating, the residents have demonstrated great dedication to.

by Karl Y. Bilimoria, MD, MS, FACS, and Clifford Y. Ko, MD, MS, MSHS, FACS
Healy Award fundraising initiative achieves $200,000 goal

The American College of Surgeons (ACS) Foundation announced in November 2015 that the fundraising initiative for the Gerald B. Healy Traveling Mentorship Award had reached a successful conclusion. The fund was established to honor ACS Past-President and Past-Chair, ACS Board of Regents, Gerald B. Healy, MD, FACS, FRCS(Hon), FRCSI(Hon)—a passionate advocate for engaging young medical trainees in lessons in safety, quality, and professionalism. Dr. Healy is Emeritus Gerald B. Healy Chair in Otolaryngology, Boston Children’s Hospital, MA; professor of otology and laryngology, Harvard Medical School, Boston; and member, board of directors, Council on Surgical and Perioperative Safety.

The Healy Award will be used by one recipient annually to visit and engage with one or more successful mentors. The recipient will be expected to publish a substantive article in the Bulletin of the American College of Surgeons detailing the educational experience. Over time, Healy award recipients will preserve their mentors’ wisdom and guidance for themselves and future generations of surgeons.

The ambitious goal of $200,000 was set to initiate the annual award and was achieved through the generous support of many Fellows and friends. Those who would like to honor Dr. Healy in this unique way may continue to donate to the fund. Learn about other ways you can give to the ACS Foundation at https://web4.facs.org/eBusiness/fundraising/. For more information, call 312-202-5338.

Dr. Healy standing next to a list of donors to his eponymous traveling mentorship award at the ACS Clinical Congress 2015 in Chicago, IL.
Obituaries have always been somewhat challenging to me. An individual is born, lives his life to the fullest, and then dies. And so it was with Isidore Cohn, Jr., MD, FACS, who died October 14, 2015, at age 94. However, in Dr. Cohn’s case, living life to the fullest was an incredible adventure that had a lasting impact not only on generations of surgeons, but on the multitude of patients who received care from his emissaries—the surgeons he trained.

Dr. Cohn has been described as an icon in surgery. Few surgeons would dispute such a descriptor, nor would many challenge his characterization as the ultimate Southern gentleman.

Different drummer
When one thinks of the passing of an icon, it is easy to list in chronological order the achievements that the individual accomplished in his or her lifetime and for which many accolades were bestowed. However, our time is better spent trying to understand the qualities and accomplishments that brought Dr. Cohn to this profound state of acknowledgement.

Dr. Cohn’s achievements are monumental, but the lessons to be learned are even more essential. What was the most important trait that Isidore brought to a relationship? Each person who knew him seems to have a unique assessment, although many linger on the pervasive calm; the insightfulfulness; the wry, quiet smile; or the restrained, soft-spoken comments that drove to the heart of the matter. Though he was not necessarily exuberant, his enthusiasm was palpable.

There was always a sense of the collected self that gave a certain assurance to his comments. The whispered word from Isidore Cohn had a greater effect on most people than the shouted rhetoric so common in our lives.

Isidore Cohn walked to the beat of a slightly different drummer—one whom not all could hear—but he had about him a presence that all could understand. He was not a loner, but he held himself in reserve. He was mature beyond his years, even as an elder statesman.

Isidore was of slender build, had a twinkle in his eye, and always wore a hint of a smile on his face. He often tilted his head slightly and focused carefully on the conversation at hand, letting you know that you had his full and undivided attention. You also sensed that when he gave you advice, he was not merely offering suggestions but rather sharing a certain wisdom. You inherently knew that if you shared a problem with him, he would follow up on the situation to see how the events had worked out.

Product of his upbringing
To understand the complex individual that was Dr. Cohn, it is important to bear in mind that he was a product of another era—one that began in the early 20th century when his father, Isidore Cohn, Sr., MD, rose to prominence in New Orleans, LA. In many ways, the junior Dr. Cohn’s carriage and demeanor reflected those mannerisms and behaviors that he expressed in his childhood. As Ian Cohn noted in his eulogy for his father, this coming year will be the first in more than 110 years that a Dr. Isidore Cohn will not be listed in the roster of the citizens of New Orleans.

The senior Dr. Isidore Cohn was a stalwart of not only the medical community of New Orleans, but also the community of New Orleans, LA. He was a man of the people, a man of the city, and a man of the medicine. He was a true giant in the world of medicine and a true giant in the world of humanity. He was a man of great compassion, a man of great wisdom, and a man of great love. He was a man who lived his life to the fullest, and he will be missed by all who knew him.

In memoriam:
Dr. Isidore Cohn, Jr.: A life well-lived

by J. Patrick O’Leary, MD, FACS
Each person who knew [Dr. Cohn] seems to have a unique assessment, although many linger on the pervasive calm; the insightfulness; the wry, quiet smile; or the restrained, soft-spoken comments that drove to the heart of the matter.

Orleans but of the Jewish community as well. The Cohn house of that era focused on scholarly activity, study of the classics, proper use of the English language, and a general sense of curiosity. Academic achievement was the order of the day.

Dinner was served precisely at the same time each night and all family members were expected to attend. Etiquette was emphasized. Frequently, dinners would be accompanied by readings from Shakespeare or other intellectually stimulating activities. Proper attire and manners were expected. Although some might call this a privileged upbringing, it carried with it serious responsibilities and demands, especially for children and adolescents.

As one who came later into the shadow cast by the light of Dr. Cohn’s influence, I realized that he expected excellence not only from the members of his family, but also from his “extended” family—those whom he had trained in surgery.

Marianne, his wife for almost 40 years, was his constant companion during his later years. She had a wonderful effect on Isidore. Marianne had brought with her to the Cohn family her own interest in philanthropy and the arts. Together, she and Isidore contributed substantially to the city of New Orleans and its cultural life. Isidore had always been interested in Steuben crystal (“glass,” as he called it) and the Cohns’ collection of these delicate pieces was perhaps one of the largest private assemblages in the world. They also had an interest in jade, and their collections of this semi-precious stone and Steuben glass were often included in exhibits at the New Orleans Museum of Art.

Dr. Cohn’s commitment to New Orleans was deep and lifelong. He served on the boards of the greater New Orleans Convention and Visitors Bureau, the New Orleans Museum of Art, the Touro Synagogue Foundation, and the Jewish Endowment Foundation.

**LSU**

At the time of his death last October, Dr. Cohn held the title of emeritus chairman and emeritus professor of surgery at the Louisiana State University (LSU) School of Medicine, New Orleans. His impact on the School of Medicine was enormous.

Dr. Cohn’s education started in New Orleans at the preparatory Isidore Newman School and included a protracted tenure at the University of Pennsylvania, Philadelphia, where he received his undergraduate and his medical degrees. He completed surgical training at that institution, returning to New Orleans in 1952 to pursue a career in academic surgery.

James D. Rives, MD, FACS, then chairman of the department of surgery at LSU, recruited Isidore with the intent of developing a research arm for the department of surgery. In 1962, Dr. Cohn succeeded Dr. Rives as chairman of the department of surgery, a position that he held for 27 years. At that time, and even today, his was one of the longest tenures of a chairman at any major department of surgery in the U.S. Concurrently, he served as chief of the LSU service at Charity Hospital in New Orleans.

In these roles, he influenced thousands of medical learners. More than 300 surgical residents completed their training under Dr. Cohn. The James D. Rives Surgical Society—subsequently renamed the Isidore Cohn Jr.–James D. Rives Surgical Society—raised money to establish the first $1 million endowed chair. The Isidore Cohn, Jr., MD, Professor and Chair position was formally established in 1989. I had the honor of being the first occupant of that position. This society spearheaded the development of the Isidore Cohn, Jr., MD, Student Learning Center, which continues to function as a state-of-the-art surgical training facility.
The lasting impact that Dr. Isidore Cohn, Jr., had on surgery and New Orleans was remarkable.

**Recognition in career and community**

Dr. Cohn’s skill was acknowledged by numerous awards and his election to numerous leadership positions. A Fellow of the American College of Surgeons (ACS) since 1954, he served on the Board of Governors starting in 1985 and chaired that body from 1990 to 1991. He was elected First Vice-President of the ACS in 1993. He was Chair, Committee on Chapter Relations (1990), and served on the Advisory Councils for Surgical Specialties (1986–1991).

He also was elected president of the New Orleans Surgical Society (1967), Surgical Association of Louisiana (1968), Southeastern Surgical Congress (1972), and Southern Surgical Association (1982–1983).

Furthermore, Dr. Cohn was honored with the Founders Medal of the Society of Surgeons of the Alimentary Tract and the Spirit of Charity Award from the Medical Center of Louisiana (2002). He was awarded an honorary Doctorate of Humane Letters from the University of South Carolina (1995), the Outstanding Alumnus of the Isidore Newman School (2003), the Tzedakah Award from the Jewish Endowment Foundation of Louisiana (2009), the Chairman’s Award from the Arts Council of New Orleans (2012), and the Isaac Delgado Award from the New Orleans Museum of Art.

**Legacy**

The truest legacy of an individual is not the feats he accomplishes during his time on this earth, but the impact that lives on after he is gone. It also is true that substantial parts of this legacy are those lessons learned through the example the individual sets. Such lessons we have learned are awakened and punctuated by the sense of loss that we feel for the deceased.

The lasting impact that Dr. Isidore Cohn, Jr., had on surgery and New Orleans was remarkable. He is greatly missed.

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**January 17 deadline for 2016 ACS NSQIP National Conference abstracts**

The deadline for submitting abstracts for presentation at the 2016 American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP®) National Conference, July 16–19 at the Hilton San Diego Bayfront, CA, is Sunday, January 17.

The conference will provide a forum for the exchange of the most current information regarding national and local surgical quality initiatives, current methods for analyzing and applying ACS NSQIP data, and the management, analysis, and interpretation of the data. A number of breakout sessions will promote an interactive format.

Abstracts that have been submitted or recently presented at meetings are eligible for presentation at the conference. Presentation of a paper at the ACS NSQIP National Conference does not prohibit the presentation or publication of the material elsewhere.

Obtain more information on the conference and submit an abstract online at facs.org/nsqipconference. If you have questions, e-mail nsqipconference@facs.org or call 312-202-5261.
Call for nominations for the ACS Board of Regents and ACS Officers-Elect

The American College of Surgeons (ACS) Nominating Committee will select nominees for leadership positions in the College, as follows.

Call for nominations for the ACS Board of Regents
The 2016 Nominating Committee of the Board of Governors (NCBG) will select nominees for pending vacancies on the Board of Regents that will need to be filled at Clinical Congress 2016. The deadline for submitting nominations is February 26, 2016.

Criteria
The NCBG uses the following criteria when reviewing candidates for potential nomination to the Board of Regents:

• Loyal members of the College who have demonstrated outstanding integrity and medical statesmanship along with an unquestioned devotion to the highest principles of surgical practice.

• Demonstrated leadership qualities that might be reflected by service and active participation on ACS committees or in other components of the College.

• Recognition of the importance of representing all individuals who practice surgery.

• Practice location, surgical specialty, and academic or community practice.

• The College encourages consideration of women and other under-represented minorities.

• All surgical specialties will be considered, although special consideration will be given to general surgery and urology recommendations.

• Individuals who are no longer in active surgical practice should not be nominated for election or reelection to the Board of Regents.

All nominations must include a letter of recommendation, a personal statement detailing the candidate’s ACS service, and the name of one reference. In addition, entities such as surgical specialty societies, ACS advisory councils, and ACS chapters must provide a description of their selection process and a list of all applicants reviewed. Any attempt to contact members of the NCBG by a candidate or on behalf of a candidate will be viewed in a negative manner and may result in disqualification. Applications submitted without the requested information will not be considered.

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

For information only, the current members of the Board of Regents who will be considered for reelection are (all MD, FACS) Margaret M. Dunn, James W. Gigantelli, and Michael J. Zinner.

Call for nominations for ACS Officers-Elect
The 2016 Nominating Committee of the Fellows (NCF) will select nominees for the three Officer-Elect positions of the ACS: President-Elect, First Vice-President-Elect, and Second Vice-President-Elect. These positions will be filled at the Annual Business Meeting of the Members at Clinical Congress 2016. The deadline for submitting nominations is February 26, 2016.

Criteria
The NCF will use the following criteria when considering potential candidates:

• Nominees must be loyal members of the College who have demonstrated outstanding integrity and medical statesmanship, along with an unquestioned devotion to the highest principles of surgical practice.

• Nominees must have demonstrated leadership qualities that might be reflected by service and active participation.
on ACS committees or in other components of the College.

- Members of the Nominating Committee recognize the importance of achieving representation of all who practice surgery.

- The College encourages consideration of women and other under-represented minorities.

All nominations must include a letter of recommendation, a current curriculum vitae, and the name of one individual who can serve as a reference. Nominees for President-Elect also should provide a personal statement detailing service to the ACS.

Further details
In addition, nominating entities, such as surgical special societies, ACS advisory councils, and ACS chapters, must provide a description of their selection process and a list of all applicants reviewed. Applications submitted without the requested information will not be considered.

Nominations may be submitted to officerandbmnominations@facs.org. Any attempt to contact members of the NCF by a candidate or on behalf of a candidate will be viewed negatively and may result in disqualification. If you have questions, contact Betty Sanders, staff liaison for the NCF at 312-202-5360 or bsanders@facs.org.
Nominations for 2016 volunteerism and humanitarian awards due February 29

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 by prospective, planned surgical care to underserved patients with no anticipation of reimbursement or economic gain.

**Humanitarian Award**
The ACS/Pfizer Surgical Humanitarian Award recognizes an ACS Fellow whose career has been dedicated to ensuring the provision of surgical care to underserved populations without expectation of commensurate reimbursement. This award is intended for surgeons who have dedicated a significant portion of their surgical careers to full-time or near full-time humanitarian efforts rather than routine surgical practice. Examples include a career 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.

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YouTube.com/AmCollegeofSurgeons

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

American College of Surgeons
Inspiring Quality:
Highest Standards, Better Outcomes

100 years
The Board of Regents of the American College of Surgeons (ACS) took the following disciplinary actions at its October 3, 2015, meeting in Chicago, IL:

• Konstantino A. Avradopoulos, MD, a general surgeon from Northborough, MA, had his Fellowship placed on probation with conditions for reinstatement. This action was taken following an action by the Massachusetts Board of Registration in Medicine, which placed his license on probation for five years with terms and conditions. The state took action based on an investigation involving his treatment of six patients, which determined that he had not met the standard of care in those cases.

• John E. Fattore, MD, a plastic surgeon from Norwood, MA, had his Fellowship placed on probation with conditions for reinstatement. This action was taken following an action by the Massachusetts Board of Registration in Medicine suspending his license based on a finding that he had committed misconduct in the practice of medicine, practiced medicine deceitfully, engaged in conduct that has the capacity to deceive or defraud, and had engaged in conduct that undermines the public confidence in the integrity of the medical profession.

• A Fellow who is an otolaryngologist–head and neck surgeon from Elkton, MD, was admonished. This action was taken after the Maryland Board of Physicians issued a reprimand due to failure to supervise a certified registered nurse anesthetist and performance of a procedure at a facility that was not properly accredited.

• Richard Ian Reid, MD, an obstetrics and gynecological surgeon currently living and

DEFINITION OF TERMS

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

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

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

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

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

• **Expulsion:** The certificate of Fellowship and all other indicia of Fellowship or membership previously issued by the College must be forthwith returned to the College. The surgeon thereafter shall not explicitly or implicitly claim to be a Fellow or Member of the American College of Surgeons and may not participate as a leader, speaker, or panelist in College programs.
practicing in Edgecliff, New South Wales, Australia, had his Fellowship suspended with conditions for reinstatement. This action was taken following disciplinary actions taken by the State of Michigan and the Australian Health Practitioner Regulation Agency. These actions were taken following allegations expressing concerns about his ability to safely and skillfully practice medicine, constituting incompetence.

• John Wallace Smith, MD, a plastic surgeon from Hoffman Estates, IL, was suspended from the College. This action was taken after the Illinois Department of Financial and Professional Regulation (IDFPR) ordered him to voluntarily relinquish his license after he violated his 2009 probationary agreement with the IDFPR. His license to practice medicine in the State of California was revoked in 2010 based on his conduct in responding to the California investigation and his probation in the state of Illinois. ♦
R. Clement Darling III, MD, FACS, recently was elected vice-president of the Society for Vascular Surgery (SVS). Dr. Darling, who has been active in the leadership of the 5,300-member society for more than 25 years, is board-certified in general and vascular surgery. He is president of the Vascular Group, Albany, NY, which oversees one of the largest vascular care networks in the U.S., encompassing 15 hospitals and 19 vascular surgeons; director of The Institute for Vascular Health and Disease; chief of the division of vascular surgery at Albany Medical Center Hospital; and professor of surgery, Albany Medical College. Dr. Darling has been involved in clinical research throughout his career, participating in more than 60 clinical trials and publishing more than 190 manuscripts in peer-reviewed journals and 100 book chapters. He most recently co-edited the Master Techniques in Surgery: Vascular Surgery, a two-volume text.

G. E. Ghali, MD, DDS, FACS, FRCSEd, professor and chairman, department of oral and maxillofacial surgery, and Jack W. Gamble Chair in Oral and Maxillofacial Surgery, Louisiana State University Health Sciences Center, Shreveport, was inducted into Fellowship ad hominem in the Royal College of Surgeons of Edinburgh (RCSEd) at a diploma ceremony in October 2015. Established in 1505 in Scotland, the RCSEd is among the world’s oldest surgical organizations, and selection into its fellowship is based on professional prominence. Through its worldwide membership, the RCSEd pursues excellence and...
advancement in surgical and dental practice via education, training, and examinations.

After completing his one-year term as president of the SVS, Peter F. Lawrence, MD, FACS, began a one-year term as chair of the SVS Foundation at the society’s 2015 annual meeting in Chicago, IL, in June 2015. The Foundation supports research to improve the quality of vascular patient care. He will then start a three-year renewable term as the senior editor of the *Journal of Vascular Surgery* in July 2016. Dr. Lawrence is Wiley Barker Chief of Vascular Surgery and professor of surgery, University of California-Los Angeles (UCLA) David Geffen School of Medicine and director of the Gonda Vascular Center, Rochester, MN. The UCLA division for which he works has earned $5.5 million from the National Institutes of Health, the Department of Defense, and other organizations to fund research related to aneurysm, limb salvage, and venous disease.

Scott D. Schoifet, MD, FACS, was one of six recipients of the 2015 American Association of Hip and Knee Surgeons (AAHKS) Clinical Research Award. The AAHKS award recognized clinical research on the topic of Liposomal Bupivacaine and Peri-Articular Injection Are Not Superior to Single-Shot Intra-Articular Injection for Pain Control in Total Knee Arthroplasty. The award was presented at the AAHKS annual meeting in November 2015.

Omaida C. Velazquez, MD, FACS, professor of surgery, radiology, and biochemistry and molecular biology, and David Kimmelman Endowed Chair in Vascular and Endovascular Surgery, in August 2015 was named chair of the DeWitt Daughtry Family Department of Surgery at the University of Miami Miller School of Medicine, FL. Dr. Velazquez is the first Hispanic woman to chair a U.S. department of surgery. More than 20 percent of the chairs at the Miller School of Medicine are women, twice as many as in 2006.

Jeffrey J. Wise, MD, FACS, president, Blue Ridge Orthopaedic and Spine Center, Warrenton, VA, received the inaugural North American Spine Society (NASS) Spine Advocacy Award in October. The annual award recognizes NASS members who have contributed significantly to federal advocacy efforts on behalf of patients and members of the society. Dr. Wise led efforts to formalize the advocacy council and became its first official chairman. NASS is a multidisciplinary medical organization that fosters high-quality, evidence-based, and ethical spine care through education, research, and advocacy. ♦
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View webcasts on demand. Individualize your education. Receive a certificate of completion.

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**2015 Complete Package**
Access all 118 webcast sessions from Clinical Congress 2015 and MP3 audio recordings of all Named Lectures and most Panel Sessions. More than 175 CME credits and 175 self-assessment credits are available for practicing surgeons.

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For Practicing Surgeons* For Residents
Member Non-Member Member Non-Member Non-Member/Non-Physician
$575 $625 $275 $325 $375

**2015 Webcast Package**
Access all 118 webcast sessions from Clinical Congress 2015.

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For Practicing Surgeons* For Residents
Member Non-Member Member Non-Member Non-Member/Non-Physician
$475 $525 $225 $275 $325

**Pick 25 of 2015**
Select 25 of the 118 webcast sessions from Clinical Congress 2015.

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For Practicing Surgeons* For Residents
Member Non-Member Member Non-Member Non-Member/Non-Physician
$325 $375 $175 $225 $275

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

For more information, visit [www.facs.org/education/resources/elearning/webcasts](http://www.facs.org/education/resources/elearning/webcasts) or contact Olivier Petinaux at 866-475-4696 or elearning@facs.org.
Report on ACSPA/ACS activities, October 2015

by Fabrizio Michelassi, MD, FACS

The Board of Directors of the American College of Surgeons Professional Association (ACSPA) and the Board of Regents of the American College of Surgeons (ACS) met October 3 at the Hilton Chicago, IL. The following is a summary of their discussions and actions.

ACSPA
At the time of the meeting, the ACSPA’s political action committee (ACSPA-SurgeonsPAC) had raised $390,337 (including both personal and corporate funds) from 1,132 members of the College and staff, with the average contribution totaling $345. Of this amount, $358,003 is personal (hard) dollars and $32,334 is corporate (soft) dollars. Thus far in the 2015−2016 election cycle, SurgeonsPAC has disbursed $334,340 to 96 individual candidates, leadership PACs, and party committees. In alignment with congressional party ratios, 60 percent of these funds went to Republicans and 40 percent to Democrats, with more disbursements planned.

ACS
The directors of the ACS divisions provided updates on their activities. Following are highlights from their reports.

Division of Education
The ACS Division of Education and the MacLean Center for Clinical Medical Ethics at the University of Chicago recently established a new Fellowship in Surgical Ethics. The purpose of the program is to prepare surgeons for careers that combine clinical surgery with scholarly studies in surgical ethics. The inaugural fellow, Regan Berg, MD, entered the program in July 2015. Dr. Berg completed his general surgery training at Queen’s University, Kingston, ON, and then completed three fellowships at the University of Southern California, Los Angeles—the first in surgical critical care, the second in trauma surgery, and the third in hepatobiliary and pancreatic surgery. He is assistant professor of surgery, trauma, acute care, and critical care at Case Western Reserve University, Cleveland, OH. Dr. Berg’s ethics interest area is futility of care, and he will continue in the fellowship program through June 2016. The Fellowship in Surgical Ethics encompasses research, teaching, and clinical ethics consultations and includes bimonthly surgical ethics case conferences, participation in the surgical ethics curriculum, and mentored research in surgical ethics.

Division of Member Services
As of September 1, 2015, the College had 78,623 members: 64,890 Fellows (58,000 U.S., 1,364 Canadian, and 5,526 International); 2,327 Associate Fellows; 9,473 Resident Members; 1,664 Medical Student Members; and 269 Affiliate Members. The 2015 Initiate class totaled 1,679, including 1,228 U.S., 34 Canadian, and 417 International. A total of 354 women and 1,325 men were initiated. Initiate class size continues to rise and is at its highest point since 2001. The Board of Regents accepted resignations from 18 Fellows:

• One cardiothoracic
• Two colorectal
• Three general
• One gynecology (oncology)
• One obstetrics and gynecology
• One orthopaedic
• Five otolaryngology
• One pediatric
• Three urologic

The B/R also approved a change in status from Active (dues paying) to Retired for 65 Fellows, and from Senior (non-dues paying) to Retired for 69 Fellows, for a total of 134 Fellows.

Recruitment and retention activities

• Networking events are planned for Philadelphia, PA, and Seattle,
WA, to engage and recruit young surgeons. A successful event took place in Sacramento, CA, hosted by the University of California-Davis, with 45 attendees representing general surgery, otolaryngology, orthopaedics, neurosurgery, obstetrics/gynecology, ophthalmology, urology, cardiothoracic surgery, and pediatric surgery.

The design and implementation of a specialty-by-specialty recruitment campaign including “Top 10 Benefits” flyers for each specialty, specialty-specific Web pages, and targeted recruitment communications to specialty program directors and ACS specialty Fellows, has been completed.

A new Bulletin column, “Your ACS benefits,” debuted in June to highlight the value of ACS fellowship. This column was created in response to feedback from a member survey conducted in November 2014.

A new international dues structure, which will take effect in 2016, was developed to respond to concerns that the current application fees and dues structure may be inhibitory to surgeons in low-income countries who would like to become Fellows of the College. The B/R approved the new dues structure in June 2015. A communication was sent to all Fellows in mid-September outlining the new dues and fees.

**Chapters**
Chapter Services continues to provide guidance and assistance to the College’s 108 chapters, of which 67 are domestic and 41 are international.

Two new international chapters joined the ACS in 2015—Jordan and Nigeria. Other countries exploring chapter formation include Iraq, the Dominican Republic, Sweden, and Bahrain. Successful regional chapter meetings were held in April with participants from the Latin American countries and in August with the Middle East.

A detailed domestic chapter-by-chapter needs assessment to guide strategic plan development for each chapter is in progress. To further assist the domestic chapters, an association management services pilot program has been launched with several chapters to determine the level of interest in having the ACS assist in administrative matters. Planning also is under way for a Chapter Leader Training Program that will be offered annually beginning in 2016.

**Operation Giving Back (OGB)**
Primary initiatives include redesign of the OGB website and creation of an Advisory Committee.

Girma Tefera, MD, FACS, OGB Medical Director, is reevaluating and reestablishing OGB partnerships and creating new direct relationships with surgical groups in developing countries, nongovernmental organizations that are involved in global outreach programs, and strategic partnerships with organizations such as the World Health Organization. Furthermore, the ACS has completed a member survey to assess engagement and needs relative to volunteerism activities and to develop disaster management, international or domestic volunteerism opportunities, and advocacy rosters. New program areas, such as development of domestic volunteer opportunities, establishment of a humanitarian volunteer boot camp, and collaboration with the military in areas of mutual interest, are priorities.

**Advisory Councils**
The Advisory Councils have been restructured to include pillars aligned with the divisions of the College—Membership, Communications, Advocacy, Quality, and Education. An inaugural meeting of the Advisory Council pillars was convened at the 2015 Leadership & Advocacy Summit, and members of the pillars met again at the Clinical
Congress. Initial meetings have focused on identifying leadership and establishing goals for each pillar.

The Advisory Council for Rural Surgery will host a symposium in April in Chicago. The theme will be Surgical Care of Rural America: Quality Care in the Right Place at the Right Time.

Member benefit flyers for the 12 specialties plus rural surgery were completed earlier this year, and specialty-specific Web pages have been created to include information about the value of membership.

Board of Governors
At present, 273 individuals serve on the ACS Board of Governors (B/G), including 147 Governors-at-Large representing U.S. states and territories and Canadian provinces, 83 specialty Governors representing surgical associations and societies, and 43 international Governors.

The B/G Workgroup on Physician Competency and Health developed a Statement on the Aging Surgeon. The B/R approved the statement at its October meeting (see page 42).

Military Health System Strategic Partnership
David B. Hoyt, MD, FACS, ACS Executive Director, and Jonathan Woodson, MD, FACS, Assistant Secretary of Defense for Health Affairs, signed an agreement at Clinical Congress 2014 in San Francisco, CA, under which the military health system (MHS) and the ACS agreed to share information about the following topics:

- Training and sustainment of trauma surgical skills for military surgeons
- Preparation for disasters and humanitarian missions
- Review of the Department of Defense Combat Casualty Research Program and trauma registry
- Systems-based practice related to surgery in military treatment facilities
- Quality initiatives and databases, including the ACS National Trauma Data Bank®, the Trauma Quality Improvement Program, and the ACS National Surgical Quality Improvement Program (ACS NSQIP®)

The charter outlined the key members of the Executive Leadership Group, to be co-chaired by U.S. Navy Captain Eric Elster, MD, FACS, and Dr. Hoyt. The members of the Executive Leadership Group include key military surgeons; the ACS Governors of the U.S. Army, Navy, and Air Force; and Directors of the ACS divisions most affected by the new charter, including Member Services, Advocacy and Health Policy, Education, and Research and Optimal Patient Care.

This group met for the first time in March 2015 and through a series of brainstorming sessions identified three subcommittees and the focus areas for each panel for the first year’s efforts, as follows.

Education and Training: Co-Chairs Eric A. Ritter, MD, FACS, and Ann G. Rizzo, MD, FACS

- Undertake a needs assessment and codify/memorialize the lessons learned from the previous engagement
- Construct metrics for skills acquisition to measure readiness and effectiveness
- Build on existing efforts to develop a standardized curriculum
- Accredit centers of excellence in education for military, disaster response, and humanitarian efforts

Quality Initiatives: Co-Chairs Paul R. Cordt, MD, FACS, and Pierre F. Saldinger, MD, FACS

- Create a collaborative between the ACS and the MHS that focuses on a shared agenda
Integrate ACS NSQIP and other ACS quality measurement tools into the MHS.

Develop a culture of quality and refine/implement a leadership skill set in collaboration with the Uniformed Services University of the Health Sciences, Bethesda, MD.

Joint Trauma System: Co-Chairs Jay A. Johannigman, MD, FACS, and Jeff A. Bailey, MD, FACS.

Perform a formal ACS Committee on Trauma (COT) systems evaluation of the military’s Joint Trauma System (JTS).

Codify JTS lessons learned and translate applicable lessons to the civilian sector.

Create a proposal for long-term durability of the JTS.

In addition, an Excelsior Surgical Society Committee was formed under the leadership of Gordon G. Wisbach, MD, FACS and Yong U. Choi, MD, FACS. The society held its inaugural meeting at Clinical Congress 2015.

Division of Research and Optimal Patient Care

At present, 664 hospitals participate in ACS NSQIP, of which 591 sites participate in the Adult option. The Essentials option, which is the conventional sampling frame, has the highest enrollment of the adult participation options; however, the Procedure Targeted option is experiencing the highest level of growth. The Pediatric option represents almost 11 percent of overall participation. The following is a breakdown of participating sites by ACS NSQIP option:

- Small and rural: 46
- Procedure targeted: 246
- Essentials: 276
- Measures (National Quality Forum (NQF)-endorsed measures only): 13
- Pediatric: 74

The 2015 ACS NSQIP National Conference took place in July 2015 in Chicago. This was the 10th anniversary of the conference with a record attendance of approximately 1,400 attendees, representing 676 medical institutions and 15 countries.

In spring 2015, The Joint Commission and the NQF presented the ACS NSQIP with the John M. Eisenberg Patient Safety and Quality Award in the category of Innovation in Patient Safety and Quality at the National Level. The Eisenberg Awards recognize major achievements of individuals and organizations in improving patient safety and health care quality, consistent with the aims of the National Quality Strategy—better care, healthy people and communities, and affordable care.

At present, 802 centers participate in the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP). A total of 647 centers are fully accredited and 99 are initial applicants. The remaining 56 centers are data collection sites, which were originally American Society for Metabolic and Bariatric Surgery provisional centers that chose to continue with data entry but did not complete the process to meet full accreditation status. From October 2014 to September 2015, 377 site visits were completed to determine compliance with MBSAQIP standards, and, as of October 2015, 86 more site visits were scheduled in 2015. Nine new surgeon surveyors were trained for the 2015 cycle, for a total of 71 surgeon surveyors.

The ACS continues to develop the Surgeon Specific Registry (SSR) as a tool for individual surgeon data capture. At the time of the meeting, the SSR contained reports from approximately 6,000 surgeons who had submitted at least 20 cases and nearly 6 million records. Surgeons continue to use the registry as a case log system in addition to the other program benefits.

The ACS Clinical Scholars in Residence program is a two-year on-site fellowship in applied surgical outcomes research, health services research, and...
health care policy. Second-year Clinical Scholars in Residence are Elizabeth Berger, MD; Julia Berian, MD; and Michael W. Wandling, MD. First-year scholars are Kristen A. Ban, MD, and Jason Liu, MD.

With respect to ACS Cancer Programs, 1,532 centers in the U.S. and Puerto Rico have received Commission on Cancer (CoC) accreditation. CoC accreditation encourages hospitals, treatment centers, and other facilities to improve their quality of care through various cancer-related programs and activities.

Furthermore, National Accreditation Program for Breast Centers Program accreditation has been awarded to 640 centers in the U.S. Another 31 programs were added as of the October B/R meeting; 32 additional centers were pending survey in late 2015/early 2016. Reaccreditation rates for 2015/2016 remain at 99 percent. Approximately 20 percent of breast centers ask to be surveyed.

Other ACS activities
As of September 2015, more than $3,261,540 had been raised toward the goal of $5 million for the ACS Foundation’s 1913 Legacy Campaign.

In addition to the nearly 400 Scientific Forum abstracts published in the October 2015 supplement of the Journal of the American College of Surgeons (JACS), a total of 374 additional abstracts from Clinical Congress 2015, including Scientific Papers and Scientific Poster Presentations, were published online in JACS and can be accessed via the ACS mobile app. As ACS members increasingly access JACS’ Continuing Medical Education program online, 2015 saw the journal’s highest number of users, with nearly 3,000 individual test takers through the first nine months of the year.

At Clinical Congress 2015, the ACS welcomed the following new Officers and Regents:

**Officers-Elect, 2015–2016**
- President-Elect—Courtney Townsend, Jr., MD, FACS, Galveston, TX
- First Vice-President-Elect—Hilary A. Sanfey, MB, BCh, BAO, MCh, MHPE, FACS, FRCSI, FRCS, Springfield, IL
- Second Vice-President Elect—Mary C. McCarthy, MD, FACS, Dayton, OH

**Board of Regents appointments**
- James C. Denneney, III, MD, FACS, Alexandria, VA
- Timothy J. Eberlein, MD, FACS, St. Louis, MO
- Linda G. Phillips, MD, FACS, Galveston, TX
- Anton N. Sidawy, MD, FACS, Washington, DC

**Board of Governors Executive Committee**
At Clinical Congress 2015, the B/G reelected Fabrizio Michelassi, MD, FACS, New York, NY, to chair its Executive Committee. Diana L. Farmer, MD, FACS, Sacramento, CA, was elected Vice-Chair of the B/G; and Steven C. Stain, MD, FACS, Albany, NY, was elected Secretary.

In addition, the College acknowledges the contributions of the following retiring Regents and Officers:
- Julie A. Freischlag, MD, FACS, Regent and Past-Chair, B/R
- Jay L. Grosfeld, MD, FACS, First Vice-President
- Kenneth L. Mattox, MD, FACS, Second Vice-President
- Raymond F. Morgan, MD, FACS, Regent
- Andrew L. Warshaw, MD, FACS, FRCSI(Hon), President
- Mark C. Weissler, MD, FACS, B/R Chair

We also recognize Carlos A. Pellegrini, MD, FACS, FRCSI(Hon), FRCS(Hon), FRCS(Ed)(Hon), Immediate Past-President, for his invaluable contributions in 2015. ♦
Save Up to $3,762 on Group Long Term Disability Insurance

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

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

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

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

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MEETINGS CALENDAR

Calendar of events*

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

JANUARY 2016

Louisiana Chapter
January 15–17
New Orleans, LA
Contact: Janna Pecquet,
janna@laacs.org,
www.laacs.org

Southern California Chapter
January 15–17
Santa Barbara, CA
Contact: James Dowden,
jdowden@prodigy.net,
www.socalsurgeons.org

FEBRUARY

Montana and Wyoming
Chapter & Idaho Chapters
February 5–7
Sun Valley, ID
Contact: Cyan R. Sportsman,
csportsman@msurgical.com

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

North Texas Chapter
February 19–20
Dallas, TX
Contact: Carrie Steffen,
carrie@stefenmanagement.com,
www.ntexas.org

South Texas Chapter
February 25–27
San Antonio, TX
Contact: Janna Pecquet,
janna@southtexasacs.org,
www.southtexasacs.org

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

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

MARCH

Alberta Chapter
March 15
Calgary, AB
Contact: John Barry Kortbeek,
john.kortbeek@albertahealthservices.ca

FUTURE CLINICAL CONGRESSES

2016
October 16–20
Washington, DC

2017
October 22–26
San Diego, CA

2018
October 21–25
Boston, MA

APRIL

Japan Chapter
April 1
Osaka, Japan
Contact: Kazuhiro Yoshida,
kaz-yoshida@jikei.ac.jp

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

Indiana Chapter
April 22–24
French Lick, IN
Contact: Carolyn Downing,
cdowning@ismanet.org,
www.infacs.org

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

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

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