Committee on Trauma introduces NBATS

Needs assessment tool for trauma centers
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continued on next page
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We are now only a month away from the American College of Surgeons’ (ACS) biggest event of the year—the annual Clinical Congress. The 2016 meeting will focus on the theme chosen by ACS President J. David Richardson, MD, FACS—Challenges for the Second Century.

Clinical Congress 2016, October 16–20 at the Walter E. Washington Convention Center in Washington, DC, will feature several new elements and activities along with the array of educational programs that you’ve come to expect from the premier surgical meeting in the world.

Key events
A highlight of each Clinical Congress is the Convocation Ceremony, at which we welcome new ACS Fellows. This year’s class of more than 1,820 Initiates is expected to be the largest ever. Moreover, the expected number of Initiates and guests attending this year’s Convocation Ceremony is expected to exceed the capacity of the originally planned space, so we are making arrangements to build out the site.

During the Convocation, we also recognize Honorary Fellows, present the Distinguished Service Award, and install ACS Officers, including the new President, who will address the Initiates. In addition, the inaugural Mary Edwards Walker Inspiring Women in Surgery Award will be presented at this year’s Convocation. This award was conceived by the ACS Women in Surgery Committee and will be presented annually to an individual who has made significant contributions to the advancement of women in the field of surgery. Mary Edwards Walker, MD, graduated with honors from Syracuse Medical School in 1855 and went on to serve with the Union Army in the U.S. Civil War. To this day, she is the only woman to have ever received the Congressional Medal of Honor for bravery.

Convocation will take place at 6:00 pm Sunday, October 16, at the Walter E. Washington Convention Center. After the ceremony, Initiates and their guests are invited to attend the President’s Reception for New Fellows in the Grand Lobby of the Convention Center.

The Opening Ceremony, 8:00–9:00 am Monday, October 17, will signal the official start of the Clinical Congress. The Colors and Canadian and American national anthems will be presented, along with a short video highlighting the new President’s theme for the year. The President will lead the ceremony, introducing the Honorary Fellows, the recipient of the Distinguished Philanthropist Award, Past-Presidents, ACS Officers and Regents, invited guests, Resident Research Scholars, and International Guest Scholars.

Scientific program
The Scientific Program kicks off immediately after the Opening Ceremony with the presentation of the Martin Memorial Lecture sponsored by the American Urological Association. This year’s Martin Memorial Lecturer will be Delos M. Cosgrove III, MD, FACS, chief executive officer and president, Cleveland Clinic, OH, who will speak on Transforming Health Care. A total of 10 other Named Lectures will be presented throughout the course of the meeting, featuring a range of highly regarded experts on a variety of topics, including trauma, surgical history, ethics, the basic and surgical sciences, global health care, cancer, and other issues of relevance to surgeons today.

Other Sessions of Special Interest will include programs targeted to residents, medical students, young Fellows, and attendees who want to learn more about surgical history, Operation Giving Back, and financial issues. In addition, this year’s program will include the following three new Special Sessions on timely and important topics:

- Firearm Injury Prevention, 1:00–2:30 pm, Monday, October 17
- ACS Strong for Surgery, 11:15 am–12:45 pm, Tuesday, October 18
- Global Engagement, 11:15 am–12:45 pm, Wednesday, October 19
Because these sessions will take place during the lunch hour, attendees will have an opportunity to purchase a meal before entering the session.

The scientific program is arranged around both thematic and specialty tracks and should afford you ample opportunities to address board requirements for Maintenance of Certification, regulatory mandates, and specific credentialing and privileging requisites. The Clinical Congress will feature 18 Didactic/Experiential and 14 Surgical Skills Postgraduate Courses employing leading-edge education and training methods. A total of 127 Panel Sessions will be presented on a diverse mix of subjects. The Scientific Forum will include surgical research presentations delivered from the podium or as posters, while Video-Based Education Sessions, 32 in all, will showcase surgical procedures. This year's
Clinical Congress 2016, October 16–20 at the Walter E. Washington Convention Center in Washington, DC, will feature several new elements and activities along with the array of educational programs that you’ve come to expect from the premier surgical meeting in the world.

program also will comprise 45 Meet-the-Expert Luncheons and 18 Town Hall Meetings.

During the Clinical Congress, we also will be rolling out a course on bleeding control that is aligned with the Hartford Consensus™ recommendation that members of the public be trained to serve as immediate responders in mass casualty incidents. Through this inaugural effort, we will be presenting the Bleeding Control—Basic course to members of the Board of Regents, Board of Governors, Resident and Associate Society, Young Fellows Association, and Committee on Trauma. Specifically, we will be training these surgeons to train members of the public in essential bleeding control techniques. Some of these participants will then test their ability to pass on these skills to laypeople by having them train a group of high school students. We will use our findings to modify the course as necessary.

Have some fun

Last year the Clinical Congress also included a networking event—ACS Taste of the City, which was well received, with approximately 1,000 participants. This year’s event will focus on the diverse dining and cultural scene in our host city of Washington, DC. Bring your appetite and enjoy live music, activities, and camaraderie with ACS leaders, staff, friends, colleagues, and family members. ACS Taste of the City is open to all attendees at no charge and will take place 5:00–7:00 pm, Wednesday, October 19, at the convention center.

This year’s Congress also will feature a variety of wellness activities, including a Fun Run around the city, early morning yoga, Zumba, and Pilates.

Lastly, I encourage you to bring your family and take the opportunity to explore our nation’s capital (see Figure 1, page 9). Many key attractions are within walking distance of the convention center and hotels, including the Smithsonian Museums; the U.S. Capitol building; the Supreme Court Building; the Holocaust Memorial Museum; the White House; the Washington, Jefferson, and Lincoln monuments; and the Vietnam War, World War II, and Korean War memorials. All Americans should experience these national treasures.

Be sure to visit the College’s Washington, DC, office, the headquarters of our Division of Advocacy and Health Policy, at 20 F Street, NW. And, if you’re looking to immerse yourself in some further scholarly pursuits, head up to nearby Bethesda, MD, to check out the National Library of Medicine on the campus of the National Institutes of Health.

I want to congratulate the members of the Clinical Congress Program Committee, the Advisory Councils, Standing Committees, and Task Forces for developing an outstanding program and to commend the staff for all of their hard work to make this event run smoothly and to meet the needs of our Fellows. We look forward to seeing you in Washington, DC. ♦

If you have comments or suggestions about this or other issues, please send them to Dr. Hoyt at lookingforward@facs.org.
Committee on Trauma introduces needs assessment tool aimed at resolving trauma center debate

by Robert J. Winchell, MD, FACS; Ronald M. Stewart, MD, FACS; and Michelle Price, PhD
A total of 428 U.S. trauma centers have been surveyed and verified by the American College of Surgeons (ACS), which means the College has confirmed the presence of support mechanisms as outlined in the Resources for Optimal Care of the Injured Patient at these facilities.* † In recent years, there has been intense controversy surrounding the number of trauma centers that should be available in a given region, their level of designation, and the designation process. One side argues that trauma centers, especially Level II institutions, have proliferated at an uncontrolled pace. The individuals on this side of the debate argue that this lack of restraint has resulted in an oversupply of care in specific areas, increased spending, and enhanced competition between centers, thereby destabilizing the system as a whole.

Individuals on the other side of the debate maintain that the new centers fill a perceptible community need and that the decision for a hospital to become a trauma center is the prerogative of the individual institution. According to the individuals who hold this view, any hospital capable of meeting the standards should be free to pursue trauma center designation.

To assist in resolving this debate, the ACS Committee on Trauma (COT) has taken two significant steps in recent years: (1) released a position statement on trauma center designation, and (2) developed a new instrument to measure the trauma center needs of the various regions in the U.S. This article focuses largely on this tool—the ACS Needs Based Assessment of Trauma Systems (ACS NBATS).

**COT position statement**

In 2014, the ACS COT developed and the ACS Board of Regents approved a Statement on Trauma Center Designation Based upon System Need, which was published in the January 2015 Bulletin.‡ In this statement, the College makes the following assertions: the designation of trauma centers is the responsibility of the lead state or county-level agency; the distribution of trauma centers should be guided by a regional plan based on the needs of the populations served, with health care providers advocating for the collective interests of patients served; and that system needs to be assessed using objective measures of trauma system access, quality of care, trauma-related mortality rates, and system efficiencies.‡ Although the importance of controlling the allocation of trauma centers by the lead governmental entity based on regional population need has been recognized since the 1980s, few trauma systems have been able to meet the criteria outlined in the ACS position statement.
### TABLE 1. NEEDS BASED TRAUMA CENTER DESIGNATION CONSENSUS CONFERENCE PARTICIPANTS

<table>
<thead>
<tr>
<th>Participant</th>
<th>Title (at time of conference)</th>
<th>Affiliation</th>
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COT statement. Therefore, trauma system designation has been driven by individual institutional priorities, and timely access to trauma care has fluctuated with the economic tide. The authors of the statement called for an international group of experts, stakeholders, and policymakers to convene and plan for optimal future regional trauma system development.

Needs Based Trauma Center Designation Consensus Conference

In August 2015, the ACS COT convened the Needs Based Trauma Center Designation Consensus Conference. A broad group of stakeholders involved in the establishment, operation, and designation of trauma centers throughout the U.S. attended the meeting, which featured representatives of national professional organizations, including emergency medicine, prehospital professionals, and surgeons, as well as administrators from individual trauma centers, regional advisory councils, state health and hospital departments, and the national U.S. Department of Homeland Security and U.S. Health and Human Services (HHS) Office of the Assistant Secretary for Preparedness and Response (see Table 1, page 13). The goal of this conference was to review the principles outlined in the ACS COT statement and to begin work on a set of practical methods and metrics to determine a needs based designation of trauma centers that would be broadly accepted.

This diverse group of attendees unanimously supported the concept that trauma center designation within a regional trauma system should be based on the needs of the population served, as outlined in the ACS position statement. The consensus group also unanimously endorsed each of the ACS COT Principles for Trauma Center Designation outlined in Table 2, this page. Furthermore, meeting attendees confirmed the immediate need for a practical tool that draws from existing data and can be used to assist regions that are struggling with the issue of new trauma center designation.

The group collaborated on the development of a tool to assist administrators from various regions in performing a needs assessment and determining the number of trauma centers required to meet patient demand. The conference workgroup was fully cognizant of the challenges involved in this process, not the least of which is a lack of proven metrics that accurately evaluates need. Ultimately, the group determined two goals in developing this tool: (1) to produce a pragmatic and relatively simple instrument that would be based on presently available data, and (2) to start a process that would lead to future improvements and refinements in the approach.

ACS NBATS

The final product—the ACS NBATS tool—is designed to evaluate the need within a particular geographic area, termed a trauma service area (TSA). A TSA can range in size from a small county to a multistate region, and from several thousand to several million people. The assessment tool evaluates the number of centers continued on page 16
### TABLE 3.
**ACS NBATS TOOL**

1. **Population**
   - Total TSA population of less than 600,000: 2 points
   - Total TSA population of 600,000–1,200,00: 4 points
   - Total TSA population of 1.2 million–1.8 million: 6 points
   - Total TSA population of 1.8 million–2.4 million: 8 points
   - Total TSA population of greater than 2.4 million: 10 points
   Points assigned: ____

2. **Median transport times (combined air and ground—scene only, no transfer)**
   - Median transport time of less than 10 minutes: 0 points
   - Median transport time of 10–20 minutes: 1 point
   - Median transport time of 21–30 minutes: 2 points
   - Median transport time of 31–40 minutes: 3 points
   - Median transport time of greater than 41 minutes: 4 points
   Points assigned: ____

3. **Lead agency/system stakeholder/community support**
   Lead agency support for a trauma center (if none exists) or an additional trauma center in the TSA: 5 points
   Trauma System Advisory Committee (or equivalent body) statement of support for a trauma center (if none exists) or an additional trauma center in the TSA: 5 points
   Community support demonstrated by letters of support from 25 percent to 50 percent of city and county governing bodies within the TSA: 1 point
   Community support demonstrated by letters of support from more than 50 percent of city and county governing bodies within the TSA: 2 points
   Points assigned: ____

4. **Severely injured patients (injury severity score [ISS] > 15) discharged from acute care facilities not designated as Level I, II, or III trauma centers**
   - Discharges of 0–200 severely injured patients: 0 points
   - Discharges of 201–400 severely injured patients: 1 point
   - Discharges of 401–600 severely injured patients: 2 points
   - Discharges of 601–800 severely injured patients: 3 points
   - Discharges of greater than 800 severely injured patients: 4 points
   Points assigned: ____

5. **Level I Trauma Centers**
   - For the existence of each verified Level I trauma center already in the TSA: −1 point
   - For the existence of each verified Level II trauma center already in the TSA: −1 point
   - For the existence of each verified Level III trauma center already in the TSA: −0.5 points
   Points assigned: ____

6. **Numbers of severely injured patients (ISS > 15) seen in trauma centers (Level I and II) already in the TSA**
   The expected number of high-ISS patients is calculated as:
   \[
   500 \times (\text{number of Level I and Level II centers in the TSA}) =
   \]
   - If the TSA has more than 500 severely injured patients above the expected number: 2 points
   - If the TSA has 0–500 severely injured patients above the expected number: 1 point
   - If the TSA has 0–500 fewer severely injured patients than the expected number: −1 point
   - If the TSA has more than 500 fewer severely injured patients than the expected number: −2 points
   Points assigned: ____

   The following scoring system shall be used to allocate trauma centers within the TSAs:
   - TSAs with scores of 5 points or less shall be allocated 1 trauma center
   - TSAs with scores of 6–10 points shall be allocated 2 trauma centers
   - TSAs with score of 11–15 points shall be allocated 3 trauma centers
   - TSAs with scores of 16–20 points shall be allocated 4 trauma centers
   If the number of trauma centers allocated by the model is greater than the existing number of trauma centers in the TSA, efforts should be undertaken to recruit and designate additional trauma centers.

   If the number of trauma centers allocated by the model is less than the number of existing trauma centers, the lead agency should not designate additional trauma centers in the TSA.
needed within the TSA, starting from a clean slate and then making adjustments for existing trauma centers (Level I, II, and III) in the TSA. The ACS NBATS tool does not specifically assess the impact of adding an additional center to a TSA, nor does it determine the relative merit of a particular facility becoming a trauma center within the TSA.

The group drafted ACS NBATS (see Table 3, page 15), working from a model first applied in Florida. The group chose this approach because it incorporates the critical data elements that have been considered in other system benchmarking efforts and represented a reasonable starting point. Although the Florida model provided the initial backbone for the ACS NBATS tool, the group intended to use it purely as a starting point and did not seek to recreate the Florida experience with this system.

The ACS NBATS assigns points based upon four elements: population, transport time, community support, and the number of severely injured patients discharged from centers in the TSA that are not Level I, Level II, or Level III trauma centers. This raw score is then adjusted based upon the number of existing Level I, Level II, and Level III centers and the volume of severely injured patients who receive care at those existing centers. The final score provides a guideline for the number of trauma centers needed in the TSA.

The conference participants acknowledged that no clear evidence is available to support the use of any of the specific measures proposed, and, as a result, all recommendations reflect the expert opinion of the convened group, as derived through a deliberative process. The tool itself, along with point assignments for each element and the point totals to determine trauma center need in this draft, are for initial evaluation purposes only. It is anticipated that both the individual element scores as well as the final target ranges will vary depending upon the demographics of the particular TSA (population, population density, size, geography, and so on) and will reflect the balance of priorities within the specific trauma system.

**Next steps**

The ACS COT has endorsed the operational principles summarized in Table 1 as tenets of optimal trauma system function. The ACS NBATS tool is being circulated to a larger audience of stakeholders and groups involved in the trauma center designation process for comment and for initial testing in a range of existing systems in an effort to validate this system and to collect data that can be used to improve and refine the tool. The ACS COT also is working with a handful of states and regions to test the utility of the tool and application of the model with the intent of refining data elements, benchmark levels, and the relative weight of the individual elements to provide the best model performance. It is anticipated that this will be an iterative process. Data collection and analysis is currently under way, and a summary report and version updates are planned by the time of the spring COT meeting in March 2017.

The consensus group is seeking regions willing to participate in the process of analysis and refinement and is seeking stakeholder feedback on the ACS NBATS tool. Contact Maria Alvi, Manager, Trauma Systems and Quality Programs (malvi@facs.org), for additional information or to become part of the evaluation process. An online feedback form is available at facs.org/quality-programs/trauma/tscp/nbats.

At press time, a follow-up meeting of the consensus group was scheduled to convene this year to continue the work of refining the tool and to expand pilot testing.
Before accepting my current position as Congressional Lobbyist for the American College of Surgeons (ACS) Division of Advocacy and Health Policy, I worked as an emergency medical technician (EMT) in Connecticut for six-and-one-half years—so it was a natural fit to focus on trauma policy when I joined the College in October of 2013.

To gain a better understanding of trauma care from the hospital side, I scheduled an observation shift in June at the R. Adams Crowley Shock Trauma Center in Baltimore, MD. Given my EMT background, I had some idea of what to expect from a 24-hour stint at an inner-city trauma center, and yet I was astonished by the volume of patients and the severity of the injuries that kept coming in on a near-constant basis. The evening was filled with patients suffering from gunshot wounds, motorcycle and motor vehicle collisions (MVC), assaults, and, unfortunately, a case of traumatic cardiac arrest. Despite all the tragedy that came through the bay while I was at the Shock Trauma Center, which is affiliated with the University of Maryland Medical Center, I came out of the experience incredibly proud to be an ACS staff member and to work alongside a team of physician and staff advocates who fight daily to create a better health care system.

Although Baltimore has a reputation for being a violent city where traumatic injury is common, the truth is, these events can and do happen throughout the U.S. However, in Baltimore, thanks to a great trauma system, the patients who receive care at Shock Trauma Center have an inherently better chance of survival simply because they live in the state of Maryland. As a health care advocate, the ACS recognizes the need to increase access to quality trauma care for all Americans.

What makes the Shock Trauma Center unique?

As the accompanying article on the ACS Committee on Trauma Needs Based Assessment of Trauma Systems (ACS NBATS) indicates (see page 11), every community is different, and no cookie-cutter solution is likely to improve trauma systems. The Shock Trauma Center...
model of trauma care, however, is one from which we can all learn.

The Shock Trauma Center is designated through the Maryland Institute of Emergency Medical Services as the only Primary Adult Resource Center in the state of Maryland and averages nearly 8,000 patients annually.* This freestanding trauma center encompasses a 13-bay trauma resuscitation unit to manage trauma-activated patients from the entire state of Maryland. This volume of care is supported by a trauma system that uses Maryland State Police helicopters to transport trauma patients throughout the state, and ground units for transport within the vicinity of a trauma center.

Funding for the Maryland trauma system comes from a $17 fee assessed on motor vehicle registrations. This revenue is used to cover the costs of the trauma system, including the Maryland State Police medical helicopter program. In addition, trauma hospitals in the state are divided in an effort to preserve quality and volume at all trauma facilities to ensure all patients are treated at the facility with the most appropriate resources.

**A catalyst for change**

In June, the American Medical Association House of Delegates approved the ACS-led resolution to support the concepts set forth in the Hartford Consensus™, encouraging the education of official first responders (police, fire, emergency medical services) and potential immediate responders (civilian bystanders) about bleeding control and tourniquet use. This type of public education is a revolutionary step in saving lives and turning bystanders of traumatic events into lifesaving heroes. This initiative is just another example of why the ACS is at the forefront of trauma care and why surgeons need to be leaders in advocating for legislation on trauma care funding and systems development.

I finished my observation shift 17 hours before the deadliest mass shooting in U.S. history at the Pulse nightclub in Orlando, FL, on June 12. Thankfully, the Orlando Regional Medical Center, an ACS-verified Level I trauma center, having prepared through drills, was ready. As the hospital was within the immediate vicinity of the scene, several lives were saved. We can't allow tragic events such as this one to act as the catalyst for lawmakers to begin thinking about trauma care—the funding, education, systems planning, and preparation must happen well in advance.

In the last several years, the College has sent a trauma-focused message to Capitol Hill. Now, it’s time for us to bring legislative leaders to our trauma facilities. The only way to truly understand the vital role trauma surgeons and trauma centers play in keeping Americans healthy is to show our leaders this reality firsthand. Outside of health care, it’s difficult for people to think about or plan for a health care emergency, but when the unthinkable happens, it’s imperative to have a well-funded and well-equipped trauma system in place.

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Editor’s note: The American College of Surgeons recently revised its Statements on Principles to include more details about the surgeon’s responsibility in the provision of operative care (see “Section II.D: The operation—Intraoperative responsibility of the primary surgeon”). In light of these revisions, the ACS leadership requested that the Bulletin publish the latest iteration of the Statements on Principles in their entirety.
PREAMBLE

FELLOWSHIP PLEDGE

CODE OF PROFESSIONAL CONDUCT

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VI. REFERENCES

VII. APPENDIX

(These statements were collated, approved by the Board of Regents, and initially published in 1974. They were revised in March 2004 and updated again in April 2016.)
PREAMBLE

Founded to provide opportunities for the continuing education of surgeons, the American College of Surgeons has had a deep and effective concern for the improvement of patient care and for the ethical practice of medicine. The ethical practice of medicine establishes and ensures an environment in which all individuals are treated with respect and tolerance. Discrimination or harassment on the basis of age, sexual preference, gender, race, disease, disability, or religion, are proscribed as being inconsistent with the ideals and principles of the American College of Surgeons.

Applicants for Fellowship are evaluated for professional conduct, established reputation, and ethical standing. At the organizational meeting of the College in 1913, the assemblage strongly endorsed a resolution that Fellows of the College must practice in strict honesty and must avoid any and all forms of fee splitting. Since then, applicants have been denied Fellowship because of unacceptable financial practices or other unethical behavior. Furthermore, Fellows have been disciplined or expelled for violation of the Fellowship Pledge and the Bylaws of the College.

FELLOWSHIP PLEDGE

Recognizing that the American College of Surgeons seeks to exemplify and develop the highest traditions of our ancient profession, I hereby pledge myself, as a condition of Fellowship in the College, to live in strict accordance with the College’s principles and regulations.

I pledge to pursue the practice of surgery with honesty and to place the welfare and the rights of my patient above all else. I promise to deal with each patient as I would wish to be dealt with if I was in the patient’s position, and I will respect the patient’s autonomy and individuality.

I further pledge to affirm and support the social contract of the surgical profession with my community and society.

I will take no part in any arrangement or improper financial dealings that induce referral, treatment, or withholding of treatment for reasons other than the patient’s welfare.

Upon my honor, I declare that I will advance my knowledge and skills, will respect my colleagues, and will seek their counsel when in doubt about my own abilities. In turn, I will willingly help my colleagues when requested.

I recognize the interdependency of all health care professionals and will treat each with respect and consideration.

Finally, by my Fellowship in the American College of Surgeons, I solemnly pledge to abide by the Code of Professional Conduct and to cooperate in advancing the art and science of surgery.
As Fellows of the American College of Surgeons, we treasure the trust that our patients have placed in us because trust is integral to the practice of surgery. During the continuum of pre-, intra-, and postoperative care, we accept the following responsibilities:

• Serve as effective advocates of our patients’ needs

• Disclose therapeutic options, including their risks and benefits

• Disclose and resolve any conflict of interest that might influence decisions regarding care

• Be sensitive and respectful of patients, understanding their vulnerability during the perioperative period

• Fully disclose adverse events and medical errors

• Acknowledge patients’ psychological, social, cultural, and spiritual needs

• Encompass within our surgical care the special needs of terminally ill patients

• Acknowledge and support the needs of patients’ families

• Respect the knowledge, dignity, and perspective of other health care professionals

Our profession also is accountable to our communities and to society. In return for their trust, as Fellows of the American College of Surgeons, we accept the following responsibilities:

• Provide the highest quality surgical care

• Abide by the values of honesty, confidentiality, and altruism

• Participate in lifelong learning

• Maintain competence throughout our surgical careers

• Participate in self-regulation by setting, maintaining, and enforcing practice standards

• Improve care by evaluating its processes and outcomes

• Inform the public about subjects within our expertise

• Advocate for strategies to improve individual and public health through communication with government, health care organizations, and industry

• Work with society to establish just, effective, and efficient distribution of health care resources

• Provide necessary surgical care without regard to gender, race, disability, religion, social status, or ability to pay

• Participate in educational programs addressing professionalism

As surgeons, we acknowledge that we interact with our patients when they are most vulnerable. Their trust and the privileges we enjoy depend on our individual and collective participation in efforts to promote the good of both our patients and society. As Fellows of the American College of Surgeons, we commit ourselves and the College to the ideals of professionalism.
I. QUALIFICATIONS OF THE RESPONSIBLE SURGEON

A. Competencies
A surgeon should acquire and maintain competence in all six necessary general competencies identified by the American Board of Medical Specialties (ABMS) Task Force on Competence and published by the Accreditation Council for Graduate Medical Education (ACGME): 1 patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. A responsible surgeon should demonstrate competence in the following areas:

• Patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of good health

• Medical knowledge of established and evolving biomedical, clinical, and cognate (for example, epidemiological and social-behavioral) sciences and the application of this knowledge to patient care

• Practice-based learning and improvement that involves investigation and evaluation of a surgeon’s patient care, appraisal and assimilation of scientific evidence, and improvements in patient care

• Interpersonal and communication skills that result in effective information exchange and effective interaction with patients, their families, and other health care professionals

• Professionalism manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population

• Systems-based practice, manifested through actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively utilize system resources to provide care that is of optimal value

Maintenance of these competencies requires a commitment to lifelong learning through self-study, formal continuing medical education, and periodic assessment.

B. Commitment to Scientific Knowledge and Research
The surgeon should base care on the best available scientific evidence and should seek and give consultation appropriately. Responsible surgeons should uphold scientific standards, promote research, and create new knowledge and strive for the appropriate use of this knowledge and these findings.

C. Commitment to Maintain Fitness
The surgeon should maintain a satisfactory level of mental and physical fitness. A surgeon who becomes temporarily impaired by illness or injury, chemical dependence, fatigue, or other conditions that affect surgical judgment or performance should arrange for a qualified colleague to assume his or her clinical responsibilities until the impairment has been resolved.

D. Eligibility to Perform Surgical Procedures
The responsible surgeon’s eligibility to perform a surgical procedure is based upon the surgeon’s education, training, experience, and demonstrated proficiency. The surgeon should be a member in good standing of the department or service through which privileges are to be recommended. The granting and continuation of surgical privileges should be based upon the staff member’s qualifications and upon a record of appropriate performance as evaluated by an established peer review mechanism and medical audit process.
Surgeons are expected to study and evaluate new procedures and to become knowledgeable of and proficient with advances that are appropriate. Technical skill alone is insufficient to qualify a surgeon to perform new procedures. Procedural skills should be acquired within the context of in-depth knowledge about the disease to be treated.

E. Educational Requirements

Only qualified surgeons can deliver high-quality surgical care to the sick and injured patient. Qualified surgeons are those physicians who have completed a surgical residency/fellowship approved by the ACGME or the Royal College of Physicians and Surgeons of Canada (RCPSC); are certified or qualified for examination by a surgical board recognized by the ABMS or the RCPSC; and who maintain continuing education and proficiency in their specialty. These qualifications are required for Fellowship in the American College of Surgeons.

Some hospitals permit arrangements through which a staff member can achieve surgical privileges under the tutelage of a qualified surgeon in the operating room without serving in a formal, organized, accredited residency training program. This situation is undesirable, because it frequently results in an inadequately trained physician who may aspire to be a surgeon.

F. Confining Practice within a Specialty

Qualification of a surgeon as a specialist carries the commitment and responsibility to conduct a surgical practice that conforms to his or her defined specialty. The appropriate surgical specialty board recognized by the ABMS or the RCPSC determines a surgeon’s scope of practice. Procedures performed are dictated by the guidelines set by a specialty board. Performing procedures outside of the field defined by a specialty board mandates that the surgeon obtain additional education and experience, as well as any appropriate certification. The College may take disciplinary action against Fellows who engage in surgical procedures outside their scope of practice as previously described or who falsely advertise their training, certification, or experience.

In those instances in which no appropriately trained surgeon is available to perform a necessary procedure, it may be necessary for the surgeon to engage in practice outside of his or her specialty limits. Appropriate consultation and/or assistance should be obtained whenever possible. These decisions must be dictated by what is in the best interests of the patient.

The medical staff and the governing body of hospitals should periodically review the quality, number, and variety of surgical procedures being performed, as well as the surgical referral policies of the staff, to ensure that the practice pattern of the community does not discourage properly trained and qualified surgeons from applying for staff membership. Performance of surgical procedures by those individual who are lacking the proper training should not be a frequent or continuing practice.

G. Surgical Assistants

The first assistant in a surgical operation should be a trained individual who is able to participate in and actively assist the surgeon in completing the operation safely and expeditiously by helping to provide exposure, maintain hemostasis, and serve other technical functions. The qualifications of the person in this role may vary with the nature of the operation, the surgical specialty, and the type of hospital or ambulatory surgical facility.

The American College of Surgeons supports the concept that, ideally, the first assistant at the operating table should be a qualified surgeon or a resident in an approved surgical training program. Residents who have appropriate levels of training should be provided with opportunities to assist and participate in operations. If such assistants are unavailable, other physicians who are experienced in assisting may participate.

It may be necessary to have nonphysicians serve as first assistants. Surgeon assistants (SAs) or physician assistants (PAs) with additional surgical training should meet national standards and be credentialed by the appropriate local authority. These individuals are not authorized to operate independently. Formal
application for appointment to a hospital as a SA or PA should include the following qualifications and credentials:

- Specification of which surgeon the applicant will assist and of the duties that will be performed.
- Indication of which surgeon will be responsible for the supervision and performance of the SA or PA.
- Review and approval of the application by the hospital board.
- Registered nurses with specialized training also may function as first assistants. If such a situation should occur, the size of the operating room team should not be reduced; the nurse assistant should not simultaneously function as the scrub nurse and instrument nurse when serving as the first assistant. Nurse assistant practice privileges should be granted based upon the hospital board’s review and approval of credentials. Registered nurses who act as first assistants must not have responsibility beyond the level defined in their state nursing practice act.

Surgeons are encouraged to participate in the training of allied health personnel. Such individuals perform their duties under the supervision of the surgeon.

II. RELATION OF THE SURGEON TO THE PATIENT

A. Informed Consent

Informed consent is more than a legal requirement. It is a standard of ethical surgical practice that enhances the surgeon/patient relationship and that may improve the patient’s care and the treatment outcome. Surgeons must fully inform every patient about his or her illness and the proposed treatment. The information must be presented fairly, clearly, accurately, and compassionately. The surgeon should listen carefully to understand the patient’s feelings and wishes and should answer all questions as accurately as possible. The informed consent discussion conducted by the surgeon should include:

- The nature of the illness and the natural consequences of no treatment.
- The nature of the proposed operation, including the estimated risks of mortality and morbidity.
- The more commonly known complications, which should be described and discussed. The patient should understand the risks as well as the benefits of the proposed operation. The discussion should include a description of what to expect during the hospitalization and posthospital convalescence.
- Alternative forms of treatment, including nonoperative techniques.
- A discussion of the different types of qualified medical providers who will participate in their operation and their respective roles.

The surgeon should not exaggerate the potential benefits of the proposed operation nor make promises or guarantees. For minors and incompetent adults, parents or legal guardians must participate in the informed consent discussion and provide the signature for elective operations. Any adequately informed, mentally competent adult patient can refuse any treatment, including operation. When mentally incompetent patients or the parents (guardians) of minors refuse treatments, jeopardizing the patient’s best interests, the surgeon can request legal assistance.

When patients agree to an operation conditionally or make demands that are unacceptable to the surgeon, the surgeon may withdraw from the case.

B. Scope of Surgical Care

Surgical care includes providing preoperative diagnosis and care, educating the patient about the risks and benefits of operation and obtaining informed consent, selecting and performing the operation, and providing postoperative surgical care.

C. Preoperative Diagnosis and Care

Because a team of specialists undertakes much of modern patient care, nonsurgeon physicians often
may conduct the initial evaluation of patients. However, the surgeon bears the ultimate responsibility for determining the need for and the type of operation. In making this decision, the surgeon must give precedence to sound indications for the procedure over pressure by patients or referring physicians or the financial incentive to perform the operation. The surgeon is responsible for the patient’s safety throughout the preoperative, operative, and postoperative period, including ensuring the elimination of risk of wrong site, wrong procedure, and wrong patient surgery.

D. The Operation—Intraoperative Responsibility of the Primary Surgeon

General Statement
The primary attending surgeon is personally responsible for the patient’s welfare throughout the operation. In general, the patient’s primary attending surgeon should be in the operating suite or should be immediately available for the entire surgical procedure. There are instances consistent with good patient care that are valid exceptions. However, when the primary attending surgeon is not present or immediately available, another attending surgeon should be assigned to be “immediately available.”

The definitions at the end of this Statement provide essential clarification for terms used herein.

Concurrent or Simultaneous Operations
Concurrent or simultaneous operations occur when the critical or key components of the procedures for which the primary attending surgeon is responsible are occurring all or in part at the same time. The critical or key components of an operation are determined by the primary attending surgeon. A primary attending surgeon’s involvement in concurrent or simultaneous surgeries on two different patients in two different rooms is inappropriate.

Overlapping Operations
Overlap of two distinct operations by the primary attending surgeon occurs in two general circumstances. The first and most common scenario is when the key or critical elements of the first operation have been completed, and there is no reasonable expectation that the primary attending surgeon will need to return to that operation. In this circumstance, a second operation is started in another operating room while a qualified practitioner performs noncritical components of the first operation—for example, wound closure—allowing the primary surgeon to initiate the second operation. In this situation, a qualified practitioner must be physically present in the operating room of the first operation.

The second and less common scenario is when the key or critical elements of the first operation have been completed and the primary attending surgeon is performing key or critical portions of a second operation in another room. In this scenario, the primary attending surgeon must assign immediate availability in the first operating room to another attending surgeon. The patient needs to be informed in either of these circumstances. The performance of overlapping procedures should not negatively affect the seamless and timely flow of either procedure.

Multidisciplinary Operations
Contemporary surgical care often involves a multidisciplinary team of surgeons. During such operations, it is appropriate for surgeons to be present only during the part of the operation that requires their surgical expertise. However, an attending surgeon must be immediately available for the entire operation.

Delegation to Qualified Practitioners
The surgeon may delegate part of the operation to qualified practitioners including but not limited to residents, fellows, anesthesiologists, nurses, physician assistants, nurse practitioners, surgical assistants, or another attending under his or her personal direction. However, the primary attending surgeon’s personal responsibility cannot be delegated. The surgeon must be an active participant throughout the key or critical components of the operation. The overriding goal is the assurance of patient safety.

Procedure-Related Tasks
A primary attending surgeon may have to leave the operating room for a procedure-related task, such as review of pertinent pathology (“frozen section”)
and diagnostic imaging, discussion with the patient’s family, and breaks during long procedures. The surgeon must be immediately available for recall during such absences.

Unanticipated Circumstances

Unanticipated circumstances may arise during procedures that require the surgeon to leave the operating room before completion of the critical portion of the operation. In this situation, a backup attending surgeon must be identified and available to come to the operating room promptly.

Circumstances in this category might include sudden illness or injury to the surgeon, a life-threatening emergency elsewhere in the operating suite or contiguous hospital building, or an emergency in the surgeon’s family.

If more than one emergency occurs simultaneously, the attending surgeon may oversee more than one operation until additional attending surgeons are available.

Surgeon-Patient Communication (see Section II.A.)

The surgical team involved in an operation is dependent on the type of facility where the operation is performed and on the complexity of the surgical procedure. At a freestanding outpatient surgery center, many procedures are performed solely by the primary attending surgeon with no assistant. In contrast, a complex procedure at an academic medical center may involve multiple qualified medical providers in addition to the primary attending surgeon. As part of the preoperative discussion, patients should be informed of the different types of qualified health care professionals who will participate in their operation (assistant attending surgeon, fellows, residents and interns, physician assistants, nurse practitioners, and so forth) and their respective role should be explained. If an urgent or emergent situation arises that requires the surgeon to leave the operating room unexpectedly, the patient should be informed subsequently.

Definitions

In an effort to provide some standardization of nomenclature, the following definitions are provided:

Backup surgeon/surgical attending
The qualified surgical attending who has been designated to provide immediately available coverage for an operation, during a period when the primary surgeon might be unable to fill this role.

Concurrent or simultaneous operations
Surgical procedures when the critical or key components of the procedures for which the primary attending surgeon is responsible are occurring all or in part at the same time.

“Critical” or “key” portions of an operation
The “critical” or “key” portions of an operation are those stages when essential technical expertise and surgical judgment are necessary to achieve an optimal patient outcome. The critical or key portions of an operation are determined by the primary attending surgeon.

Immediately available
Reachable through a paging system or other electronic means, and able to return immediately to the operating room. This term should be defined more completely by the local institution.

Informed consent
Described in American College of Surgeons Statements on Principles II.A.

Multidisciplinary operations
An example of a multidisciplinary operation is a procedure in which a surgeon of one specialty provides the exposure required by a second surgeon who performs the main surgical intervention (such as a general or thoracic surgeon providing exposure for a neurosurgeon or orthopaedist to operate on the spine). Another example would be an operation that requires the involvement of two or more surgeons of different specialties (such as chest wall or head and neck resection followed by plastic surgical reconstruction, face or hand transplantation, and repair of complex craniofacial defects).

“Overlapping or sequenced” operations for surgeons
The practice of the primary surgeon initiating and participating in another operation when he or she has
completed the critical portions of the first procedure and is no longer an essential participant in the final phase of the first operation. These are by definition surgical procedures where key or critical portions of the procedure are occurring at different times.

Physically present
Located in the same room as the patient.

Primary attending surgeon
Considered the surgical attending of record or the principal surgeon involved in a specific operation. In addition to his or her technical and clinical responsibilities, the primary surgeon is responsible for the orchestration and progress of a procedure.

Qualified practitioner
Any licensed practitioner with sufficient training to conduct a delegated portion of a procedure without the need for more experienced supervision and who is approved by the hospital for these operative or patient care responsibilities.

E. Postoperative Care
The responsibility for the patient’s postoperative care rests primarily with the operating surgeon. The emergence of critical care specialists has provided important support in the management of patients with complicated systemic problems. It is important, however, that the operating surgeon maintain a critical role in directing the care of the patient. When the patient’s postoperative course necessitates the involvement of other specialists, it may be necessary to transfer the primary responsibility for the patient’s care to another physician. In such cases, the operating surgeon continues to be involved in the care of the patient until surgical issues have been resolved. Except in unusual circumstances, it is unethical for a surgeon to relinquish responsibility for the postoperative surgical care to any other physician who is unqualified to provide similar surgical care.

If the operating surgeon must be absent during a portion of the critical postoperative period, coverage should be provided by another surgeon who is skilled and who can render surgical care—including reoperation, if necessary—equivalent to that provided by the surgeon who performed the operation. The patient should be informed of this arrangement in advance.

The surgeon’s responsibility extends throughout the surgical illness. When this period has ended, it is appropriate for the surgeon to relinquish the responsibility for management of the patient. When a patient is ready for discharge from the surgeon’s care, it may be appropriate to transfer the day-to-day care to another physician.

F. Continuity of Care of the Surgical Patient
The surgeon will ensure that the surgical patient receives appropriate continuity of care. An ethical surgeon should not perform elective surgery at a distance from the usual location where he or she operates without personal determination of the diagnosis and of the adequacy of preoperative preparation. Postoperative care should be rendered by the operating surgeon unless it is delegated to another physician who is equivalently qualified to continue this essential aspect of total surgical care.

It is recognized that for many operations performed in an ambulatory setting, the pattern of the patient’s postoperative visits to the surgeon may vary considerably; it is, however, the responsibility of the operating surgeon to establish communication to maintain proper continuity of care. Similar circumstances may apply when patients travel great distances for elective surgery.

Emergency surgery performed in locations unusual for the surgeon may be necessary on occasion, but habitual or even frequent performance of operations under these circumstances cannot be condoned. If the condition of the patient permits and additional skills are required, the patient should be transported to a medical center where adequate resources and appropriately trained health care professionals are available.

G. Freedom of Choice
Patients usually choose their surgeons, and surgeons, in turn, may accept or refuse patients. In emergencies or when required by law, the surgeon should provide the needed care and arrange for follow-up care. Certain circumstances (for example, the military and health
maintenance organizations) restrict freedom of choice, and patient and surgeons are assigned. An ethical surgeon should abstain from a system that denies serving the best interests of the patient by refusing referral out of the system.

Freedom of choice means that either the patient or the surgeon may terminate the physician-patient relationship. When a patient exercises this right, the surgeon should transfer copies of the medical record to the new surgeon or another appropriate physician. When a surgeon exercises this right, he or she should notify the patient in writing and provide copies of the medical record to the new surgeon or physician. All parties should cooperate to ensure continuity of care during the transfer.

H. Confidentiality of Medical Records

Patient confidentiality is a fundamental tenet of medical care. The information in the medical record belongs to the patient but is shared with those health care professionals responsible for providing care. However, in most jurisdictions, the records belong to the physician or institution that compiles and maintains them for the caregivers. Access to medical records by caregivers, insurers, government, and other parties places patient privacy in jeopardy. Nevertheless, every health care worker is honor bound to protect patients’ confidentiality. U.S. law—the Health Insurance Portability and Accountability Act (HIPAA), which went into effect April 14, 2003—protects all medical records from unauthorized disclosure. All surgeons in the U.S. are obliged to understand and abide by HIPAA regulations. HIPAA provides for the use of medical information in the public interest—for example, reducing public health risks and accumulating vital statistics.

Surgeons should avoid disclosing identifiable health care information to any person without authorization from the patient. Also, discussion of identifiable patient information in public places is unethical.

I. Conflict of Interest

The physician-patient relationship requires that the patient’s interests supersede all other interests, including the personal and financial interests of the surgeon, the corporate and financial interests of the payor, and the corporate and financial interests of all vendors including pharmaceutical companies and the manufacturers of instruments, equipment, prosthetic devices, supplies, and services. Modern marketing strategies and tactics place extraordinary pressure on surgeons. Surgeons must strive to maintain the knowledge, insight, and discipline required to keep the patient’s interests above all others.

J. Unnecessary Operations

No operation should be performed without suitable justification. It is the surgeon’s responsibility to perform a careful evaluation, including consultation with others when appropriate, and to recommend surgery only when it is the best method of treatment for the patient’s problem.

K. Quality Assurance

Quality assessment and improvement have become integral concepts in the effort to improve patient outcome. Hospitals have established formal committees to assess and improve the quality of patient care. Fellows are strongly encouraged to be actively involved as leaders of quality assessment and improvement activities in their own hospitals.

L. Surgical Fees

In the U.S., government and private insurance carriers establish many professional fee schedules. Payments for services may require documentation. Surgeons should accurately document services in compliance with government standards.

Fellows of the College are urged to hold to the traditional principles of ethics and compassion in providing patient care and must not participate in any arrangements that encourage unnecessary operations or referrals made primarily for reasons other than optimal patient care.

Surgeons provide many uncompensated services, particularly when patients are unable to pay. If the surgeon expects the patient to personally pay a fee, he or she or a qualified representative should discuss the fee with the patient before the operation. Fees should be commensurate with services rendered and may be related to the economic status of the patient.
III. INTERPROFESSIONAL RELATIONS

A. Surgeons and Colleagues
The surgeon's relationship with colleagues is often an important part of ensuring the best care is provided to the patient. No single physician or surgeon can be an expert in all areas of medicine. Team medicine has become the norm, and surgeons have a responsibility to work with colleagues.

Surgeons who have intimate personal relationships with individuals at their workplace should seek to minimize their supervisory responsibilities with those individuals and should excuse themselves from the evaluation process.

B. Discrimination or Harassment
The ethical practice of medicine establishes and ensures an environment in which patients, staff, colleagues, students, residents, and all other individuals are treated with respect and tolerance. Discrimination, harassment, or creation of a hostile working environment on the basis of personal attributes, including but not limited to age, sexual preference, gender, race, disease, disability, or religion, is inconsistent with the ideals and principles of the American College of Surgeons.

C. Consultations
The surgeon is responsible for obtaining consultation for his or her patients when appropriate, and for providing consultation for the patients of colleagues when requested. These consultations may be for opinion only, to assist with management, or for the transfer of care. The patient should be informed in any instance that requires such a consultation. An appropriate report that is, by letter or by placement in a common chart or medical record, should be made available to the referring physician.

D. Payment
Payment of any kind, or by any method, by the surgeon to a referring physician to induce referral of a patient (fee splitting) is unethical (and usually is illegal). Although a number of practices and procedures that represent modified and subtle forms of fee splitting now exist, surgeons are responsible for recognizing and avoiding them.

Payment to another physician for required assistance that is provided at operation may be made properly to that assistant by the patient. The patient should be informed of the nature and amount of the payment. The means and mechanisms of such payment may be dictated by certain contractual obligations of the patient and the surgeon.

E. Relationships to Nonphysicians
Dentists, podiatrists, and chiropractors are on staff at many institutions and may ask a surgeon to assist in the management of their patients. The surgeon, as always, must be guided by the overriding principle that the patient’s best interests are to be served.

Dentists
Many oral surgeons possess MD and DDS degrees, and dental surgery has expanded to include maxillofacial surgery. In the care of patients with injuries or lesions that involve complicated dental surgical problems, oral surgeons may be an essential part of the surgical team and may act independently in the area of their special competence. In the hospital setting, oral surgeons and other dentists may be included as members of the department of surgery.

Podiatrists
In many hospitals, licensed podiatrists may admit patients in collaboration with physicians who will assume responsibility for the overall care of the patient. Such an arrangement must be under the supervision of the collaborating physician, with the type and extent of their operative procedures determined by the institution’s credentialing process.

Chiropractors*
The American College of Surgeons declares that, except as provided by law, there are no ethical or collective impediments to full professional association and cooperation between doctors of chiropractic and medical practitioners.

*Adopted pursuant to settlement agreement in Wilk et al v. AMA et al, September 1987. See the Appendix for full text.
physicians. Individual choice by a medical physician to voluntarily associate professionally or otherwise cooperate with a doctor of chiropractic should be governed only by legal restrictions, if any, and by the individual medical physician’s personal judgment as to what is in the best interests of a patient or patients.

IV. MEDICAL EDUCATION

It is vitally important that the practicing surgeon keep up with changes and advances in the art and science of his or her field of surgery and of medicine in general. To do so, a Fellow of the College should engage in a lifelong program of education and self-assessment.

A. Continuous Medical Education and Professional Development

A Fellow of the College should meet the obligation for continuous education and development using multiple pathways. The goal of continuous education and self-assessment is to assist the Fellow in providing high-quality care to the surgical patient.

The Fellow should engage in continuing educational programs to ensure a high level of skill in the domains of medical knowledge, technical proficiency, professionalism, interpersonal communications, and systems-based practice.

The Fellow may achieve these educational goals by attending programs sponsored by the College or other scientific organizations, through continuing study of current peer-reviewed journals and texts, and through participation in other continuing education programs. Ideally, the Fellow should engage in a variety of educational programs, including, at least once per year, programs that allow an interchange of ideas with faculty and other participants.

Acquisition of skills in new procedures should be fostered by attendance at courses with both didactic and hands-on training sessions. The Fellow should seek appropriate proctoring of cases as new procedures are added to the surgeon’s surgical portfolio. Continuous self-appraisal of surgical outcomes is strongly encouraged, with the goal of improving patient outcomes.

The Fellow will maintain certification by a member board of the ABMS throughout his or her surgical career. Additionally, the College encourages periodic, voluntary self-assessment of medical knowledge by nonproctored testing formats.

B. Students/Residents

It is the responsibility of surgeons, as members of the medical profession, to be “teachers” of patients, medical students, residents, and other health care professionals. Surgeons have a special responsibility to supervise resident training because of the unique characteristics of surgical conditions and operations.

V. SURGEONS AND SOCIETY

A. Surgical Research

Progress in medical care depends on research that often includes an informed collaboration between patients and physicians. Research should be distinguished from innovations that are departures from standard practice. Although new practices that are designed solely to benefit a patient may be described as “experimental” in the sense that they are new and untested, that does not automatically place them in the category of research. Research implies an activity intended to test a hypothesis so that scientific conclusions may be drawn. Research should be conducted under a formal written protocol that sets forth an objective and a set of procedures designed to reach the objective. When an innovation departs significantly from standard or accepted practice, the innovation should become the object of formal research at an early stage to determine its safety and effectiveness. It is the responsibility of individual surgeons and of medical practice committees to see that major innovations are incorporated into formal research protocols.

When applicable, humanely conducted animal studies should precede the testing of new techniques in humans. Before research programs involving human beings are undertaken, an impartial, qualified committee on human investigation should approve the protocol and the process for obtaining informed consent.

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consent. Human research must meet the highest ethical standards. The primary principles of patient autonomy and safety must be preserved. Every patient has the right to understand completely the nature, as well as the risks, of such research activities and has the right to withdraw from the investigation at any time.

B. Scientific Publications
Presentation of results of an investigation must be governed by the principles of ethics. All authors must assume full public responsibility for the material presented. Surgeons should first report research contributions to professional audiences of peers and/or to peer-reviewed scientific publications. Many scientific organizations, scientific publications, and research facilities have rules governing news releases and require that approval be obtained before a news release is distributed to the media. In the event that an individual patient is identified, approval should be obtained from the physician who is providing care for any identified patient, and, equally important, permission should be obtained from the patient. The patient’s right to privacy must be protected.

C. Public Relations
A surgeon’s release of material to communications media or nonprofessional publications should be designated only for education and public information. Such releases must be accurate. They must not convey false, untrue, deceptive, or misleading information through statements, testimonials, photographs, graphics, or other means, and they must contain sufficient supporting material information. Releases must not create unjustified expectations of results. If treatment through a surgical procedure involves significant risks, realistic assessment of the safety and benefit of the procedure must be included, as well as the availability of alternative treatments and their benefits and hazards. Releases must not misrepresent a surgeon’s credentials, training, experience, or ability, and should contain only claims that can be substantiated. If a surgeon is reimbursed or sponsors a communication, that fact must be made clear to the public.

D. Advertising
Advertising is legal; prohibitions of truthful advertising are considered to be restraints of trade. An advertisement may include information about specialty training, board certification, type of practice, office hours, languages spoken, and other such information that might assist the patient in contacting the surgeon. Advertising must be truthful, both in terms of what is said and in what is not said. Similarly, any illustrations or photographs must be truthful. Advertising should not entice patients to undergo operations if better alternative treatments are available.

E. Expert Testimony
When appropriate, physicians have an obligation to testify in court as expert witnesses. Physician expert witnesses are expected to be impartial and should not adopt a position as an advocate or partisan in the legal proceedings. The physician acting as an expert witness must have a current, valid, and unrestricted license to practice medicine in the state, province, or region in which he or she provides surgical services. The physician acting as an expert witness should be familiar with the standard of care provided at the time of the alleged occurrence and should be actively engaged in practice of the specialty or the subject matter of the case during the time the testimony or opinion is provided. The specialty of the physician acting as an expert witness should be appropriate to the subject matter in the case. The physician acting as an expert witness is ethically and legally obligated to tell the truth. Compensation of the physician acting as an expert witness should be reasonable and commensurate with the time and effort given to preparing for depositions and court appearances. It is unethical for a physician acting as an expert witness to link compensation to the outcome of the case.

The American College of Surgeons has a more complete Statement on the Physician Acting as an Expert Witness.

F. Impaired Physicians
It is every surgeon’s responsibility to safeguard patients from harm as a result of the action or decisions of a colleague impaired by illness, aging, or substance abuse. In
addition, there is a collegial and a medical responsibility to assist the impaired colleague in obtaining care, even if the individual must be reported to the appropriate authority to begin the steps toward adequate care.

G. Incompetent Surgeons

When incompetent patient management is recognized, the surgeon’s responsibility is to assist the regular institutional peer review mechanism in remedying the situation. Physical, moral, or mental impairment that renders a colleague incompetent to care for patients, or that is associated with fraud or other malfeasance, should be disclosed to protect patients and society. On the other hand, it is indefensible to disparage the actions, knowledge, or skills of another physician for malicious reasons.

H. Maintenance of Fellowship

Maintenance of Fellowship is jeopardized by infractions of College principles as specified in the Bylaws of the American College of Surgeons. Fellows are expected to report knowledge of violations of these principles or of the Bylaws. When a Fellow is convinced that another Fellow is violating the Fellowship Pledge, the Bylaws of the College, or its principles, a confidential written communication should be sent to the Executive Director of the College. The information so submitted will then be further investigated and processed according to the provisions in the Bylaws.

REFERENCES

APPENDIX

Statement on Interprofessional Relations with Doctors of Chiropractic*

The American College of Surgeons declares that, except as provided by law, there are no ethical or collective impediments to full professional association and cooperation between doctors of chiropractic and medical physicians. Individual choice by a medical physician voluntarily to associate professionally or otherwise cooperate with a doctor of chiropractic should be governed only by legal restrictions, if any, and by the individual medical physician’s personal judgment as to what is in the best interests of a patient or patients. Professional association and cooperation, as referred to above, includes but is not limited to the following:

- Referrals, consultations, group practice in partnerships, health maintenance organizations, preferred provider organizations, and other alternative health care delivery systems

- The provision of treatment privileges and diagnostic services in or through hospital facilities

- Collaboration with doctors of chiropractic in hospital settings where the hospital’s governing board, acting in accordance with the applicable law and that hospital’s standards, elects to provide privileges or services to doctors of chiropractic

- Association and cooperation in hospital training programs for students in chiropractic colleges under suitable guidelines arrived at by the hospital and chiropractic college authorities

- Participation in student exchange programs between chiropractic and medical colleges

- Cooperation in research programs and the publication of research material in appropriate journals in accordance with established editorial policy of said journals

- Participation in health care seminars, health fairs, or continuing education programs

- Any association or cooperation designed to foster better health care for patients of medical physicians, doctors of chiropractic, or both ♦

*Adopted pursuant to settlement agreement in Wilk et al v. AMA et al, September 1987.
Earlier this year, I had the opportunity to participate in my first pediatric surgery mission aboard the Africa Mercy, reportedly the largest nongovernmental hospital ship in the world. During my two weeks aboard the ship, which at the time was docked in Tamatave, Madagascar, I wrote a blog for the Montreal Children’s Hospital of the McGill University Health Centre, QC, called Dispatches from the Africa Mercy.¹,² The following is an edited version of these blog entries.

Dispatch # 1: The end of the earth
February 27

If there is such a place as the end of the earth, it is likely Madagascar. Leaving Montreal, QC, February 24 on a night of freezing rain, I arrive in Paris, France, a few minutes too late to catch my connecting flight to Madagascar. Air France gives me a choice of staying three days in Paris or connecting through three different airlines and two African cities to reach Antananarivo [the capital of Madagascar] almost two days later. Neither option is feasible. I settle on paying an extra fare to reach Tamatave, the port of the Africa Mercy, through a new route, Saint-Denis de la Réunion, a small French territory in the southern Indian Ocean. I arrive in Tamatave 36 hours after leaving Montreal, tired, sleepless, and jetlagged, only to find my luggage missing.

However, my fatigue immediately starts to dissipate upon first glimpse of the ship. As I climb the gangway, I think of the thousands of patients who have climbed these same steps to find hope and healing. I board to find a genuinely warm and welcoming environment. Everyone from the receptionist to the managing director approaches me with warmth and compassion, expressing their gratitude for my decision to join them. All of the staff and health care professionals I meet in my first few hours are resident volunteers on the ship and have been part of this venture for months and years. And they are thanking me for coming for two weeks, which is a truly humbling experience.

Within a few hours, I settle into my cabin, take a tour of the vessel, and complete the embarkation paperwork and emergency training. I already feel like...
part of this community of several hundred people from more than 40 countries, representing different professions, cultures, races, languages, and various denominations, all united by one purpose: serving the least among us.

Dispatch # 2: Can it get any better?
February 29

As I settle in for the night after my first day of work on the *Africa Mercy*, I find myself marveling at what can be achieved when good people commit to a mission, no matter how hard, no matter how challenging. Yesterday, I had a two-hour conversation over coffee with Gary Parker, MD, the chief medical officer of the *Africa Mercy*.

Gary is one of those people who strengthens your faith in humanity. A craniofacial surgeon originally from California, he and his family have called the *Africa Mercy* home for 29 years. His two children were raised on the ship and educated in the vessel’s fully accredited school. Dr. Parker has tackled some of the most difficult craniofacial problems in the world and is probably one of the world’s foremost experts on resection of aggressive tumors and mandibular reconstruction. Yet he exudes humility and expresses a genuine desire to continue to learn from others.

A few hours after meeting Gary, I jump into the operating room (OR) rather unexpectedly. I came here to perform elective operations, but in the late afternoon, my cabin phone rings. Major Christopher Elliott, MD, is on the line. Dr. Elliott is a U.S. Army Medical Corps surgeon, and chief of general surgery, Landstuhl Regional Medical Center, Germany, who is using 75 percent of his annual leave time to volunteer on the *Africa Mercy*, leaving a big family behind in Germany. We knew we would be here at the same time but were unable to connect before our arrival.

Chris calls to tell me about a little boy who had undergone a hernia repair several weeks earlier by another surgeon and who is back with a recurrent incarcerated hernia. I hurry to the ward to confirm Dr. Elliott’s impression. The child does not look well, and we rush him to the OR. My first procedure on the *Africa Mercy* is an emergency procedure, a great way to
jump head-first into a new OR. All goes well. “Chris, there is no better place for two surgeons to first meet than in the OR,” I tell him.

I awake in the morning to a real treat. Don Stephens, the founder of Mercy Ships, is on board and flying out today. I had read so much about Mr. Stephens when I first learned of Mercy Ships and would recommend his book, Ships of Mercy, to anyone with a desire to see how one person’s dream can translate into something larger than life. I have a brief conversation with Don and take some pictures with him before he leaves the vessel.

The rest of the day is spent in the screening clinic, where I see 35 patients with pediatric surgical problems who were initially screened by nursing staff. These patients are from all parts of Madagascar and are temporarily housed in Tamatave, which is paid for by Mercy Ships. Mirjam Plomp, RN, a young Dutch nurse who has been screening patients throughout the country for more than three years, leads the screening team. Their diagnostic accuracy and appropriate patient selection makes my job easier, and the efficiency of the screening process is amazing. I thought I was going to see patients through the late evening, but we are done by 3:00 pm, and at that point we move on to other matters.

I return to my cabin before dinner for a few minutes of rest to find a very special gift—my luggage has arrived after three days in limbo. Everything is intact, including some surgical supplies I intend to use in my first elective operation tomorrow. Can it get any better?

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**Dispatch # 3: The heroes of Africa**

**March 3**

At the end of the third consecutive operating day, I leave the port of Tamatave for the first time to have dinner at one of the local restaurants with Heuric Rakotomalala, MD, one of four practicing pediatric surgeons in Madagascar, a country of 24 million people. Dr. Rakotomalala has come to the Africa Mercy to operate with me for three days. In addition to providing me with a chance to collaborate with local surgeons and learn from them, our joint work has very special significance.

In late 2008, I arrived at Montreal Children’s Hospital with an ambitious dream, to integrate a low-income country rotation into our pediatric surgical training program. I felt it would give our fellows a unique perspective on pediatric surgical practice in resource-poor areas of the world and an appreciation of our own resources. With the help of Dan Poenaru, MD, FACS, FRCSC, who had established East Africa’s first pediatric surgical training program in Kijabe, Kenya, we succeeded in creating the rotation and sending Robert Baird, MD, CM, FACS, FRCSC, as our first fellow in 2010. The program then evolved into an exchange of fellows between the Montreal Children’s and Bethany Kids Kijabe Hospitals. Five of our fellows have gone to Kijabe, and we’ve hosted five of theirs. Dr. Rakotomalala was the first graduate of the Kijabe program. Working alongside him on the Africa Mercy in his home country is profoundly satisfying, the fruit of a unique collaboration between North and South.
Dr. Rakotomalala is one of the unsung heroes of Africa, striving to provide pediatric surgical care in the most difficult of circumstances with major deficiencies in equipment, personnel, funding, and resources. Before arriving on the Africa Mercy, he had traveled to several cities to provide care to children who were in need of his expertise. Dr. Rakotomalala's trip back home takes two days on difficult, dangerous, winding roads through this vast country. His commitment to his profession, his patients, and his country are unquestionable.

In addition to his pediatric surgical care services, he adds a unique flavor to all our work, particularly ward rounds. The patients are proud to see one of their own among the surgical team. His ability to speak the Malagasy language helps break barriers. The nursing staff welcomes him warmly and is grateful for his presence. I am comforted having Dr. Rakotomalala with me in the most difficult and challenging cases. In a continent where children die by the thousands every day due to completely treatable surgical diseases and anomalies, Dr. Rakotomalala and other physicians like him are Africa's best hope for improved pediatric surgical care. They are the heroes of Africa.

**Dispatch # 4: The Power of Camaraderie**

**March 5**

The only act in life that requires more trust than a patient surrendering himself or herself to a surgeon is a parent surrendering a child to a surgeon. Every time I take a child from his or her parents, whether it is for a minor procedure or a major intervention, I am cognizant of the awesome responsibility I am carrying, as is the entire surgical team. All of us who work in the OR—surgeons, anesthesiologists, nurses, and respiratory therapists—have pledged to do our best to be worthy of this responsibility. However, it also makes for a stressful environment. Emotions often run high, and the margin of tolerance can be quite narrow.

The OR on the Africa Mercy is not like any OR I have experienced. There is a clear understanding that surgery is at the heart of the Africa Mercy’s mission to serve the forgotten poor of Africa. A deep sense of camaraderie pervades every moment and every action in the OR. This atmosphere is not easy to maintain, since new volunteer surgeons, anesthesiologists, and nurses join and leave every week. Monday starts with a meeting of all OR personnel to welcome new members and Friday starts with the same to bid farewell to those departing. On Tuesday, half an hour is set aside before starting for all those aboard who want to join in devotion, prayer, and reflection. Before we bring in the first patient every morning, we have a group huddle to review all the patients and discuss any anticipated difficulties.

Keeping the same team intact for the entire week on the ship enhances the camaraderie. My three nurses are from the Netherlands, Germany, and New Zealand. They obviously hail from different cultural backgrounds and have different native tongues; however, together they create a wonderful atmosphere in the OR, an atmosphere not just of competence, but also one of pervasive warmth and care for the patient and for the team. By the end of my first day, I truly feel like I have worked with this team for years, like I am among friends. Here, at the bottom of the
world, on a hospital ship, I feel like I am in a familiar environment.

My last case of the week on Friday was exceptionally challenging, a large lymphaticovenous malformation, giving the appearance of a large breast in a pre-teenage boy. He was being ostracized and teased. I proceed with trepidation, knowing it will be difficult and bloody, and the procedure goes exactly as anticipated. But as I successfully complete the operation and put in the last stitch, I look at the team of nurses who have worked so hard, who have skipped their meals and their breaks, who were so profoundly engaged during the most difficult moments of the operation, and I offer them a simple but heartfelt acknowledgement of their sacrifice and skill. I thank them for being who they are and for leaving the comfort of their homes and coming to this ship of mercy docked at the “end of the world” to take care of patients whose language they do not understand and whose culture they do not share—patients who had no other options. The personnel of the Africa Mercy OR have taught me many lessons in a single week, the most profound of which is the power of camaraderie.

Dispatch # 5: It takes a Mercy Ship
March 8

Today marks the sixth day after Polly’s operation. She is looking better and better, brighter and brighter. She is her mother’s child, but she is also the child of the Africa Mercy, a testimony to the power of this ship.

Polly is identified by Mercy Ships during one of their screenings far from Tamatave. I find out about her before arriving on the ship. Mirjam, the screening coordinator, sends me her pictures, hoping that a pediatric surgeon might be able to help.

I had opened the electronic file in my office at Montreal Children’s Hospital in a moment of disbelief. The baby had a rare tumor called a sacrococcygeal teratoma, larger than any I had ever seen. She was born in November 2015, and continues to grow and thrive despite this massive tumor on her back, approximately twice the size of her head. I ask Mirjam to get some imaging done, which is accomplished by the ship’s radiology technician, and sent to a radiology group in Canada for review. I receive the report days before I leave for Madagascar. I see no convincing reasons not to attempt removal of this tumor, which will eventually turn malignant and take her life.

Days later, I am face to face with Polly and her mother. I review the imaging and examine the baby. She is beautiful, and it hurts to see her mother struggling to hold her due to the mass, which is now even larger and essentially obliterates her buttocks and lower back. But it is still resectable. I discuss the operation and its potential complications with Polly’s mother. She has no questions. This is the day she has been waiting for since the baby’s birth.

The Africa Mercy operates at a high level of accountability and responsibility. The ship is not an acute care hospital. It does not manage major pediatric congenital anomalies early in life. No tumors like the one Polly had been previously resected on the ship. The
case therefore has to be reviewed by a hospital board to decide whether to take it on. The main concerns are whether this procedure can be done safely and whether the child has a high chance of disabilities that will be unmanageable after the ship’s departure. I point out that this child has already proven her desire to live. She was delivered vaginally without rupture or hemorrhage from the tumor and has thrived and grown despite it. A decision is made to proceed. Together with anesthesia and nursing, we plan every step.

On the day of the operation, I start by placing a subclavian central venous line for access. We proceed slowly and deliberately, one small step at a time. Three hours later, the tumor is out, and Polly has been stable the entire time. We extubate her and send her to the recovery room, where Polly’s mother will see her for the first time without the deformity.

That night, as I head to dinner, I experience the power of the Africa Mercy community. The food servers and cooks, who have nothing to do with the OR, ask me how the operation went. In response to my puzzled look, they tell me that their entire team prayed for her as she was heading into the OR. This experience is repeated throughout the evening as many residents of the Africa Mercy with whom I do not work and had not yet met approach me to ask about Polly and to reassure me that they will continue to pray for her recovery.

In the ensuing days, their prayers are answered. Polly is in a ward of 12 patients sharing a single, large room. The other patients and families rally around her. The nurses take impeccable care of her, attending to her almost hourly to keep the wound clean and dry. On the second day, the drain in Polly’s buttocks is removed. On the third day, her bladder catheter is removed, and her bladder starts to function normally.

Today, her biggest challenge is to satisfy the wishes of all the nurses who want to cuddle her.

What does it take to see hundreds of patients like Polly safely through deforming diseases and severe anomalies? A case like Polly’s requires the following: screening throughout the host country, linking the patient with the appropriate surgeon, transporting the patient and mother to the port city, performing the necessary imaging, hosting the patient in the port city for several weeks pending the surgeon’s arrival, planning responsibly to perform the case safely, providing excellent nursing care, and having an entire community of 420 crew from 40 countries support the mission in faith and prayer. It takes a Mercy Ship.

Dispatch # 6: Jane
March 9

I sit at breakfast about to try a new fruit. I am not exactly sure what it is—maybe a Malagasy pear or apple. But my teeth hit solid rock. Jane White, RN, sitting across from me, shows me a sharp knife and tells me with a gentle smile, “That’s what these are for.” She splits the fruit into two and gives me a spoon. Sweet and sour all at once—passion fruit! Despite coming to Africa for medical missions since 1999, I obviously still have a lot to learn about this continent.

Jane has been my shadow since my arrival. A nurse from Northern Ireland, she is serving her second long haul on the ship. After the first stretch, she returned home. When she wanted to return to the ship and her hospital refused to grant her the leave she needed, she resigned and came back to the Africa Mercy. “This is
where I need to be at this time,” she tells me without hesitation.

Jane is the team leader for the ward nurses—a team leader who is always there, always passionate. I first met her at screening, where she saw all the patients with me, not because she had to, but because she wanted to. That allowed her to know the patients who would be in my care from the first day. She will follow them, facilitate their recovery, decide their disposition, arrange their follow-up, and make sure they get home safely.

There is no such thing as outpatient surgery on the ship. Patients come from all over the country and are housed in the Hope Center, essentially a hotel run by Mercy Ships for patients to stay in while they’re waiting for surgery or recovering from an operation. Every patient stays at least one night on the ship before surgery and one night after surgery. Every morning, I round with Jane and check on all the patients. Jane and I make a plan for the day for each patient, and she sees it through. Every afternoon, when we’re finished in the OR, I round again with her to visit all the patients who will be having an operation the following day. We answer questions. We get consents. We provide reassurance. She gives me updates during the day, whenever needed. Knowing that Jane is there is knowing that everyone will get what they need through their full recovery—impeccable continuity of care.

Jane White is an Africa Mercy nurse and like her colleagues she is multi-talented and multi-gifted. She has decided to put these talents and gifts at the service of those who need her most.

The final dispatch: A vision of mercy
March 11

Dr. Chris Elliott, whom I mention earlier, and I are very different surgeons. He is a military general surgeon who has served in war zones and come face to face with raw violence. I am a pediatric surgeon who practices in the safe and protected environment of a children’s hospital. Despite these differences, we have found much in common, and today there is yet another shared experience. We are both quite emotional, conflicted, and ambivalent as we perform our last operations on the Africa Mercy. We both miss our families, but we both also yearn to spend more time in this healing environment, which is different from any we’ve experienced in our medical careers.

Over the last two weeks on the ship and in its hospital, we have lived with the crew through the high-highs and the low-lows—the triumphs and the losses—the wars won and the battles lost. We have seen them celebrate together and mourn together, and rally to each other’s side during the most difficult of moments.

In our OR hall meeting this morning, my voice cracks as I thank the team who supported me through operations on 30 children. They have done so much for me and have taught me so much. I came here to serve, but I have been served. I came here to give, but in fact, it is I who was on the receiving end. I came here to teach, but I have learned. I came here to heal, but I have experienced healing in the most profound of ways.

I tried to share the story of the Africa Mercy but I have only scratched the surface. You see, the real story of the
Africa Mercy is not just about free surgical care provided to the poorest of Africa’s poor. It is not just about planting hope in the midst of despair. It is not just about capacity building in resource-poor countries. It is not even just about making a difference in the lives of tens of thousands, one life at a time, and one country at a time. The real story of the Africa Mercy is about mercy—a merciful community, diverse and always changing, that has chosen to show its love through its actions. And in a world where evil actions are not only done, but also often publicly celebrated, the people of the Africa Mercy remind us of what we, as humans, can accomplish when we are driven by mercy.

As I get ready to start my long trip home, I will cherish the vision of mercy I have experienced these last two weeks. And if I can apply that lesson in my own life—among my family, my patients, my colleagues—then I will succeed in keeping part of the Africa Mercy experience within me, until I join this loving community again at a new port in a new country.

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REFERENCES

Fellow initiates program to train Future Doctors for South Sudan

by Brittanie Wilczak, MPH

Editor’s note: Many Fellows of the American College of Surgeons (ACS) are actively involved in medical relief organizations. Following is a summary of an interview that Brittanie Wilczak, Program Administrator, Operation Giving Back, conducted earlier this year with Kenneth S. Waxman, MD, FACS, a retired general and trauma surgeon, a Past-Governor of the ACS, and the founder of Future Doctors for South Sudan (FDSS).

What is FDSS?

Founded in 2011, FDSS is a not-for-profit organization that I established to help improve the future of health care in the Republic of South Sudan, the world’s newest nation. The goals of FDSS are to help South Sudan develop a new health care system, to help educate health care professionals by supporting medical education, and to support efforts to develop quality hospitals in the country.

Why did you decide to start FDSS?

After working in South Sudan with Doctors Without Borders in 2010, it became clear to me that a sustainable future for health care in this newly formed, underdeveloped nation will not be based upon expatriate volunteerism. Instead, a new paradigm is needed, one that is led by South Sudanese health care professionals.
How did you become interested in the health care challenges facing South Sudan?

While working as an expatriate provider in South Sudan, I was overwhelmed with the suffering caused by a lack of health care. I have come to the realization that educating health care professionals and working together with South Sudanese leaders to create a vision and plan for a health care system offers the best hope for a brighter future.

What is the health care situation like in South Sudan?

After decades of invasion and war, South Sudan has been left without any semblance of a modern health care infrastructure. There is a terrible shortage of South Sudanese physicians and nurses, and patients have no access to quality secondary or tertiary care hospitals. Expatriate organizations have provided most of the care that is available, but many of these organizations have withdrawn from South Sudan due to ongoing violence and political unrest. The vast majority of the South Sudanese population has no access to quality health care.

What is the ratio of physicians to patients in South Sudan?

There is a severe shortage of medical workers within South Sudan. According to the World Health Organization, there may be as few as one trained physician per 63,574 people.1

What are the predominant health care issues facing South Sudan?

South Sudan faces many health care issues as a result of an intense workforce shortage, poor public health infrastructure, and violent conflict.2,3 Approximately 63 percent of total deaths for all ages and both sexes are due to “communicable, maternal, perinatal, and nutritional conditions,” while injuries and other noncommunicable diseases each account for 10 percent of total deaths for all ages and both sexes.4 Moreover, surgical diseases are ubiquitous, and the use of surgical interventions to treat health-related issues are increasingly in more demand within South Sudan.

How many trips have you personally made to South Sudan?

After traveling to South Sudan as a volunteer for Doctors Without Borders, and subsequently establishing FDSS, I have been to South Sudan on three separate occasions, for as long as three months at a time.

How did you get funding for FDSS?

FDSS is an approved 501(c)(3) not-for-profit organization. We initially relied upon personal funds, but have now received help from dozens of individual donors. At this time, we have not been successful in obtaining

continued on page 46
Malueth was about 19 years old when I met him. (Like most South Sudanese, he does not know his actual date of birth.) Malueth’s father is a tribal leader of a small Dinka village, who raises cattle but has no income. Malueth is a middle child of his mother’s 10 living children, and his father has four other wives, also with multiple children. Because Malueth has so many older siblings, he was not required to tend the cattle, and therefore was allowed to attend primary school. He did so well that he received a scholarship to attend a missionary high school in Kenya, where he became the top student. Upon his return to South Sudan, Malueth was hired by Doctors Without Borders to work as a medical assistant.

Malueth and I worked closely together in Gogrial, a small village, caring for patients and developing policies and procedures for Doctors Without Borders’ new critical access facility in 2010. I was amazed by Malueth’s intelligence, integrity, drive, motivation, and sincere desire to help his community. Malueth also was inspired by the care we were able to provide, and asked me to help him become a surgeon. However, we faced enormous barriers. At present, South Sudan lacks a functional medical education system. Malueth’s excellent academic record would have qualified him to attend medical school in Kenya or Uganda, but the costs were completely prohibitive, and no financial support was available.

I told Malueth that I would raise the funds to support his medical education. This was the beginning of FDSS in 2011. Malueth is now in his fourth year of medical school in Nairobi, Kenya, and is excelling in his studies. He remains passionate about returning to South Sudan to serve his country. Malueth is one of many young Sudanese who have enormous potential to become outstanding doctors. FDSS is committed to identifying as many of these young people as we can, to financing their education, and to supporting and mentoring them as they become the future of health care for South Sudan. ♦
grants from agencies. We continue to struggle to raise sufficient funds to sustain and grow FDSS.

**How many physicians has FDSS trained?**

At present, we are providing financial support for 11 South Sudanese students to attend medical school. We will have our first medical school graduate, a postgraduate student named Ruot, in 2017. We also have a list of more than 20 exceptionally qualified applicants from South Sudan who desire to become doctors through FDSS.

**What educational resources does FDSS use?**

We provide our students with tablet computers loaded with medical textbooks and online reference resources. When our students graduate, we intend to support their postgraduate training, and, at that time, we hope to facilitate access to all of the educational resources that the American College of Surgeons offers.

**Where do you see the health care situation in South Sudan heading in the future?**

The greatest need in South Sudan is to have a vision and plan for a modern health care system. FDSS has been working closely with South Sudanese physician leaders and with the Ministry of Health to plan for development of a tertiary teaching hospital and medical school. We are prepared to begin implementation as soon as the political turmoil in South Sudan allows progress. The first priority must be to develop the hospital and medical school within the country. This facility will serve as a model for high-quality and safe medical care and as a home for medical, nursing, and other professional training and education. A national health care system must also be planned, which will include the development of universal access to care, including prehospital care and transportation. There will be a great opportunity to develop this system using modern technology, such as telecommunication, to provide national connectivity and integration.

**Is FDSS working with any Republic of South Sudan government agencies to achieve this goal?**

FDSS has worked with leaders in the Ministry of Health, medical education leaders, and physician leaders in South Sudan. While at present there is insufficient political stability or resources to implement our plans, we are well-positioned to work together with South Sudanese leaders when the political situation allows progress to occur.

**What advice would you give other health care providers who want to work in South Sudan specifically?**

Clearly, expatriate health care providers can play an important role in South Sudan. However, the greater need is to help develop a sustainable health care system, beginning with educating South Sudanese physicians and other health care professionals. So my advice is to work with groups that make medical education and infrastructure development a priority. Such groups prioritize development of high-quality facilities and
equipment, establishing sustainable pipelines for medications and supplies, and training local surgeons to provide ongoing care.

What are the strengths that Fellows of the ACS have to offer in terms of providing health care to the underserved?

As surgeons, we have a tendency to want to be heroic. That inclination is noble and may feel rewarding, but we should also understand that the impact of providing health care during disasters or unstable political situations is transient. My belief is that our greatest contributions are those that provide education and help local governments develop sustainable solutions.

What’s next for FDSS?

We believe the most pressing need at this time is to support as many South Sudanese students as possible to attend medical school and then to obtain postgraduate training. These individuals will become the doctors who create a better health care future for South Sudan. Financial support for their education is critically needed; FDSS continues its efforts to identify funding sources in order to support more students.

In the meantime, we have great hope that the political turmoil in South Sudan will stabilize, at which point we are well prepared to work with South Sudanese leaders to implement the development of a new tertiary care teaching hospital. From then on, partnerships to help develop clinical programs as well as medical school and surgical specialty training will be invaluable.

REFERENCES

Statement on general helmet use

The American College of Surgeons Committee on Trauma (ACS COT), through its Subcommittee on Injury Prevention and Control, prepared the following statement to educate surgeons about the effectiveness of general helmet usage in preventing severe traumatic brain injury and to encourage surgeons to support appropriate legislation in their respective states. The ACS Board of Regents approved the statement at its June 3–4 meeting in Chicago, IL.

Helmet use is widely accepted as an effective means of preventing severe traumatic brain injury (TBI) in bicyclists and motorcycle riders. Previous ACS statements on helmet use are as follows:

- “Statement on bicycle safety and the promotion of bicycle helmet use,” available at facs.org/about-acs/statements/75-bicycle-safety
- “Statement in support of motorcycle helmet laws,” available at facs.org/about-acs/statements/35-helmet-laws

In addition, there is an increasing appreciation of the significance of concussive injuries and the long-term effects of repetitive trauma to the head. In light of these trends, helmet usage in other recreational activities has become increasingly popular. The ACS supports the following:

- Traditional helmets are designed and tested to protect against severe TBI using primarily linear acceleration models. This strategy may not be the most effective for protection against concussive and repetitive injuries, which have a rotational component.\(^1,2\) We strongly support research in helmet design to specifically evaluate performance in protection against concussive and repetitive injuries.

- Design of head protection should be targeted to the specific activity, age, gender, and level of competition.

- Sufficient data are available to support helmet usage for participants in alpine sports (skiing and snowboarding).\(^3\) Although some data would suggest an increase in risk-taking behavior with helmet usage, the benefit of helmet protection remains strong.\(^4\)

- There is strong support for wearing a motorcycle or motorsports helmet when riding all-terrain vehicles.\(^5\)

Note
The COT finds that, at present, insufficient evidence is available to make any statement regarding helmet usage in specific sports, such as lacrosse and soccer.

REFERENCES
In a seminal symposium on wound management held in the mid-1980s, Gordon R. Tobin, II, MD, FACS, a professor of plastic and reconstructive surgery, University of Louisville, KY, described the goal of all wound management as successful closure of the wound to increase function and to decrease hospital stay and disability. Many wounds have clinical deterrents that inhibit that goal, such as excessive exudate, debris, de-vascularized tissue, bacterial bioburden, and deleterious cytokines. Control of these deterrents helps to move the healing trajectory from impaired toward ideal.

To accomplish the goal of satisfactory wound healing or wound closure, a plethora of medicants, dressings, and devices have been introduced into and placed onto both acute and chronic wounds. Not all of these materials have been innocuous to wound tissue; many have been cytotoxic to fibroblasts, keratinocytes, or other cells in the wound healing process.

A new paradigm
Primum non nocere, which means “above all, do no harm,” is typically attributed to Thomas Sydenham, MD, a physician sometimes known as the English Hippocrates who practiced during the mid-1800s. The admonition of “above all, do no harm” should be a therapeutic imperative for wound care. Based on the principles of not doing harm to the wound, a new paradigm was reported for effective wound healing by simplifying the approach to wound care.

This new paradigm revolves around meticulous wound bed preparation to allow the wound to proceed to endogenous healing or to set the stage for successful wound closure with autologous tissue.
Several new products that remove deterrents to wound healing without adding agents that inhibit healing have been introduced. Antimicrobials that mimic the leukocyte’s oxidative burst to eradicate pathogens, and dressings and devices that can draw debris, bacteria, and harmful cytokines from the wound are replacing agents that are placed into the wound and have harmful side effects. Closure with autologous skin is supplanting skin substitutes. Despite these advances, many aspects of wound healing and wound care have failed to address the directive of primum non nocere.

During a recently held symposium titled Scientific Advances in Wound Care: An Update, which was hosted by the department of surgery at the Uniformed Services University of the Health Sciences and the Walter Reed National Military Medical Center, Bethesda, MD, participants discussed the need for tools to be developed in the areas of inflammation, infection, biomarkers, wound strength, and scarring that could improve outcomes without the addition of injurious agents. In each area, novel approaches could be developed that would do no harm to the wound and allow the healing trajectory to shift from its present compromised position toward a more ideal trajectory as represented by fetal wound healing. It was the opinion of those present, including the panelists, that such approaches should become a therapeutic imperative.

Products used in wound care can be synergistic and designed to aid various acute and chronic wounds to heal without outside interference and without doing any undue harm to healing tissues. The paradigm of “do no harm,” particularly when it comes to wound care, allows surgeons to follow their inherent drive to do what is best for their patients.

REFERENCES
Enormous advances in surgical care have occurred over the last 50 years. Many changes were the result of clinical trials involving human subjects. Experiences such as the Tuskegee Syphilis Experiment identified a need for stringent oversight of human subjects research, while The Belmont Report of 1978 laid out a plan for ethical conduct of clinical trials. Furthermore, the research community has recognized the need for strict oversight of the scientific nature of the trials through the use of good clinical practice. Proper research design ensures that valid scientific information will be obtained as a result of patient participation in clinical trials. It is unethical to conduct a clinical trial if the scientific design precludes obtaining results that can be used to produce generalizable knowledge. As surgeons, we must ensure that our patients receive optimal care. We should seek every opportunity to contribute to the growing body of knowledge to ensure positive outcomes.

**Specific examples**

For patients with breast cancer, an axillary lymph node dissection (ALND) was the standard of care to assess and treat the axillary lymph nodes. In the 1980s and 1990s the possibility that the same diagnostic information could be obtained by sampling select nodes was explored. Early studies by Morton, Giuliano, Krag, and others described the technique of sentinel lymph node (SLN) surgery. To determine whether SLN surgery was as effective as ALND, the SLN surgery had to be tested in a larger group of surgeons. Several authors examined how many SLN operations needed to be performed to ensure that the surgeon was qualified to do the procedure. In clinical trials examining the effectiveness of SLN surgery, it was incumbent on the principal investigator (PI) to establish training and certification processes so that data obtained could be used to make a statement regarding whether SLN surgery was an acceptable alternative to ALND. If the ability of the surgeon to accurately obtain a SLN consistently was in question, meaningful results would not have been obtained. This requirement for training as a requirement for participating in a clinical trial begged the question of whether it was ethical to perform a new procedure on patients before it is an accepted part of routine care.

In 2015, the American College of Surgeons published *Operative Standards for Cancer Surgery*. This book outlines the critical elements in performing cancer operations. Surgeons participating in clinical trials should be familiar with the steps required to perform the operations in a standardized manner. Of course, each patient is different, but the key maneuvers in these standards are applicable in most situations.

**Clinical practice**

It is critical to standardize surgical technique among surgeons who participate in clinical trials. If the technique is new, the investigators must establish training guidelines and a process to monitor surgeon competence in the use of skills that were not developed as part of surgical training. Parameters for how many operations the surgeon is required to perform must be established with assessment of a defined outcome measure. In some cases, certification might be done by submitting a record of operative and pathology results. Alternatively, the surgeon might be required to submit videos that could be reviewed. For other operations, observation by
As surgeons, we must ensure that our patients receive optimal care. We should seek every opportunity to contribute to the growing body of knowledge to ensure positive outcomes.

a proctor can confirm that the surgeon is ready to perform the operation as part of a clinical trial. Techniques and operations that are already part of the surgeon’s skills still need to be assessed to measure the surgeon’s ability to perform the operation in accordance with the requirements of the study. Some of this information might be obtained from case logs of operations done as part of routine clinical care with a measure of outcomes, often including the pathology report. An example may be the percentage of low anterior resections done in which the surgeon and pathologist retrieved 12 lymph nodes. Other outcomes, like patient complications, also may be evaluated.

To maintain the rigor of the study, the PI must budget for training, including providing funds to train sub-investigators or stipends for proctors.

Verification of credentials

Hospitals grant privileges for appropriately credentialed (board-certified or eligible) surgeons to perform operations, and the surgeon’s credentials should be verified. No surgeon should be allowed to perform an operation as part of a research study if he or she is not credentialed to do that operation. For new operations that require training, the institutional review board needs to approve the training and qualification plan, and the hospital needs to be aware and grant a specific privilege for the new skill.

Auditing individual surgeon results

Once the study begins, the PI must audit and monitor the surgical results. Similar to stopping rules for drug studies, rules must be in place to allow removal of a surgeon if he or she is unable to meet the technical requirements needed to ensure patient safety and the integrity of the data. A priori decisions need to be made with regard to whether the data from surgeons who are removed will be used in the final analysis of the results.

After trial completion, a decision needs to be made as to whether the surgeon can offer that operation outside the context of the study. New procedures may or may not become a new standard of practice. The question of what an individual surgeon can do off study, and when, is complex but should be addressed by the PI as well as local hospitals.

Conclusion

Participation in clinical trials requires that surgeons have proven capability and knowledge in the conduct of the research-related operations. Failure to do so may expose patients to risk and compromise the ability of the researcher team to test the study’s hypothesis.

REFERENCES

Excellence of performance will transcend artificial barriers created by man”—such was the counsel of Charles R. Drew, MD, FACS, to his surgical trainees during his tenure as chair of surgery at Howard University’s Freedmen’s Hospital (1941–1950), Washington, DC.* Attendees of the American College of Surgeons (ACS) Clinical Congress 2016 who participate in the Panel Session titled The Enduring Impact of Three African-American Surgical Pioneers, Wednesday, October 19, 12:45–2:15 pm, in Room 206 of the Walter E. Washington Convention Center, Washington, DC, will learn about the enduring, and often underappreciated, contributions of a trio of trailblazing academic surgeons.

This session—which grew out of a discussion between members of the ACS Surgical History Group—will highlight the accomplishments of John Norman, MD, FACS; Asa Yancey, MD, FACS; and Charles Drew, MD, FACS (posthumously). Each of these surgeons was a Fellow of the College, yet many surgeons of all backgrounds and generations are not fully cognizant of the contributions of these notable physicians to the practice of American surgery. Nevertheless, their impact was remarkable by any yardstick—and downright phenomenal given the socioeconomic barriers of the times in which they lived and worked.

Transcending barriers in education
Dr. Yancey personifies the vision Dr. Drew had for his trainees. Born and raised in Atlanta, GA, Dr. Yancey matriculated at Morehouse University (class of 1937),

and in 1941, Dr. Yancey was one of four African-American students in his class at the University of Michigan Medical School, Ann Arbor, where his elder brother, Bernice, graduated from medical school in 1930. After a year of postgraduate military duty, Dr. Yancey went on to train at Freedmen’s Hospital under Dr. Drew for two-and-one-half years, from 1942 to December 1944.

A well-developed obstetrics-gynecology program at Howard left little opportunity for general surgery residents to perform much pelvic and gynecologic surgery. Drs. Yancey and Drew, therefore, felt that additional time at Meharry Medical College, Nashville, TN, would broaden his experience.

Transcending the limits of surgery
Following his time at Meharry, and with Dr. Drew’s support, Dr. Yancey became chief of surgery at the Veterans Administration Hospital in Tuskegee, AL (1948–1958)—an institution that also possessed an excellent veterinary school and animal laboratory. In the laboratory, Dr. Yancey worked on a modification of the Swenson technique (proctectomy with coloanal anastomosis) for congenital megacolon (Hirschsprung’s disease). He would later perform this procedure in a patient, stripping only the rectal mucosa and pulling the sigmoid colon through the seromuscular rectal sleeve and fashioning a coloanal anastomosis. Dr. Yancey published an article describing this technique in 1952 in the *Journal of the National Medical Association*† (a journal that was not carried by most predominately white institutions at the time), some 12 years before Franco Soave, MD, published his surgical series of the modification that bears his name.

As a surgical educator, Dr. Yancey is credited with integrating the medical staff at Grady Hospital and the surgical faculty at Emory Medical School, both in Atlanta. Dr. Yancey also led two training programs for surgeons of color in Alabama and Georgia from the 1940s to 1960s. He is one of the quiet heroes of American surgery. ♦

The Joint Commission Center for Transforming Healthcare’s Oro 2.0 High Reliability Organizational Assessment application is designed to help guide health care organizations on their journey to more predictable and better outcomes. Specifically, the tool is designed to help organizations assess their current level of maturity in 14 areas of performance in the domains of leadership commitment, safety culture, and performance improvement.

The Henry Ford Health System (HFHS), located in Detroit, MI, was one of the first systems to pilot test the tool. Michelle Schreiber, MD, senior vice-president and chief quality officer at HFHS, recently described the organization’s experience using Oro 2.0 in The Joint Commission’s Physician Leader Monthly.*

**HFHS’ first steps toward high reliability**

The Web-based Oro 2.0 is free to hospital and critical access hospital accredited health care organizations. The first step for organizations is a self-administered, anonymous questionnaire that the senior leaders of the organization complete individually. The next step involves a facilitated discussion that brings together the key leaders of the organization to reach consensus on the best answer to each question. The application then assigns a level of maturity for each of the 14 areas of performance based on the answers to the questions.

Dr. Schreiber said that HFHS used the tool to identify the organization’s readiness for the high reliability journey. Leaders in the health system thought it would take the organization to the next level after receiving the 2011 Malcolm Baldrige National Quality Award—the nation’s highest presidential honor for performance excellence through innovation, improvement, and visionary leadership.

HFHS used Oro 2.0 to survey the leadership, including the board of trustees, at the organization’s four acute care hospitals. “Our answers were a pretty broad mix. Many of the questions had a broad range of individual responses, and at the facilitated discussions, there was significant discussion to arrive at a consensus,” Dr. Schreiber said.

“I think this conversation was very important—both in seeing how individuals had answered (using the grouped, anonymous responses) and to discuss openly some of the issues and challenges.”

Dr. Schreiber said the answers and scores, ranging from “advancing” in some areas to “beginning” in others, weren’t all that surprising, as she was anticipating a broad assortment of responses.

**Starting a conversation**

“The most valuable part of the assessment was the conversation itself,” she said. “It is not often that most leadership groups take the opportunity to step back and assess culture as it relates...
“The most valuable part of the assessment itself,” Dr. Schreiber said. “It is not often that most leadership groups take the opportunity to step back and assess culture as it relates to quality and high reliability, and this was a wonderful chance to have a facilitated conversation with real-time answers to important questions and come to a consensus.”

Dr. Schreiber also said that she wondered how the frontline staff would have answered the questions in the survey. “Oro 2.0 is designed for leadership, but I think posing the same or similar questions to frontline staff would provide another level of valuable insight,” she said.

Surgeons see firsthand the results of preventable harm caused to patients; as such, they are a group that can help champion the high reliability cause at their organizations by encouraging leadership to use Oro 2.0.

Dr. Schreiber said she would recommend Oro 2.0 to other organizations. “This was a great opportunity to safely assess the culture of the organization as it pertains to quality and high reliability, including the key components of improving our performance and our value to the customer, our patients,” she said. “I suspect most organizations will find they are at mixed levels of readiness—from ‘beginning’ to ‘advancing’—and no organization in healthcare has likely achieved full high reliability. So, there are opportunities for all to learn.”

For more information about Oro 2.0, visit the Center for Transforming Healthcare’s website at www.centerfortransforminghealthcare.org/oro.aspx.

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

The online Merriam-Webster’s dictionary defines “rush hour” as a time during the day early in the morning or late in the afternoon when many people are driving to or from work—a period of the day when the demands, especially for traffic or a business, are at a peak.* From a trauma mechanism kinematics perspective, motor vehicle-related crashes that occur during a heavy rush hour often result in less severe injuries because the speed at which motor vehicles are traveling is often below the posted speed.

Highway shootings
Unfortunately, during the last year or so in at least one major city, a new mechanism of injury resulting in rush hour fatalities has surfaced—expressway shootings—and these events, unlike other motor vehicle-related injuries occurring at those peak traffic periods, often result in significant injuries.

Entering the search terms “highway shooting,” “expressway shooting,” or “interstate shooting” into a Web search engine will yield more than 500,000 results. Highway and expressway shootings have increased steadily over the last several years. In Chicago, IL, for example, the number of expressway shootings for 2015 more than doubled to 40 from the previous year’s total of 19.† As of June of this year, 21 such shootings had already occurred in Chicago.

It is my observation that, at least initially, roadway shootings typically occurred in the late hours of the night or early in the morning and resulted in the closure of all inbound or outbound lanes to allow for a crime scene investigation. The closure and chaos often allowed the perpetrator a clean getaway. More recently, several shootings have taken place in denser traffic times, including rush hours.

To examine the occurrence of cases involving highway shootings contained in the National Trauma Data Bank® (NTDB®) research dataset admission year 2014, medical records were searched using the International Classification of Diseases, Ninth Revision, Clinical Modification codes. Specifically searched were records that included the location of injury code (E-code) E849.5 (Street and Highway), which would include the subset of highway along with a mechanism of injury that involved a firearm. A total of 9,532 records were found, of which 6,773 records contained a discharge status, including 5,557 patients discharged to home, 516 to acute care/rehab, and 122 sent to skilled nursing facilities; 578 died. Of these patients, 91.4 percent were male, on average 28.1 years of age, and had an average hospital length of stay of 5.7 days, an intensive care unit length of stay of 11.9 days, an average injury severity score of 11.8, and were on the ventilator for an average of 5.8 days (see Figure 1, this page).

A growing problem
Chicago is not alone. This scenario has been playing out in other areas around the U.S., including Arizona, California, Colorado, Florida, Maryland, Michigan, Ohio, Pennsylvania, Texas, Virginia, and Wisconsin, to name a few. Some have been labeled as acts of domestic terrorism, others as the product of gang violence, road rage, and domestic violence. Whatever the reason or wherever you may travel, be aware of this potential hazard that could result in a deadly rush hour.

Throughout the year, we will be highlighting these data through brief reports that will be found 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. In addition, information is available on our website about how to obtain NTDB data for more detailed study. If you are interested in submitting your trauma center’s data, contact Melanie L. Neal, Manager, NTDB, at mneal@facs.org.

Acknowledgment
Statistical support for this article was provided by Chrystal Caden-Price, Data Analyst, NTDB.
Frank G. Opelka, MD, FACS, chosen as 2016 Distinguished Service Award recipient

Frank G. Opelka, MD, FACS, a colon and rectal surgeon and Medical Director, Quality and Health Policy, American College of Surgeons (ACS) Division of Advocacy and Health Policy, Washington, DC, has been selected as the recipient of the 2016 Distinguished Service Award (DSA). He will receive the award, the highest honor bestowed by the College, Sunday, October 16, at the Convocation Ceremony that will precede the official opening of the ACS Clinical Congress at the Walter E. Washington Convention Center in Washington. The award acknowledges Dr. Opelka’s many contributions to the ACS and his accomplishments in the field of surgery.

The ACS Board of Regents is presenting the DSA to Dr. Opelka “in appreciation for his continuous and devoted service as a Fellow of the American College of Surgeons and as the physician leader of the College’s quality and health policy efforts in the Washington, DC, office over the last 15 years.”

Champion of optimal patient care
Dr. Opelka, an ACS Fellow since 1992, has served in his current position in the ACS Washington Office since 2014. As Medical Director, Quality and Health Policy, and in his previous volunteer roles within the organization, he has made strides to improve the ACS’ visibility on strategic committees and organizations. He continues to work with federal agencies to strengthen the College’s influence in health policy decision making. Dr. Opelka has helped the ACS to define issues, develop policies, and apply these positions in regulatory and legislative comments and proposals. His work with federal agencies—including the Centers for Medicare & Medicaid Services, the Agency for Healthcare Research and Quality, the Office of the National Coordinator for Health Information Technology, the Food and Drug Administration (FDA), and the Patient-Centered Outcomes Research Institute—has strengthened the College’s role in promoting optimal surgical care.

Dedicated volunteer
In his nearly 25 years as a Fellow, Dr. Opelka has held leadership positions within the ACS and served as a member of several programs and committees. Dr. Opelka is a Founding Chair of the ACS Patient Safety and Advisory Committee, Co-Chair of the Performance Measures Committee, and a member of the ACS Health Policy Scholars Committee.

Dr. Opelka was a key architect of the ACS Health Information Technology Committee’s efforts to transform health care into a value-based system using high-quality databases. He also served as Chair of the ACS Committee on Patient Safety and Quality Improvement (2006–2010) and has been a member of the General Surgery Coding and Reimbursement Committee (GSCRC) since 2003. In 1992, he began working on the GSCRC, formerly the Socioeconomic Committee, and in this capacity served for 10 years as an advisor to specialty societies on Current Procedural Terminology codes and to the Relative Value Scale.
The ACS Board of Regents is presenting the DSA to Dr. Opelka “in appreciation for his continuous and devoted service as a Fellow of the American College of Surgeons and as the physician leader of the College’s Quality and Health Policy efforts in the Washington, DC office over the last 15 years.”

Update Committee (RUC), a group involving the American Medical Association (AMA) and national medical specialty societies. He led the AMA’s Practice Expense Advisory Committee launch at the RUC.

Dr. Opelka was a key member of the National Quality Forum’s Measures Application Partnership established under the Affordable Care Act. He has assumed leadership positions in all of the national quality improvement efforts, including serving as chair of the AMA Physician Consortium for Performance Improvement, a member of the Quality Alliance Partnership in Healthcare and the Consensus Standards Advisory Committee, and chair of the National Voluntary Consensus Standards for Hospital Care Outcomes and Efficiency.

Dr. Opelka is founder and chair of the Surgical Quality Alliance, which includes surgical specialties societies inside the Washington, DC, beltway. He served as a member of the National Committee for Quality Assurance’s Physician Advisory Committee for the Medical Home and the Committee on Overuse and Appropriateness. Dr. Opelka was co-chair of the Ambulatory Care Quality Alliance Physician Performance Group and served on the United Healthcare Group’s physician advisory committee. He is a director of the Health Care Notification Network, which serves as the FDA’s physician alert system.

A leader at LSU
Dr. Opelka was executive vice-president of the Louisiana State University (LSU) System, Baton Rouge (2012–2016). He was previously vice-chancellor, LSU Health Sciences Center (2008–2012), and before that an associate dean of health care quality and safety and associate dean of clinical affairs at LSU School of Medicine. He served as the chief executive officer of LSU’s HealthCare Network (2005–2006).

He previously worked with the Louisiana Department of Health and Human Services in pursuing statewide initiatives for quality, accountability, and transparency in health care. In addition, Dr. Opelka developed insurance programs for underinsured patients and has helped to establish links for these patients to health care services at LSU. He helped foster a culture of education and graduate medical education by removing burdens of care management from failing hospital systems.

Dr. Opelka was a member of LSU’s electronic health record (EHR) steering committee, which selected and implemented a statewide EHR and information exchange. He worked throughout the state of Louisiana to redesign the LSU health and medical education for the 21st century. Dr. Opelka also served on the Louisiana Health Care Quality Forum and, at the governor’s request, led a redesign of the statewide public hospital system into a public-partnership hospital project that created a cooperative endeavor agreement among nine Louisiana cities.

Before joining LSU, Dr. Opelka worked as the vice-chief of surgery and chief of the division of colorectal surgery, Harvard Medical Faculty and Beth Israel Deaconess Medical Center, Boston, MA.

Hurricane Katrina response
When Hurricane Katrina devastated the city of New Orleans in 2005, Dr. Opelka was part of a response team that moved the entire LSU medical school 70 miles north to Baton Rouge. He worked with the Federal Emergency Management Agency in deploying, in fewer than 28 days, a faculty trailer park, complete with roads, in-ground plumbing, and electricity. Dr. Opelka assisted in the acquisition of a Swedish cruise ship to house the medical residents and students. He then assisted in re-establishing residencies throughout the region. In one month, he worked with
When Hurricane Katrina devastated the city of New Orleans in 2005, Dr. Opelka was part of a response team that moved the entire LSU medical school 70 miles north to Baton Rouge.

others to re-establish an entirely new faculty group practice. One year later, Dr. Opelka assisted in the return of all medical school programs to New Orleans.

**U.S. Army career**

Earlier in his career, Dr. Opelka served in the U.S. Army as a surgeon, Joint Special Operations Command, Fort Bragg, NC (1987−1992); chief of surgery, Bayne-Jones Army Community Hospital, Fort Polk, LA (1990−1992); and chief of ambulatory surgery, Darnall Army Community Hospital, Fort Hood, TX (1986−1990).

In 1988 Dr. Opelka received a Meritorious Service Award from the U.S. Army, and in 1991 he was the recipient of a Desert Storm Combat Service Award.

Dr. Opelka received a bachelor of science degree from St. Mary’s University, San Antonio, TX, in 1977 and pursued his medical education at the University of Health Sciences, Chicago Medical School, IL, graduating in 1981. He completed his residency at Walter Reed Army Medical Center, Washington, DC (1982−1986), and the Eisenhower Army Medical Center, Augusta, GA (1982−1986). He also served as a fellow for one year (1989−1990) at the Oschsner Foundation Hospital, New Orleans.

Dr. Opelka belongs to a number of professional societies in addition to the ACS, including the American Society of Colon and Rectal Surgeons, from which he received the distinguished service award in 1992; the AMA; the Massachusetts Medical Association; and the Healthcare Finance Management Association. He has served as president of the Piedmont Society of Colon and Rectal Surgeons and the New Orleans Surgical Society.

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**Official notice:**

**Annual Business Meeting of Members, American College of Surgeons**

In accordance with Article I, Section 6, of the Bylaws, the Annual Business Meeting of Members of the American College of Surgeons (ACS) is called for 4:15 pm the afternoon of Wednesday, October 19, 2016, at the Walter E. Washington Convention Center, Washington, DC.

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

Edward E. Cornwell III, MD, FACS
Secretary
American College of Surgeons
September 1, 2016
The Board of Governors (B/G) Surgical Volunteerism and Humanitarian Awards Workgroup has announced the recipients of the 2016 American College of Surgeons (ACS)/Pfizer Surgical Humanitarian Award and Surgical Volunteerism Awards. As in previous years, the Workgroup received exceptional nominations, reflecting the remarkable commitment of ACS Fellows to providing care to underserved populations.

The extraordinary contributions of the award recipients are summarized in this article and will be formally recognized at the Clinical Congress 2016 in Washington, DC, during the annual B/G reception and dinner on Tuesday, October 18, at the Marriott Marquis Washington, DC. Clinical Congress attendees are invited to hear the honorees speak at a Panel Session, Humanitarian Surgical Outreach at Home and Abroad: Reports of the 2016 Volunteerism and Humanitarian Award Winners, Monday, October 17, 9:45–11:15 am, at the Walter E. Washington Convention Center, Room 102.

**Surgical Humanitarian Award**

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

*Rebekah A. Naylor, MD, FACS,* a general surgeon from Fort Worth, TX, will receive the Surgical Humanitarian Award for her work in significantly improving and expanding the Bangalore Baptist Hospital (BBH), Karnataka, India, during her 35 years as a medical missionary.

After completing her surgical training at Southwestern Medical Center and Parkland Hospital, Dallas, TX—the first woman resident in general surgery at both institutions—in 1973, she was appointed by the Foreign (now International) Mission Board of the Southern Baptist Convention as a missionary to India. She arrived at BBH in early 1974, where she began a missionary career that included a busy practice schedule, administrative responsibilities, and teaching.

Dr. Naylor began her work as a clinical surgeon at BBH, and in subsequent years became chief of the medical staff, an administrator, and, eventually, the medical superintendent. In her time at BBH, she greatly expanded patient care services, including the growth of the hospital from 80 beds to 160 beds. Today, BBH provides care to approximately 250,000 patients in the hospital and clinics and delivers more than 2,500 babies every year.
In the 1990s, Dr. Naylor organized training programs in four allied health disciplines, set up accredited residency training programs for physicians, and established the Rebekah Ann Naylor School of Nursing. More than 350 nurses have graduated from the school, many of whom are from low-income backgrounds, and 129 of whom are now employed at BBH. Dr. Naylor was engaged in formal teaching roles in all of the aforementioned programs.

In addition to improving the quality and availability of patient care at BBH, from 1999 to 2009 Dr. Naylor was involved in church development in the state of Karnataka. Working with the medical ministry and Indian pastors, she was able to help establish 900 churches in the state of 53 million people.

After returning to the U.S. in 2002, Dr. Naylor joined the faculty of the University of Texas Southwestern Medical Center, Dallas, where she served as clinical associate professor of surgery until her retirement in 2010. As global health care consultant for Baptist Global Response, she now mobilizes and trains health care personnel to meet medical needs worldwide. She continues to make frequent trips to India to participate in the ministry of BBH. Applying lessons learned overseas, she led the founding of Mercy Clinic in 2011, a free clinic for the underserved, uninsured population in south Fort Worth. She continues to serve this organization as board chair.

**Surgical Volunteerism Awards**

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

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**Sandra L. Freiwald, MD, FACS,** general surgeon, Kaiser Permanente Hospital, San Diego, CA, will receive the Domestic Surgical Volunteerism Award for her work with the San Diego County Medical Society Foundation’s (SDCMSF) Project Access San Diego, which enables low-income, uninsured individuals to receive specialty care services at no cost. A surgical champion since 2008 for Project Access, Dr. Freiwald leads a team that organizes the provision of surgical care to San Diego County residents who otherwise would not have access to elective operations.

Since Kaiser Permanente San Diego partnered with SDCMSF in 2008, Dr. Freiwald has led a team for Project Access, and in that time has led 17 Saturday Surgery Days. Offered biennially at a Kaiser Permanente outpatient surgery center, these days allow surgeon volunteers to provide outpatient general surgery.
care, including hernia repairs, cholecystectomies, and anal fistulotomies, to patients who are unable to pay for treatment on their own. Specialists, including ophthalmologists and vascular surgeons, also are involved. Dr. Freiwald facilitates the program, recruiting surgical volunteers, screening patients, and either assisting with or performing select operations. As of the second Saturday Surgery Day in 2015, the program had provided 571 uninsured patients with specialty care.

In addition to her work with SDCMSF, Dr. Freiwald is credited with saving the San Diego Medical Center $2 million to $5 million annually by assisting in the development and implementation of the trauma patient repatriation system. Dr. Freiwald has been involved in international surgical outreach, as well. She spent several months in 2006 and 2007 working as a general surgeon with Médecins Sans Frontiéres (Doctors Without Borders) in Monrovia, Liberia, providing emergency medical care to people affected by war and poverty. She also has participated in medical missions with Project Medishare in Haiti and in Jamaica with Kaiser Permanente Family Medicine Residents on a global health rotation.

Dr. Freiwald is assistant chief of general surgery at Kaiser Permanente San Diego, and subsection head, general surgery department, and chairperson, department of surgery, Palomar Medical School, Escondido. J. Nilas Young, MD, FACS, a cardiothoracic surgeon from Sacramento, CA, will receive one of the two International Surgical Volunteerism Awards for his work in developing, implementing, and sustaining children’s heart surgery programs throughout Russia. Dr. Young’s volunteerism began in 1988, when he was asked to perform pro bono surgery on a seven-year-old Soviet girl with congenital heart disease in an effort to de-escalate Cold War tensions between the Soviet Union and the U.S. Soviet cardiac surgeons had given up hope of saving the girl’s life, but Dr. Young succeeded and was subsequently inundated with requests for help from the parents of sick children throughout the country. Seeing an opportunity to save the lives of many children, Dr. Young cofounded Heart to Heart International Children’s Medical Alliance, where he is medical director. Continuing to work through the political and social unrest that came with the collapse of the Soviet Union in 1991, Dr. Young led Heart to Heart to develop what became known as Russia’s best infant heart surgery program in St. Petersburg. As his positive results became known, the St. Petersburg Ministry of Health asked him to develop surgical care for adult
patients. After developing two self-sustaining heart programs, Dr. Young realized that millions of families remained without care for heart conditions, that a basic medical infrastructure upon which high-quality surgical care could be built was already in place, and that his model had proven successful, cost-effective, and could be replicated and scaled to save thousands of children. Subsequently, in 2002, he started the Into the Heartland Campaign (2002–2019) to give children throughout Russia access to lifesaving surgery.

As Heart to Heart now expands into Latin America—the first programs launched in Lima, Peru, earlier this year—the impact of Dr. Young’s efforts are being felt throughout the world. In his 27 years of volunteer surgery and program building, he has saved the lives of more than 25,000 surgical patients. Dr. Young’s contributions have been multifaceted, as a surgeon, educator, and, perhaps most importantly, a not-for-profit leader focused on building local surgical capacity.

Heart to Heart has been uniquely effective within the international humanitarian community in consistently developing self-sustaining surgical programs, and the outcomes of Dr. Young’s volunteer work through the program are profound. For example, in Municipal Children’s Hospital No. 1 in St. Petersburg, more than 9,000 children have been saved because of his work, and the program has been self-sufficient since 1999. Other successes are evident across Russia, and more are anticipated as the program expands globally.

James A. O’Neill, Jr., MD, FACS, a pediatric surgeon from Nashville, TN, will receive the second International Surgical Volunteerism Award for his work as a clinical surgeon and educator in Kenya, among other locations.

Dr. O’Neill has been involved in medical missions for more than 30 years. His early experience was in Guatemala, where he provided pediatric surgical care, and in China, where he helped to establish a children’s hospital in Shanghai. His greatest contribution to volunteer surgical care, however, began in 2003, when he stepped down as chair of surgery at Vanderbilt University Medical Center, Nashville, TN, to dedicate his work to humanitarian activities. With the help of the ACS Operation Giving Back Program, he began a 14-year effort that has led to long-term projects at two hospitals in Kenya.

That same year, Dr. O’Neill joined a surgical team at the Naivasha District Hospital, sponsored by the Diocese of Joliet, IL. There, he worked as the hospital’s only pediatric surgeon. In addition to his...
significant clinical work, Dr. O’Neill’s efforts have contributed to a range of enhanced capabilities at Naivasha District Hospital, including mechanical ventilation for infants, functioning systems of surgical infection control and quality improvement, development of a trauma service and better organization of trauma care, and improved operating room efficiency.

The primary location of his practice has been in Kijabe Mission Hospital, where, since 2006, he has spent six to eight weeks annually supporting the sole full-time pediatric surgeon at the location. The surgical workload is heavy, with almost half of the patients coming from the United Nations’ Somalian refugee camps near the Kenyan border.

Humanitarian activities have increased in Africa in recent decades, and as College of Surgeons of East, Central, and Southern Africa-approved residency programs have developed, Dr. O’Neill has played a significant role in supporting the pediatric surgery residency program at Kijabe. He has helped to implement a pediatric surgery training program for African surgeons, based on the American model, to address critical surgical workforce shortages in Kenya and throughout Africa. His roles have been clinical, performing many operations himself, as well as didactic, delivering lectures three times per week during his annual residence in Kenya. He has helped to develop a curriculum that includes mock board examinations. Graduates of the pediatric surgery program now hold positions in Kenya, Uganda, Ethiopia, Sierra Leone, and Cameroon.

Barclay T. Stewart, MD, MPH, PhD, a general surgery resident from Beaufort, SC, will receive the Surgical Resident Volunteerism Award for his myriad volunteer efforts to provide care to underserved domestic and international populations through clinical services, research, and advocacy.

While a medical student at the Medical University of South Carolina, Charleston, Dr. Stewart and his colleagues organized the student-run Crisis Ministries Health Clinic for the homeless, which offered primary, basic antenatal care, and diabetic foot care; dental services; and legal assistance. The clinic continues to provide primary care.

In 2005, Dr. Stewart transitioned to global volunteerism, working at an International Rescue Committee hospital in Nepal during the nation’s civil war, assisting the surgeons and staff with burn care, outreach, and burn care education. The following year, he was in Malawi, where he co-created a referral system with condition-specific protocols to improve
the timeliness of care for patients with life-threatening conditions, which resulted in a model for other rural areas.

After completing his master’s in public health, Dr. Stewart was in South Sudan, where he was asked to be the interim coordinator of a joint effort between the Malaria Consortium and the government of South Sudan. The program he ran was responsible for assessing the burden of neglected tropical diseases and delivering drug treatment to millions of people across the war-torn country.

In 2014, Dr. Stewart was awarded a two-year National Institutes of Health/Fogarty Global Health Program for Fellows and Scholars. For the first 18 months, he was in Ghana, where he collected data to integrate surgical, trauma, and burn care into the national health plan. He assessed barriers across the country, described the changing epidemiology of surgical emergencies, developed trauma care quality improvement programs, improved road safety initiatives, and created courses for district hospital staff to improve trauma care standards. He also served as a visiting chief resident in one of Ghana’s largest teaching hospitals, where more than 30,000 operations are performed annually. In addition, Dr. Stewart frequently volunteered with local surgical outreach missions and covered rural hospitals lacking a surgical care provider.

He now volunteers at the World Health Organization in Geneva, Switzerland, where he is helping to create a toolkit for other countries seeking to improve care for surgical patients.

Much of Dr. Stewart’s research is important in documenting the surgical needs of people who live in low- and middle-income countries to serve as an evidence base for advocacy. He has presented these findings at numerous conferences in the U.S. and globally; this work contributed to the community advocacy efforts that led to The Lancet Commission on Global Surgery and the World Health Assembly resolution 68.15 on strengthening emergency and essential surgical care as a part of universal health coverage.
Advocacy can take many different forms. Most familiar is standard grassroots lobbying, where surgeons meet with their congressional or state elected officials, or send them e-mails and letters on a particular issue. Another excellent means of influencing public policy involves serving on state medical boards, public health committees, or other health care-related entities. A less recognized but equally important way to drive health policy is through medical professional organizations, such as the American College of Surgeons (ACS), the American Medical Association (AMA) and other specialty societies.

The ACS representatives to the AMA House of Delegates (HOD) advocate for surgical issues, serving as an example of driving health care policy through participation in a medical professional society. In preparation for the Annual Meeting of the AMA HOD June 11–15, in Chicago, IL, the College’s delegation (see sidebar, page 69) considered an agenda that included 64 reports from the AMA board and councils, and 182 resolutions from state medical associations, specialty societies, and AMA Sections.

Several of these reports and resolutions were of interest to surgery.

**Ethics**

- Council on Ethical and Judicial Affairs (CEJA) Report 2, Modernized Code of Medical Ethics, was adopted. After more than two years of discussion and comments from specialty societies, the HOD agreed that the most recent draft of the code was where it should be. Written concerns from the College’s Committee on Ethics were addressed in the revised code.

- Resolution 004, Targeted Education to Increase Organ Donation, was adopted. The AMA will study potential educational efforts on organ donations tailored to demographic groups with low organ donation rates.

- Resolution 602, Protection of Physicians’ Personal Information, was adopted. The AMA will work with the Federation of State Medical Boards to promote standardization and protection of physician personal data that are available to the public. Although this resolution addresses one avenue of potential identity theft, a more prominent source remains payer database breaches. This area will form the basis of a resolution at the November interim meeting of the HOD.

**Health care reforms**

- Council on Medical Service Report 9, Physician-Focused Alternative Payment Models (APMs), was adopted with an amendment proffered by the College’s delegation. The report promotes patient-centered, physician-led, team-based care coordination in APMs. The report defines principles to guide the development and implementation of APMs. APMs should achieve the following:
  - Be designed by physicians or with significant physician input and involvement
  - Provide flexibility to physicians to deliver the care their patients need
  - Promote physician-led, team-based care coordination that is collaborative and patient-centered
  - Reduce financial and administrative burdens of using health information technology
  - Provide adequate and predictable resources to support the services physician practices need to offer to patients, including mechanisms for regularly updating the amounts of payment to ensure...
The ACS achieved an important health and public policy victory with the passage of Resolution 519, Support for Hemorrhage Control Training.

they continue to be adequate to support the costs of high-quality care for patients

- Limit physician accountability to aspects of spending and quality that they can reasonably influence
- Avoid placing physician practices at substantial financial risk
- Minimize administrative burdens on physician practices
- Be feasible for the participation of physicians in every specialty and for practices of every size

• Resolution 104, Provider Experience as a Metric for Determining Overall Performance by ACOs (Accountable Care Organizations) and Other Payment Models, was adopted after lengthy discussion. The resolution sought AMA advocacy to expand the “Triple Aim” by adding health professional work-life balance to the mix of a “Quadruple Aim,” and to urge the Centers for Medicare & Medicaid Services (CMS) to include physician satisfaction as a clinical practice improvement activity in the Merit-based Incentive Payment System (MIPS). The Triple Aim is a concept endorsed by Donald M. Berwick, MD, MPP, president emeritus and senior fellow, Institute for Healthcare Improvement, which promotes better patient experience, better population health, and lower per capita health care costs.

• Late Resolution 1010, Fixing the VA (Veterans Affairs) Physician Shortage with Physicians, was adopted. As a result, the AMA will work with the VA to enhance its loan forgiveness programs as a way to improve physician recruitment and retention.

Legislation

• Board of Trustees Report 19, Pain as the Fifth Vital Sign, was adopted with amendments. The AMA will advocate for the elimination of pain as the fifth vital sign from professional standards and usage, and for removal of the pain management component of patient satisfaction surveys as it pertains to payment and quality metrics. Widespread concern was expressed that pain as the fifth vital sign is driving over-prescription of narcotic pain medications, particularly when complete pain relief is measured through patient satisfaction surveys. The AMA also will work with The Joint Commission to promote evidence-based, functional, and effective pain assessment and treatment measures for accreditation standards, and will strongly support timely and appropriate access to non-opioid and non-pharmacologic treatments for pain.

ACS DELEGATION AT THE AMA HOD

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

Brian J. Gavitt, MD (also Resident and Fellow Section delegate), Cincinnati, OH

Jacob Moalem, MD, FACS (also Young Physicians Delegate), general surgery, Rochester, NY

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

Naveen F. Sangji, MD, general surgery resident, Boston, MA

Patricia L. Turner, MD, FACS, general surgery, Chicago, IL, Director, ACS Division of Member Services, Chicago, IL

SEP 2016 BULLETIN American College of Surgeons
• **Resolution 242, Preserving a Period of Stability in Implementation of MACRA (Medicare Access and CHIP [Children’s Health Insurance Plan] Reauthorization Act),** passed as a late resolution. The original resolution sought legislative relief, so it was referred to the Reference Committee on Legislation. It was subsequently changed, yet remained in this reference committee report.

A result of adoption of this resolution is that the AMA will advocate for CMS implementation of MIPS and APMs in a manner consistent with congressional intent, and for a stable transition period that includes appropriate testing of physicians’ ability to participate; validation of the accuracy of scores, ratings, and necessary resources; and a suitable reporting period.

• **Late Resolution 1011, Gun Violence as a Public Health Crisis,** sponsored by the ACS and 20 other specialty societies, and 38 state medical associations, was adopted in response to the tragic nightclub shooting in Orlando, FL, that took place at the start of the HOD. The AMA continues to regard gun violence as a public health crisis and seeks to remove prohibitions to federal funding for gun violence research.

Medical education

• **Resolution 309, Continuing Medical Education Pathway for Recertification,** dominated the last day of the meeting and passed with amendments. The AMA now calls for an immediate end to any mandatory, secured recertifying examination by the American Board of Medical Specialties (ABMS) or other certifying organizations as part of the recertification process for all specialties that still require a secure, high-stakes recertification examination. The AMA will continue to work with ABMS to encourage the development of alternative assessments of medical knowledge beyond a secure exam.

• **Resolution 310, Standardizing the Allopathic Residency Match System and Timeline,** was referred to the AMA Board of Trustees for report back. The resolution asked that the AMA support the movement toward a single U.S. residency match system and notification timeline for all non-military allopathic specialties and work with the Association of University Professors in Ophthalmology, the American Academy of Ophthalmology, the Society of University Urologists, the American Urological Association, and any other appropriate stakeholders to switch ophthalmology and urology to the National Resident Matching Program. Ophthalmologists and urologists disagreed.

Science and technology

• The ACS achieved an important health and public policy victory with the passage of **Resolution 519, Support for Hemorrhage Control Training.** This resolution was sponsored by the College delegation with six specialty society cosponsors. As adopted, the AMA will encourage state medical and specialty societies to promote the training of both lay public and professional responders in essential techniques of bleeding control, as well as the inclusion of hemorrhage control kits for all first responders. (See the August Bulletin, page 76, for details.)

Medical practice

• **Resolution 703, Voluntary Reporting of Complications from medical education,** and **Life-long Commitment to Learning,** was referred to the AMA Board of Trustees for a subsequent report. The resolution asked the AMA to oppose discrimination by any hospital or employer, state board of medical licensure, insurers, Medicare, Medicaid, and other entities that results in the restriction of a physician’s right to practice medicine without interference (including discrimination by varying fee schedules) due to lack of recertification or participation in MOC or MOL programs, as well as a lapse of a time-limited board certification.
Medical Tourism, was adopted. The resolution instructs the AMA to support efforts that allow for the reporting and tracking of quality and safety issues associated with medical procedures performed abroad, rather than asking organizations to maintain a voluntary database for collection of this information.

• Resolution 710, Eliminate the Requirement of “H&P [Comprehensive Medical History and Physical Assessment] Update,” was referred for study. This resolution sought to have the AMA work to remove the H&P update from CMS regulations. ACS delegation testimony regarding the importance of confirming satisfactory patient condition on the day of surgery was a leading factor in the resolution being referred for study.

AMA elections
A number of ACS Fellows were successful in their election bids at the June meeting of the HOD. Andrew W. Gurman, MD, FACS, a hand surgeon from Pennsylvania, was inaugurated as the 171st AMA President. ACS-endorsed candidates Lynn Jeffers, MD, FACS, and David Welsh, MD, FACS, an ACS Governor from Indiana, were elected in tough campaigns to the Council on Medical Service and the Council on Science and Public Health, respectively.

Surgical Caucus of the AMA
The Caucus CME program, Navigating Health Care Policy in a Presidential Election Year, featured Sara Morse, Manager of Legislative and Political Affairs, ACS Division of Advocacy and Health Policy, and Manuel Bonilla, MS, Chief Advocacy Officer for the American Society of Anesthesiologists. Panelists provided an overview of the health policy positions of the two presidential campaigns, followed by a discussion of the dynamics of the November 2016 election season, grassroots advocacy programs of organized medicine, and the critical role of surgeons and other specialists in effective advocacy.

Upcoming HOD meeting
The next meeting of the AMA House of Delegates is the interim meeting, November 11–14 in Orlando. The College’s delegation welcomes comments and suggestions for potential resolutions and will continue to advance surgery’s agenda within the policymaking process of the HOD. For more information or to submit comments or suggestions, contact Jon Sutton, State Affairs, ACS Division of Advocacy and Health Policy Manager, at jsutton@facs.org.

IS THERE A SURGEON IN THE HOUSE? by Walter J. Pories, MD, FACS

“Well, science is always full of surprises.”

Dr. Pories’ cartoon compendium, Is There a Surgeon in the House?, is available for $12.95 plus shipping and handling on amazon.com.
Register for ACS TQIP Conference, November 5–7 in Orlando, FL

The seventh annual Trauma Quality Improvement Program (TQIP®) Scientific Meeting and Training will take place November 5–7 at the Omni Orlando Resort at ChampionsGate. Register at facs.org/tqipmeeting.

This meeting will bring together trauma medical directors, program managers, coordinators, and registrars from participating and prospective TQIP hospitals. The conference will include multiple presentations from TQIP participants describing how they use TQIP at their hospitals. Breakout sessions centered on registrar and abstractor concerns, matters that relate to the trauma medical director, and trauma program manager-focused issues will enhance the learning experience and instruct participants about their role on the TQIP team. In addition, dedicated sessions for new TQIP centers will be offered. These sessions will give centers a head start when joining TQIP, so they can immediately begin working on new activities.

Conference topics of note for 2016 include hemorrhage management; spine surgery; TQIP Collaboratives; the latest version of the Brain Trauma Foundation guidelines; and the continued integration of verification, TQIP, and Performance Improvement and Patient Safety. The TQIP Best Practices project team will present on palliative care, followed by a discussion by a panel of experts.

Visit the TQIP annual meeting website at facs.org/tqipmeeting to view the conference schedule and obtain information about lodging and transportation options, the keynote speaker, and a social outing to Cirque du Soleil at the Disney Springs complex.

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Coming in October in JACS, and online now

Insurance type and solid organ transplant outcomes: A historical perspective on how Medicaid expansion might impact transplant outcomes

Authors Derek A. DuBay, MD, MSPH, FACS; Paul A. MacLennan, PhD; Rhiannon D. Reed; and colleagues demonstrate that Medicaid organ transplant beneficiaries had significantly lower survival rates than privately insured beneficiaries. Implementation of the Affordable Care Act allows the opportunity to develop the necessary infrastructure to ensure timely transplant referrals and improve long-term outcomes in this vulnerable population.

This article and all other JACS content is available at www.journalacs.org.
A recent review of published medical studies indicates that patients who have weight loss operations at non-accredited bariatric surgery facilities in the U.S. are up to 1.4 times more likely to experience serious postoperative complications and more than twice as likely to die after the procedure in comparison with patients who undergo these procedures at accredited bariatric surgery centers. The study authors also report that accredited bariatric centers have lower costs than non-accredited centers. These results, which are posted on the Journal of the American College of Surgeons website in advance of print publication, represent the first comprehensive review of the best available evidence comparing bariatric surgery results in accredited U.S. centers with outcomes at non-accredited U.S. centers.

“A preponderance of scientific evidence demonstrates that bariatric surgery becomes safer with accreditation of the surgical center,” said principal investigator John Morton, MD, MPH, FACS, FASMBS, chief of bariatric and minimally invasive surgery, Stanford University School of Medicine, CA. “Accreditation makes a big difference.” The American College of Surgeons (ACS) and the American Society of Metabolic and Bariatric Surgeons (ASMBS) merged their accreditation programs in 2012 to create the unified Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program, and more than 700 centers in the country now hold this accreditation. This credential signifies that a surgical facility has met rigorous standards for high-quality surgical care.

Reducing the odds of complications
In their review article, Dr. Morton and first author Dan Azagury, MD, also a bariatric and general surgeon at Stanford, included 13 studies published between 2009 and 2014, comprising more than 1.5 million patients. Dr. Morton acknowledged that a number of patients might be duplicates because some studies used the same national database.

Eight of 11 studies that evaluated postoperative complications found that undergoing a bariatric operation in an accredited facility reduced the odds of experiencing a serious complication by 9 percent to 39 percent (odds ratios of 1.09 to 1.39), the researchers reported. The difference was reportedly even more pronounced for the risk of death occurring in the hospital or up to 90 days postoperatively. Six of eight studies that reported mortality showed that the odds of dying
after a bariatric procedure, while low at an accredited center, was 2.26 to 3.57 times higher at a non-accredited facility.

Nearly all the studies used risk adjustment, which compensates for different levels of patient risk and which experts believe makes results more accurate. Only three studies (23 percent) failed to show a significant benefit of accreditation.

Reducing costs
Drs. Morton and Azagury also analyzed studies that reported average hospital charges and found lower costs at accredited centers. “Accredited bariatric surgical centers provide not only safer care but also less expensive care,” Dr. Morton said.

A systematic review was the best way to study this issue, according to Dr. Morton. He said most insurers today will not cover surgical care at non-accredited bariatric centers, making it difficult to perform a randomized controlled clinical trial. In 2013, the Centers for Medicare & Medicaid Services (CMS) stopped requiring Medicare beneficiaries to undergo bariatric operations at accredited bariatric centers as a condition of coverage.

Meanwhile, a growing number of patients are choosing surgical treatment for obesity—widely considered the most effective long-term weight-loss therapy. An estimated 179,000 patients underwent gastric bypass, gastric banding, and other bariatric operations in 2013 compared with 158,000 two years earlier, according to the ASMBS.

“These results provide important information that can be used to guide future policy decisions. Perhaps CMS should revisit this policy again,” Dr. Morton suggested.

Read the JACS article at www.journalacs.org/article/S1072-7515(16)30267-8/fulltext.

Submit abstracts by November 2 for Annual ACS Surgical Simulation Meeting

The American College of Surgeons Accredited Education Institutes (ACS-AEI) Program is offering the opportunity to present original papers, descriptive papers, work-in-progress outlines, and research ideas at the Annual ACS Surgical Simulation Meeting (formerly the Annual Meeting of the AEI Consortium), March 17–18, 2017, in Chicago, IL. The abstract submission deadline is 11:59 pm (Central) Wednesday, November 2.

All consortium abstract submissions must be from original research in either simulation-based surgical education or implementation of innovative simulation-based surgical education methods. The AEI Consortium is a network of 81 Comprehensive and 13 Focused ACS-Accredited Education Institutes.

To view additional information and submit an abstract, visit the ACS website at facs.org/education/accreditation/aei/consortium-meeting/call-for-abstracts.
Don’t miss out on the sessions you want to attend—even if they’re scheduled at the same time. Webcast sessions are available on any device anytime, anywhere. Maximize your learning opportunities and earn CME Credit and Self-Assessment Credit when it’s convenient for you.

Choose one of the three webcast packages below:

2016 Complete Package
Access all 122 webcast sessions from Clinical Congress 2016 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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2016 Webcast Package
Access all 122 webcast sessions from Clinical Congress 2016.

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Pick 25 of 2016
Select 25 of the 122 webcast sessions from Clinical Congress 2016.

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*Practicing Surgeons are eligible for CME Credit and Self-Assessment Credit.

For more information
Visit [facs.org/clincon2016/about/resources/webcasts](http://facs.org/clincon2016/about/resources/webcasts) or contact Olivier Petiaux by phone at 866-475-4696 or by e-mail at elearning@facs.org.
As of earlier this year, the Japan Board of Surgery (JBS) now requires residents to earn 10 points in trauma surgery toward their completion of postgraduate training. These 10 points may be earned in a variety of ways, including functioning as the operating surgeon in a major trauma case (three points), attending a trauma seminar (one point), completion of the Japan Advanced Trauma Evaluation and Care course (four points), or completing the Advanced Trauma Operative Management (ATOM) course (four points). The Surgery Board of Japan uses a point system to tally experience; the points do not represent credit hours. Hence, surgery trainees in Japan may now use the ATOM course as a credential toward board certification in surgery. The significance of this recent change is a tangible sign of the credibility that the ATOM course has earned in Japan as a result not only of the high quality of the ATOM course, but also of the continued efforts of a large group of highly dedicated individuals who coordinate the ATOM courses in Japan.

**Differences in training**

Achieving board certification in surgery in Japan is considerably different from the process used in the U.S., but obtaining a certain amount of clinical experience is requisite in both countries. In general, residency training in Japan is less structured than in the U.S., with more of the decisions about resident training made by each department rather than centralized requirements from an agency such as the Accreditation Council for Graduate Medical Education. Furthermore, the overall training period tends to be longer in Japan than in the U.S.

Board certification in Japan is earned after passing a written examination, and criteria for board certification is determined by the Japan Surgical Society. A total of 10 trauma surgery procedures is required.

However, most of the cases used in the application for certification have involved suturing of skin lacerations. Each department cannot provide sufficient trauma cases for the residents. Thus, board-certified surgeons in Japan have limited experience in trauma surgery.

The causes of traumatic injury are different as well. Penetrating traumatic injuries are rare in Japan. Gun ownership is strictly prohibited, and compliance with this regulation is nearly 100 percent. The overall rate of assaults and attacks in Japan is extremely low, and except for suicide attempts, very few patients are seen for penetrating injuries. In 2010, just 19 murders with guns occurred in Japan (population 127 million), while in the same year there were 8,874 gun-related murders in the U.S. (population 310 million).* Taking these factors into account, as well as the fact that trauma patients are widely dispersed for initial care.

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rather than sent to centralized trauma hospitals, it can be difficult for residents to obtain operative trauma experience.

**ATOM in Japan**
The ATOM course began in Japan in December 2008, and is now offered at six centers throughout the country including Jichi Medical University, Tochigi; Osaka City University; Teikyo University, Itabashi; Hokkaido University, Sapporo; Tohoku University, Sendai; and Kysuhu University, Fukuoka, covering a broad geographical area across the nation. Since its introduction in Japan, more than 40 ATOM courses have been presented, with more than 200 providers and 37 instructors certified.

The training has proven successful. In the last five years, four patients in Japan were treated for penetrating wounds to the heart, exactly the same as one of the standard injury scenarios in the ATOM course. For each of these four patients, their surgeon had taken the ATOM course and the surgeons directly credit the ATOM course with giving them the knowledge and skill to manage the injury. In each case, the surgeon had never before seen such an injury. Now that ATOM training is an accepted credential for JBS certification, we anticipate that even more Japanese surgeons and their patients will benefit from this training.

The significance of this recent change is a tangible sign of the credibility that the ATOM course has earned in Japan as a result not only of the high quality of the ATOM course, but also of the continued efforts of a large group of highly dedicated individuals who coordinate the ATOM courses in Japan.

Visit web4.facs.org/ebusiness to purchase official FACS-branded lab coats, surgical caps, and more! Make FACS a part of your daily life.
The Board of Directors of the American College of Surgeons Professional Association (ACSPA) and the Board of Regents (B/R) of the American College of Surgeons (ACS) met June 3–4 at the College’s headquarters in Chicago, IL. The following is a summary of their discussions and actions.

**ACSPA**

As of May 10, the ACSPA’s political action committee (ACSPA-SurgeonsPAC) had raised more than $887,265 from more than 2,500 College members and staff. During the 2015–2016 election cycle, the PAC has disbursed more than $760,000 to more than 130 congressional candidates, leadership PACs, and party committees. In line with congressional composition, 60 percent of these funds were given to Republicans and 40 percent to Democrats.

**ACS**

**Approval of Statements**

At their June meeting, the Board of Regents reviewed and approved the following updated and new statements submitted by the Committee on Perioperative Care:

- Safe surgery checklist, and ensuring correct patient, correct site, and correct procedure surgery
- Surgical technology training and certification
- Prevention of unintentionally retained surgical items after surgery
- Sharps safety
- Documentation and reporting of accidental punctures and lacerations during surgery (new)
- Distractions in operating room (new)

These statements will be published in the October issue of the *Bulletin*.

**Division of Advocacy and Health Policy**

**Federal legislation**

**Payment reform**

The ACS continues to educate and influence Congress on implementation of the Medicare Access and CHIP (Children’s Health Insurance Program) Reauthorization Act (MACRA). The ACS submitted testimony to the House Energy and Commerce Committee for an April 19 hearing on physician efforts to prepare for MACRA Medicare payment reforms. Additionally, the ACS lobbying team, along with Frank G. Opelka, MD, FACS, Medical Director, Quality and Health Policy, ACS Division of Advocacy and Health Policy (DAHP), has conducted extensive meetings on Capitol Hill to ensure that policy leaders are up-to-date on the ACS-driven alternative payment model (APM) project with Brandeis University, Waltham, MA, and the Center for Surgery and Public Health at the Brigham and Women’s Hospital and their Harvard faculty in Boston, MA. The meetings are aimed at educating legislators on how the ACS APM will coalesce many surgical disciplines into a single framework for building APM solutions, applicable to Medicare and other public and private payors.

**Meaningful use**

The ACS is supporting the work of Sens. John Thune (R-SD), Lamar Alexander (R-TN), Mike Enzi (R-WY), Pat Roberts (R-KS), Richard Burr (R-NC), and Bill Cassidy (R-LA), who recently released draft legislation that would ease some of the administrative burden associated with reporting on meaningful use (MU) of electronic health records (EHRs) for 2016. Specifically, the legislation would shorten the reporting period for eligible providers from 365 days to 90 days, which would give physicians and hospitals more time to implement EHR systems, relax the “all-or-nothing” nature of the current program requirement,
and extend the timeline for eligible providers and hospitals to apply for a hardship exemption.

**Responsible data disclosure**
The ACS DAHP is working toward introduction of the Responsible Data Transparency Act. Championed by Rep. Bill Flores (R-TX), the bill would halt the Centers for Medicare & Medicaid Services (CMS) disclosure of raw Medicare physician claims data to outside entities.

**Surgical workforce in underserved areas**
Reps. Larry D. Bucshon, MD, FACS (R-IN), and Ami Bera, MD (D-CA), introduced H.R. 4959, the Ensuring Access to General Surgery Act of 2016. This legislation would direct the Secretary of the Department of Health and Human Services (HHS) to conduct a study on the designation of a general surgery Health Professional Shortage Area (HPSA). The Health Resources and Services Administration has developed designation criteria to determine whether certain geographic areas, population groups, or facilities qualify for HPSA designation.

**Opioids**
The College is tracking opioid-related bills, monitoring congressional hearings, and meeting with key congressional leaders on this issue. The ACS Legislative Committee has drafted a policy document, which was submitted to the Health Policy Advocacy Group for review.

**Graduate medical education**
The ACS continues to monitor congressional activity on direct and indirect graduate medical education funding reform. Patrick V. Bailey, MD, FACS, Medical Director, Advocacy, ACS DAHP, has convened a workgroup of Fellows and experts to develop an ACS plan to address four aspects of GME reform: workforce, finance, governance, and accountability.

**Regulatory**

**Global codes**
MACRA, discussed earlier in this article, includes a provision that prohibits CMS from implementing a policy that would have transitioned 10- and 90-day global codes to 0-day global codes. Instead, Congress called upon CMS to collect data on the number and level of visits furnished during the global period beginning by 2017. CMS is mandated to use these data starting in 2019 to improve the accuracy of the valuation of surgical services. The provision also allows the withholding of 5 percent of the surgical payment until information is reported at the end of the global period.

Over the last year, the ACS has worked to influence the implementation of this new policy. In a comment letter on the 2016 Physician Fee Schedule proposed rule, the ACS provided recommendations on how CMS should go about collecting data on the number and level of visits associated with global codes. Members of the ACS General Surgery Coding and Reimbursement Committee (GSCRC) also met with CMS February 22, 2016, to discuss the recommendations in more detail and followed up with a letter. Going forward, the GSCRC will continue discussions on how the agency will collect data starting on January 1, 2017, and how the data will be used to improve the accuracy and valuation of global surgical services starting in 2019.

**Health insurance**
In March, Highmark, a subsidiary of Blue Cross Blue Shield, announced it would cut provider reimbursement rates by 4.5 percent. Highmark reports that it lost $221 million in 2014 from health plans in Affordable Care Act exchanges. This reduction in reimbursement became effective April 1 and for now affects Pennsylvania only. For the average physician, this change would reduce revenue by 0.5 percent.

**Hospital payment**
CMS released the fiscal year 2017 Inpatient Prospective Payment System (IPPS) proposed rule in April. For general acute care
hospitals paid under the IPPS that successfully participate in the Hospital Inpatient Quality Reporting Program and are meaningful users of EHRs, the proposed increase in operating payment rates is 0.9 percent. CMS also proposes to permanently remove a 0.2 percent reduction in inpatient payments related to the two-midnight rule. The ACS has evaluated these and other proposals to determine the impact on surgery and has submitted comments to CMS.

**Medicare Part B drug payment**
On May 9, the ACS regulatory staff submitted a comment letter to CMS on the Medicare Part B Drug Payment Model proposed rule, released in March. The ACS comment letter requests that CMS withdraw the Part B Drug Payment Model until the agency has adequately collaborated with affected stakeholders, specifically physicians and patients.

**Quality**

**PQRS Qualified Clinical Data Registries**
The ACS Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program and specific trauma measures within the Surgeon Specific Registry were approved by CMS as Physician Quality Reporting System (PQRS) Qualified Clinical Data Registries for 2016.

**Physician Compare**
This year, CMS will post information on the care delivered by individual providers and groups on the Physician Compare website. In response, the ACS is creating a detailed Web page on Physician Compare that includes educational material and resources to explain to Fellows what information will be reported. (An article on Physician Compare was published in the March issue of the Bulletin, page 41.)

**Surgical Quality Alliance**
The Surgical Quality Alliance (SQA) met April 19 and addressed the following topics:

- The future of meaningful use, MACRA

- Core measures developed by America’s Health Insurance Plans (AHIP) in collaboration with CMS

- Current work on the development of patient-reported outcomes measures for surgical care

- The Brandeis and ACS APM development project

- An update on legislative issues relevant to surgical care

The SQA continues to discuss the current quality landscape, National Quality Forum activities, and member experience with CMS quality programs.

**State Affairs**
State Affairs uses an online search service to identify and monitor state legislation of interest to surgeons. In 2015, more than 2,400 bills were tagged as potentially related to ACS issues, with approximately 500 actively monitored. Numbers are similar for 2016, with more than 2,000 bills tagged and more than 400 monitored.

**State legislative highlights**
- The Georgia Society of the ACS successfully pursued passage of legislation based on the Uniform Emergency Volunteers Health Practitioners model. The bill was signed by the governor on April 26.

- The Kansas Chapter joined with numerous medical and patient organizations to pursue legislation restricting the use of tanning beds to individuals ages 18 and older. At the time of the meeting, the bill was awaiting action by the governor.

- Oklahoma surgeons began contacting their state legislators to support the Medicaid Rebalancing Act of 2020. A major component of this initiative would add $1.50 to the tobacco tax, with funds to be used to improve Medicaid payment rates to physicians. It would also expand private insurance to 350,000 Oklahoma citizens.
• Approximately 300 messages were sent in New York opposing cuts in the excess medical liability insurance program. Originally included in the governor’s budget proposal, this provision was removed from the final budget.

• Rhode Island considered legislation to change the description of the physician assistant’s relationship with physicians from “supervisory” to “collaborative.” The ACS Legislative Committee reviewed the bill and developed a position in opposition to it. Following committee hearings, the legislation is being held for further study.

• Tennessee surgeons contacted their state legislators over an opioid bill restricting initial prescriptions to seven days. Thinking this was too short a time, the chapter’s council began working to amend the bill to at least 14 days. A decision was made to focus on making amendments next year to give surgeons time to advocate with their own legislators.

• Tennessee again saw failed attempts to repeal mandatory motorcycle helmet usage.

Program attracted 18 applicants in 2016, the largest number of applicants to date. The program provides funding to ACS chapters seeking to engage with their state legislators on surgical/medical issues. All 18 applicants received grants ranging from $750 to $5,000, with each recipient expected to match half the amount of the grant. Of these 18 applicants’ states, three—Alaska, Pennsylvania, and Wisconsin—had not previously received grants.

2016 ACS Advocacy Summit
Nearly 300 physicians attended the 2016 ACS Advocacy Summit April 11–12 in Washington, DC. ACS Washington Office staff, political insiders, health care experts, and members of Congress provided details on current efforts being made to help shape the future of health care. A total of 231 Lobby Day attendees from 42 states had the opportunity to meet with their members of Congress on Capitol Hill and advance the advocacy efforts of the ACS.

Division of Education

Transition to Practice (TTP) Program
A total of 25 institutions are now approved to participate in the TTP Program in General Surgery, chaired by ACS President J. David Richardson, MD, FACS, and co-chaired by Past First Vice-President R. Phillip Burns, MD, FACS.

Resident duty hours
In response to a communication from the Accreditation Council for Graduate Medical Education (ACGME), an ACS Position Statement on Resident Duty Hours was crafted and sent to the ACGME in January 2016. The statement was co-signed by Dr. Richardson; Valerie W. Rusch, MD, FACS, Chair of the B/R; David B. Hoyt, MD, FACS, ACS Executive Director; and Ajit Sachdeva, MD, FACS, FRCSC, Director, ACS Division of Education. Subsequently, Dr. Hoyt presented the ACS position at the ACGME Resident and Duty Hours Congress in March 2016.

Master Surgeon Educators
The B/R had previously approved the creation of an ACS Academy of Master Surgeon Educators. Efforts are under way to establish the framework for this special academy. The goals of this effort are to play a critical role in providing recognition to Master Surgeon Educators; advancing the science and practice of surgical education and training; fostering exchange of creative ideas and collaboration; supporting faculty development and recognition; and underscoring the importance of surgical education and training in the changing milieu of health care. This academy is envisioned as a think tank and an

Lobby Day Grant Program
In its fifth successful year of operation, the ACS Chapter Advocacy Lobby Day Grant
advisory group to the Division of Education. The following members have been appointed to the Steering Committee for the ACS Academy of Master Surgeon Educators: L. D. Britt, MD, MPH, DSc(Hon), FACS, FCCM, FRCS(Eng)(Hon), FRCSEd(Hon), FWACS(Hon), FRCS(Hon), FCS(SA)(Hon), FRCSGlasg(Hon), Chair; Dr. Sachdeva, Co-Chair; Sir Murray F. Brennan, MD, FACS; Dr. Hoyt; Haile T. Debas, MD, FACS; L. Scott Levin, MD, FACS; Leigh A. Neumayer, MD, FACS; and ACS Past-President Carlos A. Pellegrini, MD, FACS, FRCSI(Hon), FRCS(Hon), FRCSEd(Hon).

Clinical Congress
A total of 8,276 physicians (including 1,646 residents and 749 guest physicians) attended Clinical Congress 2015. Other attendees were as follows:

- 532 medical students
- 190 allied health professionals
- 131 PhDs

Clinical Congress 2016 will include the following:

- 24 Tracks
- 127 Panel Sessions
- 17 Didactic/Experiential Courses
- 14 Skills Courses
- 45 Meet-the-Expert Luncheons
- 18 Town Hall Meetings

Surgical skills training
A new Committee on Surgical Skills Training for Practicing Surgeons has been appointed to develop, implement, and support innovative skills courses at the Clinical Congress and at regional sites. The committee is co-chaired by Barbara L. Bass, MD, FACS, and Dr. Sachdeva.

SESAP 16
The Surgical Education and Self-Assessment Program (SESAP®) 16 will be released in October 2016 and will include a variety of apps for handheld devices, as well as Web and print versions. John A. Weigelt, MD, DVM, FACS, is the Medical Director of SESAP.

Surgeons as Leaders
ACS Past-President Andrew Warshaw, MD, FACS, will lead the 12th Annual Surgeons as Leaders Course, June 5–8, 2017, in Durham, NC. A module on “Leading Beyond Surgery” has been added along with new modules “Leading in Quality” and “Leading in Advocacy.” The new faculty includes David F. Torchiana, MD, FACS, president and chief executive officer, Partners HealthCare, Boston; Michael Useem, PhD, director of the Center for Leadership and Change Management at the Wharton School of the University of Pennsylvania, Philadelphia; and Matthew M. Hutter, MD, MPH, FACS, associate professor, Harvard Medical School, and director, Codman Center for Clinical Effectiveness in Surgery, Massachusetts General Hospital.

Returning faculty include Past-Chair of the B/R Julie A. Freischlag, MD, FACS; Larry R. Kaiser, MD, FACS; Chair of the ACS Board of Governors Fabrizio Michelassi, MD, FACS; Dr. Pellegrini; Nathaniel J. Soper, MD, FACS; and ACS Regent Beth H. Sutton, MD, FACS. Once again, demand for the 2016 course exceeded capacity with 80 applicants for only 64 seats.

Surgeons as Educators Course
The 23rd Annual Surgeons as Educators Course took place August 27–September 2, in Atlanta, GA. Once again, demand exceeded capacity, and 61 individuals applied for the 32 seats available. This course is chaired by Paul J. Schenarts, MD, FACS, and the Course Director is Debra A. DaRosa, PhD.

Fundamentals of Surgery Curriculum
Under the leadership of ACS Past-President Patricia J. Numann, MD, FACS, the ACS Fundamentals of Surgery Curriculum® (ACS FSC) now comprises 110 case scenarios spanning the following 14 essential content areas:

- Patient and Workplace Safety
- Preoperative Assessment
- On-Call Issues
- Pain Management
- Unresponsive Patients and Agitated Patients
- Respiratory Management
- Gastrointestinal Conditions
• Wound Management
• Nutritional Support
• Fluid and Electrolyte Management
• Cardiac Conditions
• Vascular Conditions
• Cardiothoracic Conditions
• Oncology

Approximately 1,700 residents at more than 200 training programs are enrolled in ACS FSC.

Fundamentals of Laparoscopic Surgery
The Fundamentals of Laparoscopic Surgery® (FLS) Program, now in its 11th year, is a collaborative program between the Society of American Gastrointestinal and Endoscopic Surgeons (SAGES) and ACS. It was initially developed by SAGES and is now jointly led by SAGES and the ACS. More than 10,000 residents, fellows, and practicing surgeons have received an FLS certificate. Expansion of the program continues with 80 testing centers located throughout the U.S. and Canada, and one each in Singapore and Israel. The Joint FLS Steering Committee is co-chaired by Gerald M. Fried, MD, FACS, FRCSC, and Lenworth M. Jacobs, Jr., MD, MPH, FACS.

Program for Accreditation of Education Institutes
A total of 94 simulation centers now are accredited through the ACS Program for Accreditation of Education Institutes (ACS-AEI) as Comprehensive ACS-AEIs, and 12 are accredited as Focused ACS-AEIs. Of the ACS-AEIs, 14 are outside the U.S., including four in Canada, one in the U.K., two in Sweden, two in France, one in Greece, one in Italy, one in Argentina, one in Saudi Arabia, and one in Spain.

The Ninth Annual ACS-AEI Consortium Meeting, which took place March 7–8 in Chicago, IL, attracted a record 222 attendees. The keynote speaker was Graham T. McMahon, MD, MMSc, president and chief executive officer of the Accreditation Council for Continuing Medical Education (ACCME).

ACS CME Accreditation Program
The ACS Continuing Medical Education (CME) Accreditation Program of the Division of Education now ranks as one of the largest within the ACCME System. It was accredited with commendation in 2014 and now accredits all CME credit-bearing educational programs of the ACS and the educational programs of most surgical societies that do not have their own accreditation systems. In 2015, the program accredited 2,252 CME activities; of these activities, 292 were jointly accredited.

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

Ethics fellowship
Offered for the first time in 2015, the Fellowship in Surgical Ethics, sponsored by the ACS Division of Education and MacLean Center for Clinical Medical Ethics at the University of Chicago, has been successful. Applications for 2016–2017 are currently being accepted.

Division of Member Services
Recruitment and retention
As of June 1, the College had 78,458 members: 64,368 Fellows (57,299 U.S., 1,334 Canadian, and 5,735 International), 3,495 Associate Fellows, 8,466 Residents, 1,850 Medical Students, and 279 Affiliate Members.

The B/R accepted resignations from 18 Fellows:

• One colorectal
• One general
• One neurological
• Two ophthalmic
• Three orthopaedic
• Three otolaryngology
• Three plastic and reconstructive
• Four urological

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The B/R also approved a change in status from Active (dues paying) to Retired for 94 Fellows and from Senior (non-dues paying) to Retired for 15 Fellows—a total of 109 Fellows.

The Regents approved a Committee on ACS Global Engagement through Operation Giving Back, with the following subcommittees: International Volunteerism, Domestic Volunteerism, Disaster, Advocacy, and Global Health Education.

Division of Research and Optimal Patient Care

Joan L. and Julius H. Jacobson II Promising Investigator Award

In 2004, Julius H. Jacobson II, MD, FACS, established through the College the Joan L. and Julius H. Jacobson II Promising Investigator Award to recognize outstanding surgeons who are engaged in research, are advancing the art and science of surgery, and have demonstrated early promise of significant contribution to the practice of surgery and the safety of surgical patients. This year’s award, administered through the ACS Surgical Research Committee (SRC), is in the amount of $30,000.

After careful consideration, the SRC made the following selections for the 2016 Joan L. and Julius H. Jacobson II Promising Investigator Award:

• Recipient: Ankit Bharat, MB, BS, FACS, Northwestern University, Chicago
• Alternate: Jason K. Sicklick, MD, FACS, University of California, San Diego

ACS National Surgical Quality Improvement Program

A total of 744 hospitals participate in the ACS National Surgical Quality Improvement Program (ACS NSQIP®)—658 sites in the adult option, and 86 in ACS NSQIP Pediatric. The Essentials option, which is the conventional sampling frame, has the highest enrollment of adult participation with 318 sites, and the Procedure Targeted option follows with 279 hospitals enrolled. The Pediatric option, which continues to grow, represents 12 percent of overall participation.

Following is the breakdown of participating sites by the ACS NSQIP option:

• Small and Rural: 61
• Procedure Targeted: 279
• Essentials: 318
• Pediatric NSQIP: 86

MBSAQIP

There are currently 804 participating Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) centers; 702 are fully accredited and 63 are initial applicants.

The remaining 39 are data collection centers that participate in the MBSAQIP Data Registry but did not complete the process to meet full accreditation status.

SSR

The ACS has continued to develop Surgeon Specific Registry (SSR) as a tool for capturing individual surgeon data. The SSR has approximately 6,000 surgeons who have submitted at least 20 cases, and contains nearly 6 million records.

ACS Clinical Scholars in Residence

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. This program offers surgery residents a unique opportunity to work with the College. The application submission period for 2017−2019 appointments closed May 1. The interview process has begun to identify scholar(s) for the next appointment cycle.

Committee on Trauma (COT)

The accomplishments of the COT and its constituent programs are as follows:

• At the time of the meeting, 1,067 Advanced Trauma Life Support® (ATLS®) Courses had been presented in 2016 and offered to 17,516 students.
A total of 55 Rural Trauma Team Development Courses (RTTDCs) have been offered to 886 international students; promulgation is occurring in Kuwait.

The RTTDC program fourth edition is complete, and several sites are already offering this format.

The Disaster Management and Emergency Preparedness Course has been presented 19 times in 2016 to 299 students.

The Advanced Surgical Skills for Exposure in Trauma (ASSET) Course has been presented 33 times to 315 students, with international promulgation occurring in France and Germany.

The ASSET program continues to grow, and the committee is now in discussions to begin revisions.

The Advanced Trauma Operative Management Course has been offered 23 times to 126 students.

The Trauma Evaluation and Management program has been offered free of charge in the following countries:

- Afghanistan
- Argentina
- Bolivia
- Cambodia
- Ghana
- India
- Indonesia
- Kenya
- Malawi
- Panama
- Trinidad & Tobago
- Ukraine
- Uruguay
- Zimbabwe

As of May 16, 429 hospitals and 424 ACS-verified trauma centers are participating in the Trauma Quality Improvement Program (TQIP®); of these facilities, 397 participate in Adult TQIP, and 99 are in Pediatric TQIP.

**Cancer Programs**

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

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

The eighth edition of the Joint Committee on Cancer’s Cancer Staging Manual will be published in October 2016 and will apply to all cases diagnosed beginning January 1, 2017.

Interest in National Accreditation Program for Breast Centers (NAPBC) accreditation remains strong in the U.S. and internationally. More than 600 U.S. centers are accredited, with 38 new applications received in 2016. Reaccreditation rates for 2015/2016 remain at 99 percent. Two accredited international centers and surveys are pending in South Africa and Chile. The NAPBC Best Practices Conference convened May 13–14 in Orlando, FL.

**JACS**

In the first four months of 2016, more than 2,200 individuals completed tests on *Journal of the American College of Surgeons (JACS)* articles, earning a total of 33,061 credits toward Maintenance of Certification. *JACS* articles were picked up by major news media including Reuters, Philadelphia Inquirer, Detroit News, Seattle Times, and U.S. News & World Report. ♦
I recently returned from Japan after visiting different hepatopancreatobiliary (HPB) centers and attending the 116th Annual Congress of the Japan Surgical Society. It was truly an outstanding experience, and I am grateful to the American College of Surgeons (ACS) International Relations Committee for selecting me for the 2016 Traveling Fellowship to Japan. As a surgical oncologist with a focus on HPB surgery, I have had an interest in visiting some of the leading centers for liver surgery in Japan, and this visit exceeded my expectations.

University of Tokyo
My host at the University of Tokyo Hospital was Prof. Norihiro Kokudo, MD, PhD, FACS, chairman, hepatobiliary-pancreatic surgery division and the artificial organ and transplantation division, department of surgery. My visit was organized by Junichi Arita, MD, PhD, an HPB surgeon and associate professor, University of Tokyo.

Prior to my arrival I was assigned a “buddy” to guide me through the planned activities and events and facilitate any inquiry or interests I had. My buddy was Akihiko Ichida, MD, PhD, an assistant professor who had recently completed the hepatobiliary fellowship and a doctorate in clinical research. I had discussed with Dr. Arita specific interests for my visit, and he and Dr. Ichida ensured that I would accomplish all of my goals during this short visit.

I engaged in a number of academic and clinical activities while visiting. I first met with Professor Kokudo, and we discussed common interests as well as technical and general surgical approaches to different clinical scenarios typically considered controversial in the field. I learned about the structure of the institution’s academic program and its gradual development. Professor Kokudo was very forthcoming, sharing specifics of this process and providing input derived from his personal experiences. Subsequently, I was invited to join him in the operating room (OR) to observe an extended right hepatectomy plus caudate lobectomy with bile duct resection for colorectal metastasis, which he performed with Dr. Arita. For the most part, the surgical approaches and techniques they used are similar to those used in...
the U.S., although specific details about the procedure were unique to their center, including the use of contrast ultrasound and the processing of the specimen; residents and fellows performed the marking, cutting, and preparation of the specimen/slides. It was a great experience, and the case went smoothly and was completed almost effortlessly by Professor Kokudo.

The first night of my visit, junior faculty and residents/fellows invited me to a dinner during which we discussed the intricacies of HPB training and building academic careers in surgery. The trainees’ commitment to scientific training was impressive. All of them were pursuing doctorates as they were completing a busy fellowship in HPB surgery.

I also attended their preoperative conference, which was presented in English to facilitate understanding by visiting surgeons. Special attention was placed on liver anatomy and surgical planning. I attended the tumor board meeting, which included participation by faculty and trainees in other specialties.

On my last day, I gave a lecture to the HPB division on the role of regionalization of care for hepatobiliary malignancies. The attendees raised questions regarding the similarities and differences between the health care systems in Japan and the U.S. Japan has a universal health care system; however, care for HPB malignancies is not regionalized and can take place in essentially any hospital with the necessary infrastructure. I found this interesting, particularly in a setting with a number of high-volume leading liver centers.

During my stay in Tokyo, I had the opportunity to tour key landmarks in the city, including the oldest Buddhist temple—Sensoji in the Asakusa district, the Imperial Palace, and Tokyo’s Skytree. I was fascinated by Tokyo’s history, organization, and people. I was particularly impressed by the city’s transportation system and the warmth of its people.

My stay in Tokyo and visit to the University of Tokyo Hospital was truly a remarkable experience, and I am grateful to Professor Kokudo, Drs. Arita and Ichida, and all the staff in the division for their hospitality.

The 116th Annual Congress of the Japan Surgical Society
After my stay in Tokyo I traveled via Shinkansen (bullet train) for approximately two hours to Osaka, the second largest city in Japan and host city of the 116th Annual Congress of the Japan Surgical Society (JSS). The congress is the largest and oldest surgical meeting in Japan, typically attended by more than 10,000 people. The meeting was well organized, with a number of sessions presented in English. Close to 50 guests from different parts of the world and approximately 15 other traveling fellows attended the meeting. We all participated in a ceremony during which we received a certificate from the JSS in recognition of our visit.
I gave an oral presentation on Establishment of a Regional Network to Improve Quality of Care and Outcomes for Hepatocellular Carcinoma, which was well received, and attended invited lectures by Charles M. Balch, MD, FACS, director, Clinical Research Network, and professor of surgery, Johns Hopkins Medicine, Baltimore, MD, on The Future of Surgical Oncology, and by ACS President-Elect Courtney M. Townsend, MD, FACS, titled The American College of Surgeons Enters Its Second Century: Its Role in Quality and Education.

I attended a number of networking events, including the presidential dinner, hosted by Professor Kokudo, President of the JSS, and Prof. Yoshiki Sawa, MD, PhD, chairman, department of cardiovascular surgery, Osaka University, and president of the 116th JSS Annual Congress. This wonderful dinner took place on the rooftop of the tallest building in Osaka, with a spectacular view of the city.

I had the opportunity to meet Prof. Masaki Mori, MD, PhD, FACS, chairman, department of gastroenterologic surgery, Osaka University. David Shibata, MD, FACS, chairman, department of surgery, University of Tennessee Health Science Center, Memphis, and 2010 awardee of the ACS Traveling Fellowship to Japan, helped connect us as I was planning my visit. Dr. Mori invited visitors from Europe and me to visit his department and to a dinner where we had the opportunity to learn about his trajectory and legacy in academic surgery and to discuss ongoing research projects with one of his surgical trainees.

**Osaka University Graduate School of Medicine**

During my stay in Osaka, I visited Osaka University Hospital and spent time with Hidetoshi Eguchi, MD, PhD, associate professor and chief, HPB surgery, department of gastroenterological surgery.

Dr. Eguchi and I discussed the different training pathways to becoming an HPB surgeon in Japan, and the structure of the section. Especially impressive was the number of surgeons and trainees (nearly 60) pursuing research degrees at the university and within Professor Mori’s department and research lab. After discussing the research structure and setup, I toured the research facilities of the department and then met with other visitors to observe a laparoscopic distal pancreatectomy.

Subsequently, visiting fellows were invited to attend presentations on specific research projects in colorectal surgery and to review video presentations of innovative approaches to surgery for colorectal diseases. We discussed the different surgical approaches and treatment strategies used in Japan, the U.S., and Europe. The residents/fellows were enthusiastic, and it was a great way to end our visit. I am grateful to Professor Mori, Dr. Eguchi, and their faculty and staff for their hospitality.

**Nagoya University Graduate School of Medicine**

Next, I traveled to Nagoya, located between Osaka and Tokyo. This experience was one of the highlights of my trip to Japan. My host was Prof. Masato Nagino, MD, PhD, chairman, division of surgical oncology, first department of surgery, Nagoya University, a unique institution. Approximately 100–120 liver operations are performed annually, of which close to 80 are performed to treat hilar cholangiocarcinoma, making Nagoya University the world leader in the management of this disease. I engaged in a number of clinical and academic activities that encompassed the entire perioperative period, allowing me to gather details about the university’s clinical management of this disease.

I attended a preoperative conference presented by residents and fellows. Japanese was spoken at the conference, but given the extensive and meticulous attention placed on the anatomy and surgical planning, I understood the issues.
of each case presented and the surgical approaches and plans discussed. Preoperative imaging included 3-D reconstruction of the liver, portal vein, hepatic artery, and bile ducts for complex cases, which also is common practice in the U.S. They prepared a “surgical planning card” for each patient that contained all relevant information, 3-D reconstruction images, and, most importantly, a final picture drawn by the residents, in which each reconstruction image was superimposed and the surgical plan was finalized, with rare deviation from this preoperative diagram. This provided an accurate, detailed projection of the surgical plans that helped the trainees become more knowledgeable and proficient in liver surgical anatomy.

The next day I observed an extended liver resection with bile duct resection and portal vein resection/reconstruction in an elderly female presenting with hilar cholangiocarcinoma. The case went smoothly, and the skillful dissection reflected the team’s proficiency and experience with these complex operations. Following the operation, we went through some video recordings of similar procedures, including hepato-pancreato-duodenectomies (among the largest series in the world), and discussed their surgical approach and in many cases, details regarding techniques developed by their group. I also participated in surgical rounds during their non-surgical day and observed some crucial differences between postoperative management in their system and that of the U.S. The key difference is the prolonged length of stay following surgery in Japan, with patients returning home essentially only after a full recovery and back to their preoperative baseline (approximately 30 days in most cases).

I spent the last afternoon in Nagoya discussing difficult cases and surgical approaches with Professor Nagino. He took me on a tour of the hospital, including the wards and intensive care unit, and introduced me to the chief of interventional gastroenterology, with whom we had interesting discussions regarding preoperative biliary decompression.

I cannot say enough good things about the hospitality of the surgeons, staff, and that of Professor Nagino, and I am extremely grateful to him for inviting me and for taking the time to make my visit productive.

My traveling fellowship to Japan was an amazing experience, and I am so appreciative of the College providing me with this opportunity. This award resulted in important scientific exchanges, and I have no doubt that it has opened the doors to future collaborations and friendships with a number of exceptional colleagues and surgeons and scientists. ♦
The American College of Surgeons (ACS) and the American Society of Breast Surgeons (ASBrS) have established a new international scholarship for surgeons working to improve the quality of breast cancer surgical services in countries other than the U.S. and Canada—the ACS/ASBrS International Scholarship. Preference will be given to applicants from developing nations. All applications for the 2017 award and all supporting documentation must be received by the College’s International Liaison no later than November 15, 2016.

The scholarship award
The scholarship, in the amount of $5,000, provides the recipient with an opportunity to attend the annual meeting of the ASBrS and to visit the ACS National Accreditation Program for Breast Centers (NAPBC) headquarters in Chicago, IL, to learn about the standards for a breast cancer program/database and the importance of coordinated multidisciplinary care. The awardee will receive free registration to the annual meeting of the ASBrS and to one postgraduate course at the meeting. Assistance will be provided to obtain preferential housing in an economical hotel in the ASBrS meeting city. Hotel and travel expenses will be the responsibility of the awardee, to be funded from the scholarship award.

Criteria
To qualify for consideration by the selection committee, applicants must meet all of the following requirements:

• Medical school graduates who have completed their surgical training and are practicing attending surgeons.

• Members in good standing of both the ACS (Associate Fellow or Fellow) and the ASBrS (active or associate member).

• At least 30 years old, but younger than 50 years old on the date that the complete application is filed.

• Have been in surgical practice, teaching, or research for at least one year at their intended permanent location following completion of all formal training (including fellowships and scholarships).

• Show evidence of commitment to high-quality breast cancer surgery, to surgical teaching, and to improving access to breast cancer surgical care in their community.

• Submit a completed application form, located on the ACS website. The application and accompanying materials must be prepared using a computer and submitted in English. Submission of a curriculum vitae only is not acceptable.

• Submit independently prepared letters of recommendation from three of their colleagues. One letter must be from the chair of the department in which they hold a clinical or academic appointment or from an ACS Fellow residing in their country. The chair’s or the Fellow’s letter must directly address the applicant’s commitment to high-quality breast surgery, surgical teaching, and improving access to breast surgery locally. The other two letters of recommendation should be from colleagues who can address the applicant’s breast cancer surgical, clinical, and teaching abilities and practice. Letters of recommendation should be submitted directly by the individuals making the recommendation.

• Preference will be given to applicants who have not already experienced training or surgical fellowships in...
The ACS and the ASBrS have established a new international scholarship for surgeons working to improve the quality of breast cancer surgical services in countries other than the U.S. and Canada—the ACS/ASBrS International Scholarship.

Applicants are urged to submit their completed applications and supporting documents as early as possible in order to provide sufficient time for processing. Supporting materials and questions should be addressed to the ACS International Liaison at Kearly@facs.org or via fax at 312-202-5021.

The ACS and the ASBrS have established a new international scholarship for surgeons working to improve the quality of breast cancer surgical services in countries other than the U.S. and Canada—the ACS/ASBrS International Scholarship.
Calendar of events

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

**SEPTEMBER**

Kentucky Chapter  
**September 16**  
Lexington, KY  
Contact: Linda Silvestri,  
lsilv2@email.uky.edu,  
www.kentuckyacs.org

New Mexico Chapter  
**September 17–18**  
Albuquerque, NM  
Contact: Melissa Davis,  
davis@nmms.org

Kansas Chapter  
**September 24**  
Wichita, KS  
Contact: Denise Lantz,  
dlantz@kmsonline.org,  
www.kansaschapteracs.org

Saudi Arabia Chapter  
**September 28**  
Riyadh, Saudi Arabia  
Contact: Anna Theresa P. Baltao,  
annruh@medart.com.sa

**OCTOBER**

Southwestern Pennsylvania Chapter  
**October 1**  
Pittsburgh, PA  
Contact: James Ireland,  
jireland@acms.org,  
www.acms.org/spec/ACS/index.html

Rhode Island Chapter  
**October 20**  
Providence, RI  
Contact: Megan Turcotte,  
turcotte@rimed.org,  
www.riacs.org

Italy Chapter  
**October 21–24**  
Rome, Italy  
Contact: Giuseppe Nigri,  
giuseppe.nigri@uniroma1.it,  
www.facsitaly.org

Connecticut Chapter  
**October 28**  
Farmington, CT  
Contact: Christopher Tasik,  
info@ctacs.org,  
www.ctacs.org

Arkansas Chapter  
**October 29**  
Little Rock, AR  
Contact: Linda Gist,  
lagist@uams.edu

**NOVEMBER**

San Diego Chapter  
**November 1**  
San Diego, CA  
Contact: Jim Cox,  
elcajonjim@cox.net,  
www.sdcacs.org

South Korea Chapter  
**November 3–5**  
Seoul, Korea  
Contact: Sun-Whe Kim,  
sunkim@plaza.snu.ac.kr

Wisconsin Surgical Society  
**November 4–5**  
Kohler, WS  
Contact: Terry Estness,  
wisurgical@att.net,  
www.wisurgicalsociety.com

**AGUSTINIAANS**

Argentina Chapter  
**November 14–17**  
Buenos Aires, Argentina  
Contact: Raul Ferreres,  
albertoferreres@gmail.com,  
www.facs.org.ar

Patient-Reported Outcomes in Surgery Conference  
**November 17**  
Washington, DC  
Contact: Katie Sommers,  
ksommers@plasticsurgery.org,  
bit.ly/2bkEfjl

Keystone Chapter  
**November 18**  
Danville, PA  
Contact: Lauren Newmaster,  
lnewmaster@pamedsoc.org,  
www.keystonesurgeons.org

Arizona Chapter  
**November 19–20**  
Tucson, AZ  
Contact: Joni Bowers,  
jonib@azmed.org,  
www.azacs.org

**FUTURE CLINICAL CONGRESSES**

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

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

2018  
**October 21–25**  
Boston, MA