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Undoubtedly, many of you are familiar with the phrase “the seven year itch.” It was first used in the play *The Seven Year Itch* to describe an inclination to evaluate your marriage after seven years and gained popularity in 1955 with the release of the movie version directed by Billy Wilder and starring Marilyn Monroe and Tom Ewell. It is now used to describe any situation in which people feel the need to make a change after being in the same role for seven or more years.

I recently concluded my seventh year as Executive Director of the American College of Surgeons (ACS) and admittedly have been feeling a bit of an itch to see the goals I set when first assuming this position come fully to their fruition.

**Quality improvement**

One of my primary goals when I first became Executive Director was to improve the stature and capabilities of our Quality Programs. I wanted to ensure that the public better understood the College’s role in quality improvement and safeguarding the well-being of surgical patients. We succeeded in increasing public awareness of the impact of quality improvement in health through our multi-year ACS Inspiring Quality Forum tour. Each stop along the tour included presentations and discussions by surgeon leaders, members of Congress, and patient advocates.

Expansion of our accreditation programs was another component of this objective. We have continued to grow our verification programs, including the accreditation activities in cancer, trauma, breast, bariatric, geriatric, and pediatric surgery. Advances in these areas continue, and will expand to other surgical specialties and subspecialties in the coming years. The next step will be in setting standards for quality improvement overall based on the ACS quality manual that is in development.

Making certain that surgeons have the tools they need to measure and evaluate their performance has been a key mission in the last seven years. To this end, we have initiated the database integration system, which will bring together, under a unified platform, our clinical registries, including the National Surgical Quality Improvement Program, the National Cancer Database, the National Trauma Data Bank®, the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program data bank, and the Surgeon Specific Registry. This project, which is being implemented incrementally, will make it easier for surgeons to meet American Board of Surgery (ABS) Maintenance of Certification requirements and Medicare payment mandates under the Centers for Medicare & Medicaid Services' new Quality Payment Program (QPP). We anticipate that within the next three years, by my 10th year as Executive Director, this database of the future will be fully integrated and in widespread use.

**Advocacy**

The QPP was created through the Medicare Access and CHIP (Children’s Health Insurance Program) Reauthorization Act (MACRA). The QPP replaces the flawed sustainable growth rate (SGR) methodology that was used for many years to calculate Medicare physician reimbursement. Repealing the SGR was a major goal for all of organized medicine seven years ago. Now that we have achieved this objective, the College’s focus has turned to ensuring that surgeons are able to comply with the QPP’s reporting requirements and performance measures. We have established a resource center for surgeons who are seeking information about the QPP and other MACRA provisions moving forward and working with health policy experts at Brandeis University, Waltham, MA, and Brigham and Womens’ Hospital, Boston, to propose alternative payment models.

We anticipate that the new presidential administration and Republican-controlled Congress will leave QPP untouched—at least for a while. However, we also speculate that they will attempt to either repeal the Affordable Care Act (ACA) or overturn a number of its provisions. The College needs to be prepared to offer viable health care reforms and to take a stance on any modifications that may affect access to surgical care. We will need to offer alternatives that uphold our principles of ensuring the provision of quality and safe care, patient access to surgical care, and reduction of
We anticipate that the new presidential administration and Republican-controlled Congress will leave QPP untouched—at least for a while. However, we also speculate that they will attempt to either repeal the Affordable Care Act (ACA) or overturn a number of its provisions.

health care costs. These values served us well when the ACA was being developed and will serve us well as the law is revised and implemented.

We also need to continue to push for liability reforms that will ensure patients are justly compensated for any harm they experience while under a surgeon’s care. In addition, we need to address ongoing issues with the electronic health record and with the sustainability of graduate medical education (GME) and the surgical workforce.

With the addition of Patrick V. Bailey, MD, FACS, Medical Director, Advocacy, and Frank G. Opelka, MD, FACS, Medical Director, Quality and Health Policy, in our Washington Office in 2014, we have become better positioned as an authoritative source of information inside the Beltway. I anticipate that this trend will continue and look forward to working with the new administration.

**Education**

Surgical education and training have been at the heart of the College’s mission since the organization’s inception. We believe the ACS’ education and training programs are the cornerstones of excellence, transform possibilities into realities, and instill the joy of lifelong learning.

Of particular concern in recent years have been reports that a significant percentage of general surgeon residency graduates leave training feeling uncertain about their ability to perform advanced procedures autonomously and to manage a practice. In response, the College launched the Transition to Practice in General Surgery program, which supports the transition to independent practice in general surgery through the following activities:

- Individualized, hands-on learning tailored to individual needs
- Independence and autonomy in clinical decision making
- Practical general surgery experience under the guidance of notable practicing surgeons
- One-year, paid staff appointments at institutions accredited by the ACS
- Exposure to important elements of practice management

This program continues to grow, with 25 institutions in 21 states now participating.

In addition, the College has been working with other stakeholders, including the ABS, the Accreditation Council for Graduate Medical
Today’s residents are tomorrow’s surgeons. Given the aging population that will be seeking their services, it is imperative that the House of Surgery takes responsibility for ensuring that graduates of general surgery training programs have the full range of skills and the confidence necessary to care for these vulnerable patients.

Education, the Association of Program Directors in Surgery (APDS), and the Residency Review Committee for Surgery (RRC), to develop a roadmap to secure the future of general surgery. Concepts discussed in these meetings include the following:

- Development of boot camps, which may be added to residency requirements
- Possible addition of further training after five years of core general surgery training
- Modifications to duty hour requirements in light of findings from the ongoing Flexibility In duty hour Requirements for Surgical Trainees Trial studies
- Development of a Competency-based Education and Skills Assessment, with the ACS claiming responsibility for creating a tool to track progress and compare residents and programs and working with the APDS to develop skills training
- Provision of opportunities for mentored autonomy
- Institution of community rotations
- Establishment of guidelines for self-assessment during residency
- Capstone training
- Initiation of an effort to have surgeon reviewers participate in 10-year reviews of residency programs
- Creation of a faculty development requirement, with the ACS and APDS establishing the curriculum
- Proposal for a model for career-long record keeping starting in medical school

Today’s residents are tomorrow’s surgeons. Given the aging population that will be seeking their services, it is imperative that the House of Surgery takes responsibility for ensuring that graduates of general surgery training programs have the full range of skills and the confidence necessary to care for these vulnerable patients.

Member services and communication

The College has re-energized the internal bodies that serve as the voice of the membership—the Board of Governors, the Advisory Councils, the Young Fellows Association, the Resident and Associate Society, and the ACS chapters. As a result, the College is a more diverse, dynamic, and nimble organization than ever before.

We are offering more opportunities for engagement, including a revitalized Operation Giving Back program with an emphasis on international and domestic volunteerism. Likewise, the annual Leadership & Advocacy Summit in Washington, DC, provides members with opportunities to hone their leadership skills and advocate on their patients’ behalf. Furthermore, we strengthened our emphasis on international development and have established a Regental committee to provide direction in this regard.

The College has continued to make its communications vehicles more interactive and user-friendly. We launched a fully rebuilt website in 2014 along with our ACS Communities, which allow members to share their concerns and interests in a protected environment. We also are working to have all of our major publications, including the *Bulletin* and the *Journal of the American College of Surgeons*, move to fully digital platforms.

I am proud of the strides the College has made in the last seven years and am itching to see us continue to grow and flourish in the next three. As always, please let us know your suggestions for the College’s future.

If you have comments or suggestions about this or other issues, please send them to Dr. Hoyt at lookingforward@facs.org.
The 2017 Medicare physician fee schedule:

An overview of provisions that will affect surgical practice

by Lauren Foe, MPH; Jan Nagle, MS, RPh; and Vinita Ollapally, JD
New payment policy and coding and reimbursement changes set forth in the 2017 Medicare physician fee schedule (MPFS) final rule took effect January 1. The MPFS, updated annually by the Centers for Medicare & Medicaid Services (CMS), lists payment rates for services furnished under Medicare Part B and introduces or modifies other policies that affect physician reimbursement and quality measurement.

On September 6, 2016, the American College of Surgeons (ACS) submitted comments to CMS related to the MPFS proposed rule released earlier in the year. These comments provided CMS with feedback on a number of provisions that are in the final rule, which was released November 2, 2016. Although the MPFS final rule outlines important payment and policy changes that affect all physicians, this article focuses on updates that are particularly relevant to general surgery and its related medical specialties.

**Collecting global codes data**
CMS finalized a policy mandated in the Medicare Access and CHIP (Children’s Health Insurance Program) Reauthorization Act (MACRA) of 2015, whereby certain physicians who provide 10- and 90-day global services will be required to report information on the number of postoperative visits they provide. Starting July 1, physicians who are part of practices with 10 or more practitioners and who live in one of nine specified states—Florida, Kentucky, Louisiana, Nevada, New Jersey, North Dakota, Ohio, Oregon, and Rhode Island—will be required to report Current Procedural Terminology (CPT)* code 99024, Postoperative follow-up visit, normally included in the surgical package, to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) related to the original procedure, for each postoperative visit they provide within the global period.

The nine states were selected based on size measured by the number of Medicare beneficiaries per state and Census Bureau region. Physicians in the selected states are not required to report on all 10- and 90-day global codes; rather, CMS will publish on its website a list of approximately 260 10- and 90-day global codes that are furnished by more than 100 practitioners and are either furnished more than 10,000 times or have allowed charges of more than $10 million annually. CMS estimates that these codes will describe approximately 87 percent of all furnished 10- and 90-day global services and about 77 percent of all Medicare expenditures for 10- and 90-day global services under the MPFS. This is a mandatory reporting requirement intended to allow CMS to gather enough data on postoperative visits to revalue global codes starting in 2019. MACRA gave CMS the authority to implement a 5 percent withhold in Medicare payments to encourage compliance with reporting the postoperative data; however, the agency chose not to implement this provision in the final rule.

In addition to the claims-based data collection, CMS finalized a policy to conduct a survey of Medicare practitioners to gain information about postoperative activities to supplement the claims-based data collection. CMS had not finalized the design of the survey at press time, but intends to begin surveying in mid-2017. This survey could affect physicians in all states, not just the nine selected for claims-based data reporting. The agency intends to collect global code data from Accountable Care Organizations (ACOs) but has yet to describe how it plans to collect those data or when ACO data collection will start.

The final rule on global codes data collection is a result of aggressive ACS legislative and regulatory advocacy. CMS released a drastically improved policy on collection of data from what was in the proposed rule. The proposed rule would have been impractical for surgeons in part because it would have created an unreasonable reporting burden that was not aligned with clinical workflow. When first proposed, all physicians who perform 10- and 90-day global codes in all states would have been required to report, not just those in large practices in a limited number of states. In addition, the proposed policy would have required using new Healthcare Common Procedure Coding System (HCPCS) G-codes that would have been reported in 10-minute increments, rather than submitting CPT.

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code 99024 once for each postoperative visit. Furthermore, the proposed rule would have required reporting on all 10- and 90-day global codes, rather than the narrow list of high-volume and high-Medicare expenditure codes. Finally, the proposed rule would have required reporting to begin January 1, rather than July 1, as finalized. (See Table 1, this page, for revisions to the proposed rule advocated by the ACS.)

ACS legislative and regulatory advocacy efforts included letters to lawmakers on Capitol Hill and to CMS staff, in-person meetings with members of Congress, participation in CMS town hall meetings, strategic meetings of the ACS Health Policy and Advocacy Group and General Surgery Coding and Reimbursement Committee, and the formation of an ACS-ledGlobals Coalition made up of multiple medical associations.

### Improving payment accuracy for care of people with disabilities

In the 2017 MPFS proposed rule, CMS proposed the creation of a new add-on code (G0501) to describe additional services furnished in conjunction with evaluation and management (E/M) services to beneficiaries with disabilities that impair their mobility. CMS indicated that the proposed add-on code would be reported with physician office and outpatient E/M codes (99201–99205, 99212–99215), as well as transitional care management codes (99495, 99496).

In their comments on the proposed rule, the ACS and other medical specialty associations agreed with CMS’ statement of disability disparities and perspective on the challenges that individuals with disabilities face in accessing the health care system. However, most also agreed that the root cause and scope of these issues are not well defined and suggested that CMS work with stakeholders to conduct additional studies and gain information regarding the underlying reasons for barriers to access to care and lower quality scores on certain measures.

CMS did not finalize payment for code G0501 and instead indicated the agency will engage with interested beneficiaries, advocates, and practitioners to continue to explore improvements in payment accuracy for care of people with disabilities. In addition, the agency included the code G0501 in the HCPCS code set and noted that practitioners would be able to report the code if they were so inclined.

### Non-face-to-face prolonged E/M services

Public commenters have repeatedly recommended that CMS establish separate payments for many services that are currently bundled under the MPFS, including non-face-to-face prolonged E/M service codes: 99358, *Prolonged evaluation and management service before and/or after direct patient care; first hour*, and 99359, *Prolonged evaluation and management service before and/or after direct patient care; each additional 30 minutes (List separately in addition to code for prolonged service)*. These non-face-to-face prolonged service codes are broadly described (although they include only time personally spent by the physician or other billing
practitioner) and have a relatively high time threshold. (The time counted must be an hour or more beyond the usual service time for the primary or “companion” E/M code that also is billed.) They are not reported for time spent in care plan oversight services or other non-face-to-face services that have more specific codes and no upper time limit in the CPT code set.

In the final rule, CMS agreed that payment for 99358 and 99359 codes would provide a means to recognize the additional resource costs of physicians and other billing practitioners when they spend an extraordinary amount of time outside of an E/M visit performing work that is related to that visit and does not involve direct patient contact (such as extensive medical record review, review of diagnostic test results, or other ongoing care management work).

In addition, CMS indicated its intention to adopt the CPT code descriptors and prefatory language for reporting these services, which requires that time counted toward the codes describe services furnished during a single day directly related to a discrete face-to-face service that may be provided on a different day. One caveat is that the services must be directly related to those furnished in a face-to-face visit. CMS stressed that these codes are to be used to report extended non-face-to-face time that is spent by the billing physician or other practitioner (not clinical staff) that is not within the scope of practice of clinical staff, and that is not adequately identified or valued under existing codes or the 2017 new codes.

The College encouraged CMS to allow physicians more time to select a CDSM and recommended that AUC reporting be implemented gradually in the initial years of the program, to allow for transparency and input from specialty societies. CMS considered the College’s comments and delayed the requirement for providers to consult CDSMs from its original January 1, 2017 deadline. The agency said it will direct qualified provider-led entities to post AUC—along with the process used to develop and modify AUC—online to allow for stakeholder review.

**AUC for advanced diagnostic imaging services**

Beginning January 1, 2018, physicians will be required to report appropriate use criteria (AUC) through a qualified clinical decision support mechanism (CDSM). The MPFS final rule indicated that a list of qualified CDSMs will be published by June 30, 2017, at which time some providers will be able to begin reporting AUC.

The College urged CMS to give groups and individual practitioners the opportunity to resubmit data when errors are discovered, and requested that the agency clarify how it plans to prevent data integrity issues in the new Quality Payment Program (QPP) outlined in MACRA. CMS finalized its four informal review policies to modify physicians’ quality and cost composites based either on an informal review determination or widespread quality and cost data issues. The agency addressed the College’s comments and indicated that quality data issues will be significantly limited moving forward due to program reporting enhancements.

Starting with the 2017 performance year, the QPP will combine the existing Medicare meaningful use

<table>
<thead>
<tr>
<th>TABLE 2.</th>
<th>CALCULATION OF THE 2017 MPFS CONVERSION FACTOR</th>
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<tbody>
<tr>
<td>Conversion factor in effect in 2016</td>
<td>$35.8043</td>
</tr>
<tr>
<td>Update factor</td>
<td>0.50 percent (1.0050)</td>
</tr>
<tr>
<td>2017 RVU budget neutrality adjustment</td>
<td>-0.013 percent (0.99987)</td>
</tr>
<tr>
<td>2017 target recapture amount</td>
<td>-0.18 percent (0.9982)</td>
</tr>
<tr>
<td>2017 MPPR adjustment</td>
<td>-0.07 percent (0.9993)</td>
</tr>
<tr>
<td>2017 conversion factor</td>
<td>$35.8887</td>
</tr>
</tbody>
</table>
Physician Quality Reporting System (PQRS) and VM programs into the Merit-based Incentive Payment System (MIPS). MIPS defines four categories of eligible clinician performance (quality, advancing care information, clinical practice improvement activities, and resource use), which contribute to an annual MIPS final score to determine Medicare Part B payment adjustments. The MIPS data collection system will provide enhanced real-time support to submitters to identify VM errors in a more rapid and accurate manner than the stand-alone PQRS and VM programs.

### Conversion factor

The 2017 MPFS conversion factor (CF) is $35.8887, which is slightly higher than the 2016 CF of $35.8043. The 2017 CF reflects a budget-neutral adjustment, a 0.5 percent update adjustment factor specified under section 1848 of the Social Security Act, an adjustment due to the non-budget neutral 5 percent multiple procedure payment reduction (MPPR) rule for the professional component of imaging services, and a -0.18 percent target recapture amount. (See Table 2, page 14, for details.) The target recapture amount was specified in the Protecting Access to Medicare Act of 2014, under which CMS established an annual target for reductions in MPFS expenditures resulting from adjustments to relative values of misvalued CPT codes for 2017–2020. The Achieving a Better Life Experience Act of 2014 set a 0.5 percent target for reduced expenditures for 2017 and 2018. If the estimated net reduction in MPFS expenditures resulting from adjustments to misvalued CPT codes in 2017 is equal to or greater than the 0.5 percent target, the reduced expenditures will be redistributed within the MPFS. The amount by which such reduced expenditures exceed the target for 2017 will be treated as a reduction in expenditures for 2018 to determine whether the annual target has been met.

### Overall effect on surgery

The 2017 combined impact of changes to relative value units (RVU) for specific services under the misvalued code initiative, along with changes to practice expense (PE) and malpractice (MP) RVUs, was 0 percent for general surgery. Table 3, this page, shows the estimated impact for all providers and other surgical specialties.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Impact of work RVU changes</th>
<th>Impact of PE RVU changes</th>
<th>Impact of MP RVU changes</th>
<th>Combined impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total—all providers</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Cardiac surgery</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Colon and rectal surgery</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>General surgery</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Hand surgery</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>-1</td>
<td>0</td>
<td>0</td>
<td>-1</td>
</tr>
<tr>
<td>Obstetrics/gynecology</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>-1</td>
<td>-2</td>
<td>0</td>
<td>-3</td>
</tr>
<tr>
<td>Orthopaedic surgery</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Otolaryngology</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>-1</td>
</tr>
<tr>
<td>Plastic surgery</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Thoracic surgery</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Urology</td>
<td>-1</td>
<td>0</td>
<td>0</td>
<td>-2</td>
</tr>
<tr>
<td>Vascular surgery</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>-1</td>
</tr>
</tbody>
</table>
2017 CPT coding changes

by Albert Bothe, MD, FACS;
Megan McNally, MD, FACS;
and Jan Nagle, MS, RPh
Significant changes in Current Procedural Terminology (CPT)* coding are being implemented in 2017. Notably, new codes have been established to separately report moderate sedation when provided in conjunction with a procedure, and Appendix G in the CPT manual—“Summary of CPT Codes that Include Moderate (Conscious) Sedation”—has been eliminated. This article provides reporting information about the codes that are relevant to general surgery and its related specialties.

**Moderate (conscious) sedation**

In 2014, the CPT Editorial Panel and the American Medical Association (AMA)/Specialty Society Relative Value Scale Update Committee (RUC) convened a joint workgroup to discuss correct reporting of moderate (conscious) sedation services. This workgroup was formed after Medicare claims data demonstrated that anesthesia services were being reported for codes that include moderate sedation as inherent to the work of the physician performing a procedure. After almost two years of discussion by the joint workgroup, the CPT Editorial Panel approved the following changes for the 2017 code set:

- Creation of six new codes (99151, 99152, 99153, 99155, 99156, 99157) to report moderate sedation services in 15-minute increments

- Revision of the moderate (conscious) sedation subsection guidelines

- Deletion of the moderate sedation symbol (⊙) from all codes in the CPT code set that were previously noted to inherently include moderate sedation services

- Elimination of Appendix G, “Summary of CPT Codes That Include Moderate (Conscious) Sedation”

Subsequent to the establishment of new CPT codes for moderate sedation, the Centers for Medicare & Medicaid Services (CMS) determined that moderate sedation services furnished by the same practitioner reporting a gastrointestinal (GI) endoscopy procedure was less work than for other procedures. Therefore, CMS created a new Healthcare Common Procedure Coding System (HCPCS) code (G0500) to be reported instead of CPT code 99152.

The new HCPCS and CPT moderate sedation codes include the following (* = new code for 2017, + = add-on code):

- **G0500**, Moderate sedation services provided by the same physician or other qualified health care professional performing a gastrointestinal endoscopic service that sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient’s level of consciousness and physiological status; initial 15 minutes of intra-service time; patient age 5 years or older (additional time may be reported with 99153 as appropriate)

- **99151**, Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient’s level of consciousness and physiological status; initial 15 minutes of intra-service time, patient younger than 5 years of age

- **99152**, Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient’s level of consciousness and physiological status; initial 15 minutes of intra-service time, patient age 5 years or older

- **99153**, Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient’s level of consciousness and physiological status;
each additional 15 minutes intraservice time (List separately in addition to code for primary service)

•99155, Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intraservice time, patient younger than 5 years of age

•99156, Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intraservice time, patient age 5 years or older

•99157, Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; each additional 15 minutes intraservice time (List separately in addition to code for primary service)

Moderate sedation relative value unit (RVU) changes
As of January 1, the physician work relative value units (wRVUs) will have been reduced for all services that previously included moderate sedation as an inherent part of the procedure. GI endoscopy procedures, with a few exceptions, will have been reduced by 0.10 wRVUs and the non-GI endoscopy procedures will be reduced by 0.25 wRVUs. These wRVU reductions match the values for the new HCPCS code G0500 (wRVU = 0.10) and new CPT code 99152 (wRVU = 0.25). If a surgeon provides moderate sedation services as described by code G0500 or code 99152, the surgeon would report both the moderate sedation code and the procedure code. However, if another provider (for example, an anesthesiologist) performs the moderate sedation service, the surgeon would only report the procedure code.

In addition to reduction in wRVUs for all codes affected by this coding change, CMS also has removed the physician time, clinical staff time, supply, and equipment inputs related to moderate sedation. As a result, practice expense RVUs and professional liability RVUs will be decreased. However, if a surgeon performs moderate sedation and reports both the moderate sedation code and the procedure code, the net total RVU will not change.

It will be important for surgeons to determine whether non-Medicare payors recommend using G0500 or 99152 for moderate sedation for GI endoscopy procedures when moderate sedation is performed by the surgeon who also performs the procedure. Furthermore, for an endoscopy patient younger than five years old, the surgeon furnishing moderate sedation should not use HCPCS code G0500, but instead use the appropriate CPT code(s).

Table 1 on pages 19–22 identifies the GI endoscopy procedures for which HCPCS code G0500 should be used to report moderate sedation services for Medicare patients. As shown in this table, the wRVU has been reduced by 0.10 for calendar year 2017.

Selecting code(s) to report moderate sedation
Intraservice time is used to determine the appropriate code to report moderate sedation services. The intraservice time begins with the administration of the sedating agent(s) and ends when the procedure is completed, the patient is stable for recovery, and the physician or other qualified health care professional providing the sedation ends personal, continuous face-to-face time with the patient. If the physician or other qualified health care professional who provides the sedation also performs the procedure supported by sedation (99151, 99152, 99153, G0500), the physician or other qualified health care professional will supervise and direct an independent, trained observer who will assist in monitoring the patient’s level of consciousness and physiological status throughout the procedure. Table 2 on page 23 provides examples to assist users in selection of the appropriate code(s) to report time spent providing moderate sedation services.

continued on page 23
### TABLE 1. GI ENDOSCOPY CODES RELATED TO REPORTING CODE G0500 FOR MODERATE SEDATION FOR MEDICARE PATIENTS*

<table>
<thead>
<tr>
<th>CPT / HCPCS code</th>
<th>Descriptor</th>
<th>2016 work RVU</th>
<th>2017 work RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>43200</td>
<td>Esophagoscopy flexible transoral diagnostic</td>
<td>1.52</td>
<td>1.42</td>
</tr>
<tr>
<td>43201</td>
<td>Esophagoscopy flexible transoral with submucous injection</td>
<td>1.82</td>
<td>1.72</td>
</tr>
<tr>
<td>43202</td>
<td>Esophagoscopy flexible transoral with biopsy</td>
<td>1.82</td>
<td>1.72</td>
</tr>
<tr>
<td>43204</td>
<td>Esophagoscopy flex transoral injection varices</td>
<td>2.43</td>
<td>2.33</td>
</tr>
<tr>
<td>43205</td>
<td>Esophagoscopy flex with band ligation esophageal varices</td>
<td>2.54</td>
<td>2.44</td>
</tr>
<tr>
<td>43206</td>
<td>Esophagoscopy transoral with optical endomicroscopy</td>
<td>2.39</td>
<td>2.29</td>
</tr>
<tr>
<td>43211</td>
<td>Esophagoscopy flexible transoral mucosal resection</td>
<td>4.30</td>
<td>4.20</td>
</tr>
<tr>
<td>43212</td>
<td>Esophagoscopy transoral stent placement</td>
<td>3.50</td>
<td>3.40</td>
</tr>
<tr>
<td>43213</td>
<td>Esophagoscopy retrograde dilate balloon/other</td>
<td>4.73</td>
<td>4.63</td>
</tr>
<tr>
<td>43214</td>
<td>Esophagoscopy dilate esophagus balloon 30 mm</td>
<td>3.50</td>
<td>3.40</td>
</tr>
<tr>
<td>43215</td>
<td>Esophagoscopy flexible removal foreign body</td>
<td>2.54</td>
<td>2.44</td>
</tr>
<tr>
<td>43216</td>
<td>Esophagoscopy flexible lesion removal hot biopsy forceps</td>
<td>2.40</td>
<td>2.30</td>
</tr>
<tr>
<td>43217</td>
<td>Esophagoscopy flexible lesion removal tumor snare</td>
<td>2.90</td>
<td>2.80</td>
</tr>
<tr>
<td>43220</td>
<td>Esophagoscopy flexible balloon dilation &lt;30 mm diameter</td>
<td>2.10</td>
<td>2.00</td>
</tr>
<tr>
<td>43226</td>
<td>Esophagoscopy flexible guide wire dilation</td>
<td>2.34</td>
<td>2.24</td>
</tr>
<tr>
<td>43227</td>
<td>Esophagoscopy flexible with bleeding control</td>
<td>2.99</td>
<td>2.89</td>
</tr>
<tr>
<td>43229</td>
<td>Esophagoscopy flex transoral lesion ablation</td>
<td>3.59</td>
<td>3.49</td>
</tr>
<tr>
<td>43231</td>
<td>Esophagoscopy flexible transoral ultrasound exam</td>
<td>2.90</td>
<td>2.80</td>
</tr>
<tr>
<td>43232</td>
<td>Esophagoscopy intra/transmural needle aspiration/biopsy</td>
<td>3.69</td>
<td>3.59</td>
</tr>
<tr>
<td>43233</td>
<td>Esophagogastroduodenoscopy (EGD) esophagus balloon dilation 30 mm or larger</td>
<td>4.17</td>
<td>4.07</td>
</tr>
<tr>
<td>43235</td>
<td>EGD transoral diagnostic</td>
<td>2.19</td>
<td>2.09</td>
</tr>
<tr>
<td>43236</td>
<td>EGD submucosal injection</td>
<td>2.49</td>
<td>2.39</td>
</tr>
<tr>
<td>43237</td>
<td>EGD ultrasound (US) scope with adjacent structures</td>
<td>3.57</td>
<td>3.47</td>
</tr>
<tr>
<td>43238</td>
<td>EGD intramural US needle aspirate/biopsy esophagus</td>
<td>4.26</td>
<td>4.16</td>
</tr>
<tr>
<td>43239</td>
<td>EGD transoral biopsy single/multiple</td>
<td>2.49</td>
<td>2.39</td>
</tr>
<tr>
<td>43240</td>
<td>EGD transoral transmural drainage pseudocyst</td>
<td>7.25</td>
<td>7.15</td>
</tr>
<tr>
<td>43241</td>
<td>EGD intraluminal tube/catheter insertion</td>
<td>2.59</td>
<td>2.49</td>
</tr>
<tr>
<td>43242</td>
<td>EGD intramural needle aspiration/biopsy altered anatomy</td>
<td>4.83</td>
<td>4.73</td>
</tr>
<tr>
<td>43243</td>
<td>EGD injection sclerosis esophageal/gastric varices</td>
<td>4.37</td>
<td>4.27</td>
</tr>
<tr>
<td>43244</td>
<td>EGD band ligation esophageal/gastric varices</td>
<td>4.50</td>
<td>4.40</td>
</tr>
<tr>
<td>43245</td>
<td>EGD dilation gastric/duodenal stricture</td>
<td>3.18</td>
<td>3.08</td>
</tr>
<tr>
<td>43246</td>
<td>EGD percutaneous placement gastrostomy tube</td>
<td>3.66</td>
<td>3.56</td>
</tr>
<tr>
<td>43247</td>
<td>EGD flexible foreign body removal</td>
<td>3.21</td>
<td>3.11</td>
</tr>
<tr>
<td>43248</td>
<td>EGD insert guide wire dilator passage esophagus</td>
<td>3.01</td>
<td>2.91</td>
</tr>
<tr>
<td>43249</td>
<td>EGD balloon dilation esophagus &lt;30 mm diameter</td>
<td>2.77</td>
<td>2.67</td>
</tr>
</tbody>
</table>

*HCPCS code G0500 should be used to report moderate sedation services for Medicare patients when a surgeon performs both the moderate sedation service and the GI endoscopy procedures.

*continued on next page*
### TABLE 1. GI ENDOSCOPY CODES RELATED TO REPORTING CODE G0500 FOR MODERATE SEDATION FOR MEDICARE PATIENTS* (CONTINUED)

<table>
<thead>
<tr>
<th>CPT / HCPCS code</th>
<th>Descriptor</th>
<th>2016 work RVU</th>
<th>2017 work RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>43250</td>
<td>EGD flex removal lesion(s) by hot biopsy forceps</td>
<td>3.07</td>
<td>2.97</td>
</tr>
<tr>
<td>43251</td>
<td>EGD removal tumor polyp/other lesion snare tech</td>
<td>3.57</td>
<td>3.47</td>
</tr>
<tr>
<td>43252</td>
<td>EGD flex transoral with optical endomicroscopy</td>
<td>3.06</td>
<td>2.96</td>
</tr>
<tr>
<td>43253</td>
<td>EGD US guided transmural injection/fiducial marker</td>
<td>4.83</td>
<td>4.73</td>
</tr>
<tr>
<td>43254</td>
<td>EGD transoral endoscopic mucosal resection</td>
<td>4.97</td>
<td>4.87</td>
</tr>
<tr>
<td>43255</td>
<td>EGD transoral control bleeding any method</td>
<td>3.66</td>
<td>3.56</td>
</tr>
<tr>
<td>43257</td>
<td>EGD deliver thermal energy sphincter/cardia gastroesophageal reflux disease</td>
<td>4.25</td>
<td>4.15</td>
</tr>
<tr>
<td>43259</td>
<td>EGD US exam surgical alter stomach duodenum/jejunum</td>
<td>4.14</td>
<td>4.04</td>
</tr>
<tr>
<td>43260</td>
<td>Endoscopic retrograde cholangiopancreatography (ERCP); diagnostic collection specimen brushing/washing</td>
<td>5.95</td>
<td>5.85</td>
</tr>
<tr>
<td>43261</td>
<td>ERCP with biopsy single/multiple</td>
<td>6.25</td>
<td>6.15</td>
</tr>
<tr>
<td>43262</td>
<td>ERCP with sphincterotomy/papillotomy</td>
<td>6.60</td>
<td>6.50</td>
</tr>
<tr>
<td>43263</td>
<td>ERCP with pressure measurement sphincter of Oddi</td>
<td>6.60</td>
<td>6.50</td>
</tr>
<tr>
<td>43264</td>
<td>ERCP remove calculi/debris biliary/pancreas duct</td>
<td>6.73</td>
<td>6.63</td>
</tr>
<tr>
<td>43265</td>
<td>ERCP destruction/lithotripsy calculi any method</td>
<td>8.03</td>
<td>7.93</td>
</tr>
<tr>
<td>43274</td>
<td>ERCP stent placement biliary/pancreatic duct</td>
<td>8.58</td>
<td>8.48</td>
</tr>
<tr>
<td>43275</td>
<td>ERCP remove foreign body/stent biliary/pancreatic duct</td>
<td>6.96</td>
<td>6.86</td>
</tr>
<tr>
<td>43276</td>
<td>ERCP biliary/pancreatic duct stent exchange with dilation and wire</td>
<td>8.94</td>
<td>8.84</td>
</tr>
<tr>
<td>43277</td>
<td>ERCP balloon dilate biliary/pancreatic duct/ampulla each</td>
<td>7.00</td>
<td>6.90</td>
</tr>
<tr>
<td>43278</td>
<td>ERCP tumor/polyp/lesion ablation with dilation and wire</td>
<td>8.02</td>
<td>7.92</td>
</tr>
<tr>
<td>43450</td>
<td>Dilation esophagus unguided sound/bougie one or more pass</td>
<td>1.38</td>
<td>1.28</td>
</tr>
<tr>
<td>43453</td>
<td>Dilation esophagus guide wire</td>
<td>1.51</td>
<td>1.41</td>
</tr>
<tr>
<td>44360</td>
<td>Endoscopy upper small intestine</td>
<td>2.59</td>
<td>2.49</td>
</tr>
<tr>
<td>44361</td>
<td>Endoscopy upper small intestine with biopsy</td>
<td>2.87</td>
<td>2.77</td>
</tr>
<tr>
<td>44363</td>
<td>Enteroscopy &gt; second portion with removal foreign body</td>
<td>3.49</td>
<td>3.39</td>
</tr>
<tr>
<td>44364</td>
<td>Enteroscopy &gt; second portion with removal lesion snare</td>
<td>3.73</td>
<td>3.63</td>
</tr>
<tr>
<td>44365</td>
<td>Enteroscopy &gt; second portion with removal lesion cautery</td>
<td>3.31</td>
<td>3.21</td>
</tr>
<tr>
<td>44366</td>
<td>Enteroscopy &gt; second portion with control bleeding</td>
<td>4.40</td>
<td>4.30</td>
</tr>
<tr>
<td>44369</td>
<td>Enteroscopy &gt; second portion ablation lesion</td>
<td>4.51</td>
<td>4.41</td>
</tr>
<tr>
<td>44370</td>
<td>Enteroscopy &gt; second portion transendoscopic stent placement</td>
<td>4.79</td>
<td>4.69</td>
</tr>
<tr>
<td>44372</td>
<td>Enteroscopy &gt; second portion with placement percutaneous tube</td>
<td>4.40</td>
<td>4.30</td>
</tr>
<tr>
<td>44373</td>
<td>Enteroscopy &gt; second portion conversion to jejunostomy tube</td>
<td>3.49</td>
<td>3.39</td>
</tr>
<tr>
<td>44376</td>
<td>Enteroscopy &gt; second portion with ileum with or without collection spec</td>
<td>5.25</td>
<td>5.15</td>
</tr>
<tr>
<td>44377</td>
<td>Enteroscopy &gt; second portion with ileum with biopsy single/multiple</td>
<td>5.52</td>
<td>5.42</td>
</tr>
<tr>
<td>44378</td>
<td>Enteroscopy &gt; second portion ileum control bleeding</td>
<td>7.12</td>
<td>7.02</td>
</tr>
</tbody>
</table>

*HCPCS code G0500 should be used to report moderate sedation services for Medicare patients when a surgeon performs both the moderate sedation service and the GI endoscopy procedures.

*continued on next page*
### Table 1. GI Endoscopy Codes Related to Reporting Code G0500 for Moderate Sedation for Medicare Patients* (Continued)

<table>
<thead>
<tr>
<th>CPT / HCPCS code</th>
<th>Descriptor</th>
<th>2016 work RVU</th>
<th>2017 work RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>44379</td>
<td>Enteroscopy &gt; second portion with ileum with stent placement</td>
<td>7.46</td>
<td>7.36</td>
</tr>
<tr>
<td>44380</td>
<td>Ileoscopy thru stoma diagnostic with collection spec when performed</td>
<td>0.97</td>
<td>0.87</td>
</tr>
<tr>
<td>44381</td>
<td>Ileoscopy thru stoma with balloon dilation</td>
<td>1.48</td>
<td>1.38</td>
</tr>
<tr>
<td>44382</td>
<td>Ileoscopy thru stoma with biopsy single/multiple</td>
<td>1.27</td>
<td>1.17</td>
</tr>
<tr>
<td>44384</td>
<td>Ileoscopy thru stoma with placement of endoscopic stent</td>
<td>2.95</td>
<td>2.85</td>
</tr>
<tr>
<td>44385</td>
<td>Endoscopic evaluation intestinal pouch diagnostic with collection spec</td>
<td>1.30</td>
<td>1.20</td>
</tr>
<tr>
<td>44386</td>
<td>Endoscopic evaluation intestinal pouch with biopsy single/multiple</td>
<td>1.60</td>
<td>1.50</td>
</tr>
<tr>
<td>44388-53</td>
<td>Colonoscopy thru stoma diagnostic including collection spec</td>
<td>1.41</td>
<td>1.36</td>
</tr>
<tr>
<td>44388</td>
<td>Colonoscopy thru stoma diagnostic including collection spec</td>
<td>2.82</td>
<td>2.72</td>
</tr>
<tr>
<td>44389</td>
<td>Colonoscopy thru stoma with biopsy single/multiple</td>
<td>3.12</td>
<td>3.02</td>
</tr>
<tr>
<td>44390</td>
<td>Colonoscopy thru stoma with removal foreign body</td>
<td>3.84</td>
<td>3.74</td>
</tr>
<tr>
<td>44391</td>
<td>Colonoscopy thru stoma control bleeding</td>
<td>4.22</td>
<td>4.12</td>
</tr>
<tr>
<td>44392</td>
<td>Colonoscopy thru stoma removal lesion by hot biopsy forceps</td>
<td>3.63</td>
<td>3.53</td>
</tr>
<tr>
<td>44394</td>
<td>Colonoscopy thru stoma with removal tumor polyp/other lesion by snare</td>
<td>4.13</td>
<td>4.03</td>
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<tr>
<td>44401</td>
<td>Colonoscopy thru stoma ablation lesion</td>
<td>4.44</td>
<td>4.34</td>
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<tr>
<td>44402</td>
<td>Colonoscopy thru stoma with endoscopic stent placement</td>
<td>4.80</td>
<td>4.70</td>
</tr>
<tr>
<td>44403</td>
<td>Colonoscopy thru stoma with endoscopic mucosal resection</td>
<td>5.60</td>
<td>5.50</td>
</tr>
<tr>
<td>44404</td>
<td>Colonoscopy thru stoma with submucosal injection</td>
<td>3.12</td>
<td>3.02</td>
</tr>
<tr>
<td>44405</td>
<td>Colonoscopy thru stoma with balloon dilation</td>
<td>3.33</td>
<td>3.23</td>
</tr>
<tr>
<td>44406</td>
<td>Colonoscopy thru stoma with ultrasound exam</td>
<td>4.20</td>
<td>4.10</td>
</tr>
<tr>
<td>44407</td>
<td>Colonoscopy thru stoma with US guided needle aspiration/biopsy</td>
<td>5.06</td>
<td>4.96</td>
</tr>
<tr>
<td>44408</td>
<td>Colonoscopy thru stoma with decompression</td>
<td>4.24</td>
<td>4.14</td>
</tr>
<tr>
<td>44500</td>
<td>Introduction of long gastrointestinal tube (separate procedure)</td>
<td>0.49</td>
<td>0.39</td>
</tr>
<tr>
<td>45303</td>
<td>Proctosigmoidoscopy rigid with dilation</td>
<td>1.50</td>
<td>1.40</td>
</tr>
<tr>
<td>45305</td>
<td>Proctosigmoidoscopy rigid with biopsy single/multiple</td>
<td>1.25</td>
<td>1.15</td>
</tr>
<tr>
<td>45307</td>
<td>Proctosigmoidoscopy rigid with removal foreign body</td>
<td>1.70</td>
<td>1.60</td>
</tr>
<tr>
<td>45308</td>
<td>Proctosigmoidoscopy rigid removal one lesion cautery</td>
<td>1.40</td>
<td>1.30</td>
</tr>
<tr>
<td>45309</td>
<td>Proctosigmoidoscopy rigid removal one lesion snare</td>
<td>1.50</td>
<td>1.40</td>
</tr>
<tr>
<td>45315</td>
<td>Proctosigmoidoscopy rigid removal multi-tumor by cautery/snare</td>
<td>1.80</td>
<td>1.70</td>
</tr>
<tr>
<td>45317</td>
<td>Proctosigmoidoscopy rigid control bleeding</td>
<td>2.00</td>
<td>1.90</td>
</tr>
<tr>
<td>45320</td>
<td>Proctosigmoidoscopy rigid ablation lesion</td>
<td>1.78</td>
<td>1.68</td>
</tr>
<tr>
<td>45321</td>
<td>Proctosigmoidoscopy rigid decompression volvulus</td>
<td>1.75</td>
<td>1.65</td>
</tr>
<tr>
<td>45327</td>
<td>Proctosigmoidoscopy rigid transendoscopic stent placement</td>
<td>2.00</td>
<td>1.90</td>
</tr>
<tr>
<td>45332</td>
<td>Sigmoidoscopy flexible with removal foreign body</td>
<td>1.86</td>
<td>1.76</td>
</tr>
</tbody>
</table>

*HCPCS code G0500 should be used to report moderate sedation services for Medicare patients when a surgeon performs both the moderate sedation service and the GI endoscopy procedures.

continued on next page
### TABLE 1. GI ENDOSCOPY CODES RELATED TO REPORTING CODE G0500 FOR MODERATE SEDATION FOR MEDICARE PATIENTS* (CONTINUED)

<table>
<thead>
<tr>
<th>CPT / HCPCS code</th>
<th>Descriptor</th>
<th>2016 work RVU</th>
<th>2017 work RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>45333</td>
<td>Sigmoidoscopy flexible with removal tumor by hot biopsy forceps</td>
<td>1.65</td>
<td>1.55</td>
</tr>
<tr>
<td>45334</td>
<td>Sigmoidoscopy flexible control bleeding</td>
<td>2.10</td>
<td>2.00</td>
</tr>
<tr>
<td>45335</td>
<td>Sigmoidoscopy flexible directed submucosal injection any substance</td>
<td>1.14</td>
<td>1.04</td>
</tr>
<tr>
<td>45337</td>
<td>Sigmoidoscopy flexible with decompression with placement of tube</td>
<td>2.20</td>
<td>2.10</td>
</tr>
<tr>
<td>45338</td>
<td>Sigmoidoscopy flexible removal tumor, polyp, or other lesion by snare</td>
<td>2.15</td>
<td>2.05</td>
</tr>
<tr>
<td>45340</td>
<td>Sigmoidoscopy flexible transendoscopic balloon dilatation</td>
<td>1.35</td>
<td>1.25</td>
</tr>
<tr>
<td>45341</td>
<td>Sigmoidoscopy flexible transendoscopic US exam</td>
<td>2.22</td>
<td>2.12</td>
</tr>
<tr>
<td>45342</td>
<td>Sigmoidoscopy flexible transendoscopic US-guided needle aspiration/biopsy</td>
<td>3.08</td>
<td>2.98</td>
</tr>
<tr>
<td>45346</td>
<td>Sigmoidoscopy flexible ablation tumor polyp/other lesion</td>
<td>2.91</td>
<td>2.81</td>
</tr>
<tr>
<td>45347</td>
<td>Sigmoidoscopy flexible placement of endoscopic stent</td>
<td>2.82</td>
<td>2.72</td>
</tr>
<tr>
<td>45349</td>
<td>Sigmoidoscopy flexible with endoscopic mucosal resection</td>
<td>3.62</td>
<td>3.52</td>
</tr>
<tr>
<td>45350</td>
<td>Sigmoidoscopy flexible with band ligation(s)</td>
<td>1.78</td>
<td>1.68</td>
</tr>
<tr>
<td>45378-53</td>
<td>Colonoscopy flexible diagnostic with collection spec when performed</td>
<td>1.68</td>
<td>1.63</td>
</tr>
<tr>
<td>45379</td>
<td>Colonoscopy flexible diagnostic with collection spec when performed</td>
<td>3.36</td>
<td>3.26</td>
</tr>
<tr>
<td>G0105-53</td>
<td>Screening colonoscopy on individual at high risk</td>
<td>1.68</td>
<td>1.63</td>
</tr>
<tr>
<td>G0105</td>
<td>Screening colonoscopy on individual at high risk</td>
<td>3.36</td>
<td>3.26</td>
</tr>
<tr>
<td>G0121-53</td>
<td>Screening colonoscopy on individual not high risk</td>
<td>1.68</td>
<td>1.63</td>
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<tr>
<td>G0121</td>
<td>Screening colonoscopy on individual not high risk</td>
<td>3.36</td>
<td>3.26</td>
</tr>
<tr>
<td>45379</td>
<td>Colonoscopy flexible with removal of foreign body(s)</td>
<td>4.38</td>
<td>4.28</td>
</tr>
<tr>
<td>45380</td>
<td>Colonoscopy flexible with biopsy single/multiple</td>
<td>3.66</td>
<td>3.56</td>
</tr>
<tr>
<td>45381</td>
<td>Colonoscopy flexible with directed submucosal injection any substance</td>
<td>3.66</td>
<td>3.56</td>
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<tr>
<td>45382</td>
<td>Colonoscopy flexible with control bleeding any method</td>
<td>4.76</td>
<td>4.66</td>
</tr>
<tr>
<td>45384</td>
<td>Colonoscopy flexible with removal lesion by hot biopsy forceps</td>
<td>4.17</td>
<td>4.07</td>
</tr>
<tr>
<td>45385</td>
<td>Colonoscopy flexible with removal of tumor polyp lesion by snare</td>
<td>4.67</td>
<td>4.57</td>
</tr>
<tr>
<td>45386</td>
<td>Colonoscopy flexible with transendoscopic balloon dilatation</td>
<td>3.87</td>
<td>3.77</td>
</tr>
<tr>
<td>45388</td>
<td>Colonoscopy flexible ablation tumor polyp/other lesion</td>
<td>4.98</td>
<td>4.88</td>
</tr>
<tr>
<td>45389</td>
<td>Colonoscopy flexible with endoscopic stent placement</td>
<td>5.34</td>
<td>5.24</td>
</tr>
<tr>
<td>45390</td>
<td>Colonoscopy flexible with endoscopic mucosal resection</td>
<td>6.14</td>
<td>6.04</td>
</tr>
<tr>
<td>45391</td>
<td>Colonoscopy flexible with limited endoscopic US exam</td>
<td>4.74</td>
<td>4.64</td>
</tr>
<tr>
<td>45392</td>
<td>Colonoscopy flexible with US-guided needle aspiration/biopsy with limited endoscopic US exam</td>
<td>5.60</td>
<td>5.50</td>
</tr>
<tr>
<td>45393</td>
<td>Colonoscopy flexible with decompression</td>
<td>4.78</td>
<td>4.68</td>
</tr>
<tr>
<td>45398</td>
<td>Colonoscopy flexible with band ligation(s)</td>
<td>4.30</td>
<td>4.20</td>
</tr>
</tbody>
</table>

*HCPCS code G0500 should be used to report moderate sedation services for Medicare patients when a surgeon performs both the moderate sedation service and the GI endoscopy procedures.
### TABLE 2. MODERATE SEDATION CODING GUIDANCE

<table>
<thead>
<tr>
<th>Total intraservice time for moderate sedation</th>
<th>Patient age</th>
<th>Code(s)</th>
<th>Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 10 minutes</td>
<td>Any age</td>
<td>Not separately reported</td>
<td>Not separately reported</td>
</tr>
<tr>
<td>10–22 minutes</td>
<td>&lt;5 years</td>
<td>99151</td>
<td>99155</td>
</tr>
<tr>
<td>10–22 minutes</td>
<td>5 years or older</td>
<td>99152*</td>
<td>99156</td>
</tr>
<tr>
<td>23–37 minutes</td>
<td>&lt;5 years</td>
<td>99151 + 99153 × 1</td>
<td>99155 + 99157 × 1</td>
</tr>
<tr>
<td>23–37 minutes</td>
<td>5 years or older</td>
<td>99152* + 99153 × 1</td>
<td>99156 + 99157 × 1</td>
</tr>
<tr>
<td>38–52 minutes</td>
<td>&lt;5 years</td>
<td>99151 + 99153 × 2</td>
<td>99155 + 99157 × 2</td>
</tr>
<tr>
<td>38–52 minutes</td>
<td>5 years or older</td>
<td>99152* + 99153 × 2</td>
<td>99156 + 99157 × 2</td>
</tr>
<tr>
<td>53–67 minutes</td>
<td>&lt;5 years</td>
<td>99151 + 99153 × 3</td>
<td>99155 + 99157 × 3</td>
</tr>
<tr>
<td>53–67 minutes</td>
<td>5 years or older</td>
<td>99152* + 99153 × 3</td>
<td>99156 + 99157 × 3</td>
</tr>
<tr>
<td>68–82 minutes</td>
<td>&lt;5 years</td>
<td>99151 + 99153 × 4</td>
<td>99155 + 99157 × 4</td>
</tr>
<tr>
<td>68–82 minutes</td>
<td>5 years or older</td>
<td>99152* + 99153 × 4</td>
<td>99156 + 99157 × 4</td>
</tr>
<tr>
<td>83 minutes or longer</td>
<td>&lt;5 years</td>
<td>Add 99153</td>
<td>Add 99157</td>
</tr>
<tr>
<td>83 minutes or longer</td>
<td>5 years or older</td>
<td>Add 99153</td>
<td>Add 99157</td>
</tr>
</tbody>
</table>

*For Medicare patients, report HCPCS code G0500 for GI endoscopy procedures instead of CPT code 99152.

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**Amputation of tuft of distal phalanx**

Code 11752, *Excision of nail and nail matrix, partial or complete (for example, ingrown or deformed nail), for permanent removal; with amputation of tuft of distal phalanx*, was deleted from the 2017 CPT code set. It was determined that the work inherent to this procedure was widely variable and appropriate treatment depended on the patient presentation and diagnosis. For example, fingertip amputations are described according to the angle of loss (lateral, dorsal, transverse, palmar), skeletal loss (soft tissue only, tuft, shaft, base) and zone of injury relating to mechanism of injury (sharp, crush, saw blade, thermal knife). Treatment is individualized for each patient based on these and other factors. For correct reporting, see codes 26236, *Partial excision (craterization, saucerization, or diaphysectomy) bone (for example, osteomyelitis); distal phalanx of finger; code 28124, Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (for example, osteomyelitis or bossing); phalanx of toe; or code 28160, Hemiphalangectomy or interphalangeal joint excision, toe, proximal end of phalanx, each*. In addition, procedures related to skin (for example, pinch graft) may be separately reported when performed.

**Excisional bone biopsy**

In 2014, the RUC identified two codes used to report excisional bone biopsy (20240, 20245) as potentially misvalued in the Medicare physician fee schedule (MPFS) because the codes included more than one postoperative visit within the 010 global period. After review by the RUC, it was determined that both codes had wide variability in postoperative care and, therefore, both codes should have a 000 global period assignment; CMS agreed to this change. For 2017, both codes have a 000 global assignment and the code descriptors have been revised to include additional examples of bones to differentiate superficial bones from deep bones (▲ = revised code for 2017):
Mechanochemical ablation therapy of incompetent vein(s)

The CPT code set includes a number of codes to report the treatment of venous disease such as varicose veins and incompetence of truncal veins, including the following: direct puncture sclerotherapy with or without local anesthesia (36468, 36470, 36471); stab phlebectomy under local anesthesia (37765, 37766); laser or radiofrequency thermal ablation utilizing tumescent anesthesia (36475, 36476, 36478, 36479); and surgical vein ligation and/or vein stripping under monitored or general anesthesia (37700–37761, 37780–37785).

As of January 1, two new codes may be used to describe mechanochemical ablation (MOCA) therapy of incompetent lower extremity vein(s). The MOCA procedure can be performed using local anesthesia without the need for tumescent (peri-saphenous) anesthesia and involves concomitant use of an intraluminal device that mechanically disrupts/abrades the venous intima, and infusion of a physician-specified medication in the target vein(s). This ablation method does not use thermal energy; therefore, the potential for nerve damage is minimized. The following two new codes are used to describe MOCA therapy:

- 36473, Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated
- 36474, Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)

Note that for catheter injection of sclerosant without concomitant endovascular mechanical disruption of the vein intima or for catheter injection of an adhesive, code 37799, Unlisted procedure, vascular surgery, should be reported.

Dialysis circuit

The Joint CPT/RUC Workgroup on Codes Reported Together Frequently identified codes related to dialysis circuit interventions that are frequently reported together in various combinations. This required creation of bundled codes for reporting these services. The arteriovenous (AV) dialysis circuit is designed for easy and repetitive access to perform hemodialysis. It begins at the arterial anastomosis and extends to the right atrium. The circuit may be created using either an arterial-venous anastomosis, known as an arteriovenous fistula, or a prosthetic graft placed between an artery and vein, known as an arteriovenous graft. The dialysis circuit comprises two segments: (1) the peripheral dialysis segment, and (2) the central dialysis segment. For 2017, the CPT Editorial Panel established nine new bundled codes to report angioplasty, stent placement, thrombectomy, embolization, and radiological supervision and interpretation within the dialysis circuit, including the following:

- 36901, Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow, including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report
- 36902, with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty
- 36903, with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis segment
•36904, Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s)

•36905, with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty

•36906, with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis circuit

+•36907, Transluminal balloon angioplasty, central dialysis segment, performed through dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the angioplasty (List separately in addition to code for primary procedure)

+•36908, Transcatheter placement of intravascular stent(s), central dialysis segment, performed through dialysis circuit, including all imaging radiological supervision and interpretation required to perform the stenting, and all angioplasty in the central dialysis segment (List separately in addition to code for primary procedure)

+•36909, Dialysis circuit permanent vascular embolization or occlusion (including main circuit or any accessory veins), endovascular, including all imaging and radiological supervision and interpretation necessary to complete the intervention (List separately in addition to code for primary procedure)

•36904, Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s)

•36905, with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty

•36906, with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis circuit

+•36907, Transluminal balloon angioplasty, central dialysis segment, performed through dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the angioplasty (List separately in addition to code for primary procedure)

+•36908, Transcatheter placement of intravascular stent(s), central dialysis segment, performed through dialysis circuit, including all imaging radiological supervision and interpretation required to perform the stenting, and all angioplasty in the central dialysis segment (List separately in addition to code for primary procedure)

+•36909, Dialysis circuit permanent vascular embolization or occlusion (including main circuit or any accessory veins), endovascular, including all imaging and radiological supervision and interpretation necessary to complete the intervention (List separately in addition to code for primary procedure)

Esophageal sphincter augmentation with magnetic band

Two new codes (43284, 43285) were established to report laparoscopic implantation and to report removal of a magnetic bead sphincter augmentation device for treatment of gastroesophageal reflux disease (GERD). With establishment of these codes, the following two CPT Category III codes (0392T, 0393T) were deleted:

•43284, Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement of sphincter augmentation device (ie, magnetic band), including cruroplasty when performed

•43285, Removal of esophageal sphincter augmentation device

Abdominal aortic aneurysm screening

A new CPT Category I code (76706) was established to report abdominal aortic aneurysm (AAA) screening. An AAA is a weakening in the wall of the infrarenal aorta that typically results in an increased anteroposterior diameter of 3 cm or greater in the adult population. AAAs are often undiagnosed because a large proportion of patients are asymptomatic until the development of rupture, which is generally acute and often fatal. Screening is recommended to identify those patients who may be at increased risk and to assist in early detection.

The U.S. Preventive Services Task Force recommends one-time screening for AAA with ultrasonography in men ages 65 to 75 years who have smoked, and recommends screening for AAA be offered selectively to men ages 65 to 75 who have never smoked. Code 76706 will replace HCPCS code G0389, Ultrasound B-scan and/or real time with image documentation; for abdominal aortic aneurysm (AAA) screening, which is deleted for 2017.

In addition, it is inappropriate to report code 76770, Ultrasound, retroperitoneal (for example, renal, aorta, nodes), real time with image documentation; complete, or code 76775, Ultrasound, retroperitoneal for example, renal, aorta, nodes), real time with image documentation; limited, for AAA screening. Rather, use the following code:

•76706, Ultrasound, abdominal aorta, real time with image documentation, screening study for abdominal aortic aneurysm (AAA) ♦

Note

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

Mary T. Hawn, MD, MPH, FACS

by Juliet A. Emamaullee, MD, PhD, FRCSC, and Kamal M. F. Itani, MD, FACS

Editor’s note: The Bulletin is collaborating with the American College of Surgeons (ACS) Surgical Research Committee to present a series titled “Profiles in surgical research.” These interviews are published periodically and highlight prominent surgeon-scientist members of the ACS.

Mary T. Hawn, MD, MPH, FACS, professor of surgery and chair, department of surgery, Stanford University, CA, is the fifth interviewee in the “Profiles in Surgical Research” series. Dr. Hawn specializes in minimally invasive foregut surgery and has been a prolific health services researcher, focusing on complications and policy in postoperative patients. She has published more than 100 articles and currently serves on the editorial boards of the Journal of the American College of Surgeons, Annals of Surgery, the Journal of Gastrointestinal Surgery, and the American Journal of Surgery.

Dr. Hawn is director, American Board of Surgery; treasurer, Surgical Society of the Alimentary Tract; Chair, Scientific Forum Committee for the ACS Clinical Congress; and a member of the American Surgical Association.

Dr. Hawn earned her doctor of medicine (MD) degree, a master of public health (MPH), and completed her general surgery training at the University of Michigan, Ann Arbor. She completed a fellowship in minimally invasive surgery at the Oregon Health and Science University (OHSU), Portland.

Dr. Hawn was interviewed in September 2016 by Juliet A. Emamaullee, MD, PhD, FRCSC, a transplant surgery fellow at the University of Alberta, Edmonton, and a member of the Surgical Research Committee.
Are you the first physician in your family?

I am the first medical doctor in the family, although my father was a dentist. I am the sixth of seven kids, with four older sisters, an older brother, and a younger brother. When I was four years old, I told one of my sisters that I wanted to be a nurse when I grew up, and she said, “Well, why do you want to be a nurse? Why don’t you want to be a doctor?” My response was, “Girls can’t be doctors!” I grew up in a small town. There were no women physicians in my town, and there were no women physicians on TV at that time. She said, “Yes they can!” I went and asked my mother if my sister was telling the truth. My mom said that she was correct, and at that point, I decided that I wanted to become a doctor. I don’t know what it was that made the career seem appealing to me at such a young age, but I had decided very early on that I wanted to become a doctor.

Why did you make the decision to do much of your training in Michigan?

I was admitted to a combined pre-medical/MD program at the University of Michigan right out of high school. After I decided to go into surgery, I interviewed around the country but ultimately chose to stay at Michigan for several reasons: One, it’s a great training program, and two, we had a lot of women faculty and residents in the program. This was 1990, when many programs had, at best, a “token” woman trainee. Our chair, Lazar Greenfield, MD, was committed to training the best residents, regardless of gender. I don’t think he was explicitly recruiting women or minorities, but [simply] the “best athlete.” It was a place where I could see myself being successful as a trainee.

When did you decide on a career in general surgery?

Early in medical school, I thought I wanted to do something procedurally oriented, and based on advice from other people, I considered otolaryngology because you can do surgery and be a clinician. It was a nice combination of medicine and surgery. However, when I did my third-year general surgery clerkship, I just loved it. I loved that the residents seemed to be totally in charge of the hospital. If you were on call overnight as a student, it was clear that the general surgery residents carried a lot of responsibility. If there was anything going on, they were the ones being called to help. I loved that, and I enjoyed having an immediate impact on the patients and then seeing the outcome of what you had done in the operating room (OR).

Your husband also is a surgeon (otolaryngology). Did you meet in medical school?

I met my husband, Eben L. Rosenthal, MD, FACS, when he was a third-year medical student and I was a second-year resident in general surgery. We did not meet in the hospital; we actually met while ice skating. He had just finished his third-year surgery clerkship and recognized me from the hospital. When the Zamboni was out cleaning the ice, he came and sat down and we started talking. The rest is history.
Did you need to coordinate your training and career goals? People often struggle to coordinate those goals in two-physician families.

Yes, he was applying to otolaryngology residency programs while I was in my third year of general surgery residency. At Michigan, we all took time off for research after our third clinical year. I applied for research fellowships locally as well as at the University of Washington, Seattle, and Beth Israel Deaconess, Boston, MA. He had applied to those training programs as well as other programs. We had a tentative plan in place where I could do a research fellowship in the same city as his residency program, but luckily he matched at Michigan.

When I finished residency, he was still a resident at Michigan. I took a faculty position at Michigan for two years as a staff surgeon at the VA (Veterans Affairs) hospital. Then we applied for fellowship together, which was a different challenge as we looked for fellowships in each of our specialties that were the same length and available in the same city. We figured out that only about three places fulfilled those criteria. Fortunately, we were able to go to OHSU for fellowship.

When we were looking for jobs afterward, it required tight coordination for positions, which luckily worked out first at University of Alabama at Birmingham (UAB) and now at Stanford. We both made many compromises along the way, and the important message is that you can still be successful if you have a positive attitude.

When you started your first faculty position at Michigan, was research a major focus?

At that time, my husband was finishing his residency, and my mother had been diagnosed with gastric cancer. My father died when I was a child, so my mom was my only remaining parent. I also had my first child in August of that year. I was faced with having a newborn child and a dying parent, which took a lot of my attention and focus. I took good care of my patients, but I could not do much academically beyond that. It was a tough start to a faculty job. The second year, we were looking for fellowship positions, so it was really hard to get anything going. I honestly did not accomplish much during those first two years. I think it challenged my idea of what I wanted to do with my career, because those first two years were so tough combined with the other challenges in my life.

At this point in your career, you are a well-recognized health services researcher. How did you become interested in research?

During my research years in residency at the University of Michigan, I did bench research in colorectal tumor genetics. My research was outside the department of surgery, and I was funded through a cancer prevention and control grant from the School of Public Health. One of the requirements of the grant was that I complete an MPH program. At that time, I used my MPH training with my research project, as we were looking at responses to chemotherapy for patients with different tumor types, whether or not they had microsatellite instability. It was not until I took my faculty position at UAB that I transitioned to health services research. Before I took that job, there were buzzwords...
like “outcomes research,” which was reporting outcomes in a more detailed fashion. The field of health services research was introduced to me by a woman, Catarina Kiefe, MD, PhD, who became one of my most significant mentors at UAB. She is a prominent health services researcher and chair of preventative medicine. I had a research idea that she helped me frame so that it was not just an outcomes project; it was more of a health services project. She successfully mentored me in getting funding and getting my project off the ground. That is when I made the transition from bench research to health services research, which has been the primary focus of my research career ever since.

Like many surgeon-scientists, you have experienced gaps between your dedicated research time in training and your first faculty position. How did you maintain your research goals and interests, given the challenges you faced early on in your career as faculty?

When I arrived at UAB, I was not sure what my academic focus would be other than teaching residents. It took me some time and meeting with many different people to solidify my goals. Having my MPH opened doors for me. It allowed me to meet with clinical researchers with well-established funding to talk about how we could do that type of research in surgery. I believe that my MPH was particularly valuable because I had the training and knowledge required to transition to a health services research career. Dr. Kiefe was intrigued by surgery and thought it was an untapped area of health services research.

In some ways, I think it was the right time and the right place with the right mentor that set me on this path. It was not a specific vision that I had for myself when I took that position. I knew I wanted to do some sort of science. I had that intellectual curiosity; I just did not have a mentor or a role model for what it looked like. I had to go outside the department of surgery and meet with different types of researchers. A couple of people took me under their wing and helped me along. They were amazing mentors to me and helped me get my career going. They were incredibly supportive.

Did the department offer you a start-up package to help you become an established researcher? Did you have protected research time, for example?

Honestly, protected time was not something I had discussed when I accepted the position. When I first went to UAB, I had a part-time appointment at the VA hospital. On the university side, we were so tight for inpatient beds and OR time that it was difficult to build my clinical practice until our new hospital was completed three years later. My division chief, Selwyn M. Vickers, MD, FACS—a Past-Governor of the ACS and now the dean of medicine at UAB—was very supportive and encouraging of my scientific endeavors. I never felt the pressure to produce more clinically, only academically. Once I received my funding, I was able to accommodate my schedule to develop specific protected time for research. I received funding from the U.S. Department of Veterans Affairs, which provided full support for my research time. It was a good structure to protect my time during daytime hours. Most academic surgeons end up pushing most of their academic time to nights and weekends. You can have protected time on paper, but it is up to you to ensure you use it in that way. Having that grant funding from the VA allowed me to focus that time on my research.

After you were established with your research, did you experience any major setbacks?

Yes, we had an incident where our research center had a data breach, and we were shut down for 15 months, meaning we could not access our data. We technically could not do research during that time, at
least not within the VA system. Until then, things had been moving along very well; I had research residents working with me, and my project was at the point where we were putting all the data together. We had to be really creative about which data we could use and which papers we would publish. I thought that would be a huge blow to my research program. I was not sure if the center would re-open, if we could ever finish those grants, or if the wonderful staff that I had hired would stay with me during that time. The thought of having to rebuild it all over was really daunting. Thankfully, we found work to do during the downtime so when our center reopened, my staff was still with me and we were able to hit the ground running.

More recently, transitioning to Stanford in 2015 as chair of surgery has created new challenges. Most of my research team is still at UAB. There are more and more demands on my time, but I still want research to be part of my life. I am trying to find a way to keep things moving, and I am trying to set aside time to write the next grant.

Where did you get your experience writing grants?

I received support from the same mentors who helped me establish myself as a health services researcher. Dr. Kiefe helped me with my first letter of intent. She helped me respond to the critiques for proposal. It was literally back and forth—I would make edits and send them to her, and she would send it back with more writing on it than mine. She would carefully edit my grant proposals. It was help from her, along with examples of successful grants that were given to me by other mentors, that helped me to prepare proposals that eventually were funded. While writing this grant, I also reached out to [ACS Regent] Leigh Neumayer, MD, FACS, who was at the University of Utah, Salt Lake City, at the time. She was well connected in the VA for getting access to data. She became a co-investigator on my grant and one of my most influential mentors and is now a wonderful friend. I have also learned a lot as a grant reviewer about how to clearly communicate an idea.
Being an effective leader requires control over your emotions. In the OR, situations can become very tense, and having the ability to control your emotions and respond to events sets the tone of leadership.

You have had wonderful mentorship along the way. How has that affected you as you have become a mentor to others?

I don’t think any of us would be where we are without the influence of incredibly influential mentors. I reflect on that a lot; thinking of the people who have really affected my career and continue to do so. When I think of my mentees, I feel that same obligation to ensure they get the skills and support they need, that they get promoted, and that they are able to take advantage of opportunities as they arise. I have had the benefit of really great mentors, which allows me to be a better mentor.

You have developed significant leadership roles through your career. How has that benefited you?

The leadership roles I have held have been critically important to my career. As I have had different opportunities for leadership, I have reflected and wondered if it was a good use of my time and in line with my goals. I would also speak to my mentors and appreciate their perspective. I did not want to sacrifice time and effort on other aspects of my career, which were important, and on my family. Having the opportunity to be a leader, and being successful at it, gives you access to more leadership roles.

Did you do additional training for leadership?

I attended a course through the Association of American Medical Colleges for women leaders in medicine. I also attended a mid-career course through the Society of University Surgeons, and most recently I attended the Executive Leadership in Academic Medicine course. I have taken advantage of opportunities to work on my own leadership skills and to understand the theory behind much of what we do—behind conflict resolution and human resource management, as well as how to effectively communicate a vision.

Do you think the leadership skill set is applicable in the OR?

Yes, being an effective leader requires control over your emotions. In the OR, situations can become very tense, and having the ability to control your emotions and respond to events sets the tone of leadership. If you panic, then everyone else is going to panic. If you can keep your cool, it helps everyone else stay calm and effectively solve the problem.

You have had an active clinical, research, and leadership career. How have you balanced that with your family life?

It has not always been easy. When I was offered the chair position at Stanford, my daughter was a rising senior in high school. To say the least, it wasn’t ideal for her, but it was not the worst timing either. My son was between eighth and ninth grade. We had open communication as a family about the move. We agreed that we would move to Palo Alto as a family and have that experience together. After Sarah’s first semester in her new school in California, she was unhappy, and we agreed that she could move back to Birmingham to finish high school. She was back with us in Palo Alto for the summer before starting college. In the end, we were able to find a good compromise, and it will always be an experience that will define our family.
Do you think that for younger faculty, the pressure to generate clinical revenue compromises their ability to do research?

Margins from clinical revenue are smaller and are what we use to offset the cost of research. There is an increasing emphasis on a division’s profitability. It means that you can only support a certain number of people in research positions and still have a financially solvent division. If everybody was a funded researcher, maintenance of a positive profit margin would be nearly impossible, unless it has other significant sources of revenue, such as endowments. We use the clinical margin to supplement our researchers, so many of our faculty will generate the margin to support the academic mission. The challenge for leadership is to create a culture where everyone values each other’s contributions to the overall academic mission.

What do you think are the greatest challenges facing surgeon-scientists today?

I think the greatest challenge is keeping support for surgeon-scientists as a foremost mission in academic surgery departments. Surgeons need to be leaders in the field of scientific discovery and investigation. It is really important because surgeons bring a different perspective and have different interactions and understanding of the diseases we treat. Having that approach and mindset fundamentally changes the way you might think about a solution to a problem. The challenges to achieve this are, quite simply, talent, time, and money.

It is increasingly competitive to do basic science research. PhD-trained scientists do not have the time commitments of training residents and taking care of patients competing with their research; to compete with them head-to-head for funding is a challenge. The National Institutes of Health (NIH) funding rates have been flat. We need to keep surgeons on study sections that are advocating for grants from surgeons; otherwise, the sentiment might be that a surgeon-scientist cannot be as effective in either role as a colleague who only does science or only does surgery. We need to continue to advocate that surgeons can be effective at both of those disciplines, and that it is really important to have them do both.

What do you think the surgical community can do to support surgeon-scientists?

We can advocate for surgeon-scientists, we can celebrate their successes, and we can encourage surgeon-scientists to be on grant review committees and NIH study sections to provide their perspective and support during grant competitions. We need to value research in our training programs and find dedicated time to support surgeons who want to become scientists. However, we have to demonstrate that our scientific training process is as rigorous as that of our colleagues in the basic sciences.

You said that you have six siblings, and you are the first physician in your family. You come from a small town in Michigan. What do they think of all of your success, including your appointment to chair of surgery at Stanford?

My brothers and sisters might say, “Well, they didn’t ask us about her!” People in my hometown are really proud of me. I received many nice notes from my former high school teachers after an announcement in the local paper about my appointment at Stanford. I would not be where I am today without the support I have received from my family. We were competitive as kids, but now we’re each other’s biggest supporters.
A mentor is defined as someone who teaches or gives help and advice to a less experienced, often younger person. We’ve all had mentors throughout the various stages of our lives. I have particularly fond memories of my high school advanced placement Spanish teacher, who not only had a true gift for teaching the Spanish language to teenagers, but also for connecting with and encouraging her students to grow into responsible young adults.

Mentorship in medicine is a popular topic, with more than 4,500 PubMed articles published on the subject over the last five years. With this in mind, the prompt for this year’s annual Resident and Associate Society of the American College of Surgeons (RAS-ACS) Communications Committee essay contest was Paying It Forward: When the Mentee Becomes the Mentor. We received more than 40 submissions detailing residents’ coming of age stories, many of which occurred at different stages in medical training, but all of which highlighted the transformation of the student to a position of teaching, guiding, or advising someone with less experience.

Our winning essay, written by Kevin Koo, MD, MPH, MPhil, will resonate with many readers who have guided trainees through their first skin closure and should remind us all of what it felt like to be given an opportunity to contribute to an operation for the first time while surrounded by our colleagues impatiently watching the ticking clock.

We must remember that no matter how busy or burned out we may be or how inexperienced we may feel, we have so much to offer in the form of teaching, helping, or advising those following in our footsteps. In so doing, we keep the promise of our profession alive.
“C’mon, doc, can we get this show on the road?” the anesthesiologist asks optimistically. I couldn’t have planned a longer cystectomy if I had tried. The abdominal adhesions were a tangled mess. The bulky tumor was more invasive than anticipated. The pelvic lymph nodes bled as if avenging the dissection of their brethren.

Across the table, Andy—my medical student who has looked forward to observing this operation all week—is nervously preparing to close the midline incision.

Tick, tick, tick. The clock taunts us with each passing second.

Andy fumbles with the needle driver.

I hear a chorus of suggestions: Why don’t you close, doc? Yeah, so we can get out before midnight. He can sew next time!

Andy sets the instruments down, offering them to me.

My mind conjures a sepia-toned memory. I was standing at the operating table. It had been a long day. Everyone else’s eyes were on me, the surgery clerk, while my own eyes stared blankly at the instruments in my hands, betraying the hours I had spent practicing.

“We’ll never get out of here tonight if he keeps this up,” the attending surgeon mumbled to the resident opposite me. “I need those clinic notes dictated, and you still have to see the consults.”

I passed the needle driver to the resident.

“You finish this up, and let him practice some other time,” the attending directed.

The resident paused. “He’s already practiced with me, and he’s done a good job,” he replied. Then to me, assuredly, unwaveringly, “It’s your turn to operate.”

My surgical mask hid a smile that spread unexpectedly across my face. I was overcome by a sudden sense of belonging. Yes, I was the slowest in the room; I might make a mistake and have to start over; the fastest way out was to move on. But what a thrill to have that proverbial hand on my shoulder, to be given a chance to try! Ready my hands and sharpening my focus, I felt for the first time what it means to be a surgeon.

My mind clears; my attention returns. I place the needle driver back in Andy’s hand.

“Go on, Andy,” I say, echoing the resident who had given me my chance, “It’s your turn to operate.”

As his needle weaves back and forth, I’m reminded of the mentors who stepped aside—or stepped up—so that I could become more skilled, experienced, and compassionate. Many of us remember a calling to surgery and its appeal to those steady of hand and courageous of heart. What is not as evident—and what I’ve come to understand as I grow from student to teacher and from trainee to surgeon—is that our transformation is anchored by those who guide our hands to be steady and inspire us with their courage.

As Andy ties the final knot, his mask barely concealing a proud smile, I feel profoundly honored by the commitment of my mentors and once again humbled by the promise of our profession.
CLINICAL CONGRESS HIGHLIGHTS

Highlights of Clinical Congress 2016
The American College of Surgeons (ACS) Clinical Congress 2016 in Washington, DC, provided surgeons, medical students, surgical residents, and other members of the surgical patient care team with the opportunity to participate in myriad educational experiences and to interact with their peers. Total registration for the meeting was 12,783, including 8,700 physicians and 4,083 exhibitors, guests, spouses, and convention personnel.

Convocation
Courtney M. Townsend, Jr., MD, FACS, the Robertson-Poth Distinguished Chair in General Surgery, department of surgery, University of Texas Medical Branch (UTMB), Galveston; professor of surgery, department of surgery; professor of physician assistant studies, School of Allied Health Sciences; and graduate faculty in the cell biology program, UTMB, was installed as 97th President of the ACS at Convocation October 16.

Dr. Townsend delivered the Presidential Address, Do What’s Right for the Patient: Franklin H. Martin and the American College of Surgeons, to the College’s 1,823 Initiates, more than 800 of whom were in the audience.

Two Vice-Presidents also assumed office at the Convocation. The First Vice-President is Hilary Sanfey, MB, BCh, MHPE, FACS, FRCSI, FRCS, professor of surgery and vice-president for educational affairs, department of surgery, and associate director, Academy for Scholarship and Education, Southern Illinois School of Medicine, Springfield. The Second Vice-President is Mary C. McCarthy, MD, FACS, the Elizabeth Berry Gray Chair and Professor, department of surgery, Boonshoft School of Medicine, and adjunct graduate faculty, School of Engineering, Wright State University; and acute care surgeon at Miami Valley Hospital, Dayton, OH.

Also at the Convocation, Honorary Fellowship was conferred on five international surgeons: Hernando Abaúnza Orjuela, MD, FACS, MACC(Hon), Bogota, Columbia; Jacques Belghiti, MD, PhD, Paris, France; S. Adibul Hasan Rizvi, MB, BS, FRCSEng, FRCSEd, Karachi, Pakistan; Sachio Suita, MD, PhD, Fukuoka, Japan; and John F. Thompson, AO, MD, FACS, FRACS, FAHMS, Sydney, Australia.

Named Lectures
Clinical Congress featured 11 Named Lectures, starting with the Martin Memorial Lecture, presented immediately after the Opening Ceremony on October 17. Delos M. Cosgrove III, MD, FACS, chief executive officer, Cleveland Clinic, OH, presented the well-received lecture, Doctors in Distress: The Burnout Crisis.

Other Named Lectures presented at Clinical Congress 2016 were as follows:

• Edward D. Verrier, MD, FACS, the K. Alvin and Shirley E. Merendino Endowed Professor and chief of cardiothoracic surgery, University of Washington Medical Center, Seattle, presented the John H. Gibbon, Jr., Lecture: The Elite Athlete...the Master Surgeon.

• Andres M. Lozano, MD, PhD, FRCSC, FRSC, the Dan Family Chair in Neurosurgery, the R. R. Tasker Chair in Stereotactic and Functional Neurosurgery, and the Canada Research Chair in Neuroscience at the University of Toronto Health Network, ON, presented the I. S. Ravdin Lecture in the Basic and Surgical Sciences: Surgery to Adjust the Activity of Misfiring Brain Circuits to Improve Movement, Mood, and Memory.

• H. Hunt Batjer, MD, FACS, the Lois C. A. and Darwin E. Smith Professor and chair, department of neurological surgery, University of Texas Southwestern Medical
Center, Dallas, delivered the Charles G. Drake History of Surgery Lecture: Athletic Head Trauma: The Interface between Sport, Science, Pseudoscience, Politics, and Money.

• Robert D. Fry, MD, FACS, the Emilie and Roland DeHellebranth emeritus professor of surgery and former chairman, department of surgery, Pennsylvania Hospital, Philadelphia, presented the Herand Abcarian Lecture: Surgical Mentorship, More Than Just Teaching.

• Lenworth M. Jacobs, Jr., MD, MPH, FACS, director, Trauma Institute at Hartford Hospital, CT, and a member of the ACS Board of Regents, presented the Excelsior Surgical Society/Edward D. Churchill Lecture: Strategies to Increase Survival in Active Shooter and Intentional Mass Casualty Events.

• Susan M. Briggs, MD, MPH, FACS, associate professor of surgery, Harvard Medical School and Massachusetts General Hospital, Boston, presented the Scudder Oration on Trauma Lecture: Responding to Crisis: Surgeons As Leaders in Disaster Response.

• Alexa I. Canady, MD, FACS, former chief of neurosurgery at Children’s Hospital in Michigan, Ann Arbor, presented the Olga M. Jonasson Lecture: The Journey: Becoming a Neurosurgeon and Back Again.

• Kofi Herve Yangni-Angate, MD, professor of surgery, and consultant and head, cardiovascular and thoracic surgery department, Bouake University Teaching Hospital, and professor and chairman, cardiovascular and thoracic diseases department, Bouake University, Côte d’Ivoire, presented the Distinguished Lecture of the International Society of Surgery: Challenges in Open Heart Surgery in Africa: Côte d’Ivoire Experience.

• Carlos A. Pellegrini, MD, FACS, FRCSI(Hon), FRCS(Hon), FRCSEd(Hon), ACS Past-President and professor of surgery and chair, department of surgery, University of Washington, Seattle, delivered the John J. Conley Ethics and Philosophy Lecture: TRUST: The Keystone of the Patient-Physician Relationship.

• Richard L. Schilsky, MD, FACP, FASCO, senior vice-president and chief medical officer, American Society of Clinical Oncology, Alexandria, VA, presented the Commission on Cancer Oncology Lecture: Finding the Evidence in Real-World Evidence: Moving from Data to Information to Knowledge.

Notable events
This year’s Clinical Congress featured three Special Sessions on hot topics in surgery, including Firearm Injury Prevention, ACS Strong for Surgery, and Global Engagement. The session on Firearm Injury Prevention was presented by the ACS Committee on Trauma (COT) and focused, in part, on results from a survey of COT members to determine their views on a range of related topics. The ACS Strong for Surgery Session introduced this new College initiative, which is aimed at optimizing patients for surgery through smoking cessation, nutrition, medication management, and glucose homeostasis. The Global Engagement session introduced the College’s new strategic direction in international and domestic volunteerism.
Convocation: Maya A. Babu, MD, MBA, Chair of the ACS Resident and Associate Society, speaks on behalf of incoming Initiates

Dr. Cosgrove delivers the Martin Memorial Lecture

Dr. Briggs delivers the Scudder Oration on Trauma

Dr. Canady delivers the Olga M. Jonasson Lecture

The Commission on Cancer was honored to have Greg Simon, Executive Director of the White House Cancer Moonshot initiative, serve as the keynote speaker at its annual meeting. The Moonshot project, introduced by President Barack Obama during his 2016 State of the Union Address and led by Vice-President Joe Biden, focuses on cancer prevention, early detection, and accessible therapies.

The revitalized Excelsior Surgical Society, which is composed of military surgeons and dedicated to their unique needs and issues, held its second annual meeting October 16. A highlight of the meeting was the presentation of the Second Annual U.S. Army Major John P. Pryor Lecture by retired U.S. Army Colonel Norman M. Rich, MD, FACS, professor of military medicine, Uniformed Services University of the Health Sciences (USUHS), Bethesda, MD, and director, Vietnam Vascular Registry. Dr. Rich’s comments focused on the history of the Excelsior Surgical Society and the Vietnam Vascular Registry, which he and his colleagues started in 1966 to register the injuries of American casualties and to provide long-term follow-up care for the injured troops.

The ACS COT piloted the Bleeding Control Basic course at Clinical Congress. The new version of the Bleeding Control course, endorsed by the Hartford Consensus™, enables surgeons to teach these lifesaving techniques to nonclinical members of their communities. The course, which was offered to ACS leaders and members of several committees, was developed in conjunction with the President’s “Stop the Bleed” national campaign to bring awareness to bleeding control and techniques for saving lives after hemorrhagic injury. The course ultimately will be offered throughout the U.S. to the general public. More information on this program can be found at bleedingcontrol.org.

Member engagement activities initiated at Clinical Congress 2015 continued at this year’s meeting. The ACS Taste of the City offered Fellows, families, staff, and guests the opportunity to experience the diverse dining and cultural scene of Washington, DC, and to network with other ACS members and leaders. Clinical Congress attendees were again challenged to snap photos of themselves with ACS leaders and members at various conference events and to post the selfies on Twitter. The second annual Chapter Speed Networking event was presented to facilitate interaction by chapter leaders and ACS Governors. A Speed Mentoring event also took place this year, allowing residents to seek guidance from young Fellows of the ACS.

New this year for the youngest Clinical Congress guest attendees was a Little Medical School day offered as part of the Clinical Congress Child Care Program. Children of Clinical Congress participants were able to explore the world of medicine, science, and health in an engaging and fun environment. Each child who participated in this optional program received a disposable white physician’s coat, organ sticker set, surgical kit, and a diploma.

Awards and honors
Several surgeons were honored for their contributions to the ACS and to surgery. Frank G. Opelka, MD, FACS, a colon and rectal surgeon and Medical Director, Quality and Health Policy, ACS Division of
Advocacy and Health Policy, Washington, DC, received the ACS Distinguished Service Award, the College’s highest honor, at Convocation. The Board of Regents presented the award to Dr. Opelka “in appreciation for his continuous and devoted service as a Fellow of the American College of Surgeons and the physician leader of the College’s quality and health policy efforts in the Washington, DC, office over the last 15 years.”

The ACS presented the inaugural Mary Edwards Walker Inspiring Women in Surgery Award “with admiration and appreciation” to Mary E. Maniscalco-Theberge, MD, FACS, at Convocation. Dr. Maniscalco-Theberge, Interim Medical Inspector, Veterans Health Administration, Washington, DC, and clinical professor of surgery, USUHS, has been a champion for the advancement of women in surgery and an inspiration to women surgeons in the metropolitan Washington, DC, area.

The Fellows Leadership Society (FLS) of the ACS Foundation presented the 2016 Distinguished Philanthropist Award to past-Distinguished Service Award Recipient Mary H. McGrath, MD, MPH, FACS, professor of surgery, department of surgery, division of plastic and reconstructive surgery, University of California, San Francisco. The award was announced at the 27th annual FLS Donor Recognition Luncheon and acknowledges Dr. McGrath’s commitment as a generous donor to the College, her service to the larger philanthropic community, her longstanding record of ACS volunteerism, and her dedication to the quality of surgical patient care.

Debrah A. Kuhls, MD, FACS, received the National Safety Council Surgeons’ Award for Service to Safety at the annual ACS COT Dinner. The award citation points to Dr. Kuhls’ “persistent, patient, passionate, and effective leadership of the Injury Prevention and Control programs of the American College of Surgeons Committee on Trauma.”

Rebekah Ann Naylor, MD, FACS, a general surgeon from Fort Worth, TX, received the Surgical Humanitarian Award for her work in improving and expanding the Bangalore Baptist Hospital, Karnataka, India. Additionally, four surgeons received the ACS/Pfizer Surgical Volunteerism Awards. Sandra Lynn Freiwald, MD, FACS, a general surgeon, Kaiser Permanente Hospital, San Diego, CA, received the Domestic Surgical Volunteerism Award for her work with the San Diego County Medical Society Foundation’s Project Access San Diego, which enables low-income, uninsured individuals to receive specialty care services at no charge. James A. O’Neill, Jr., MD, FACS, a pediatric surgeon from Nashville, TN, received the International Surgical Volunteerism Award for his work as clinician and innovator, as well as his decades-long involvement in medical outreach. James A. O’Neill, Jr., MD, FACS, a pediatric surgeon from Nashville, TN, received the International Surgical Volunteerism Award for his work as clinician and innovator, as well as his decades-long involvement in medical outreach. James A. O’Neill, Jr., MD, FACS, a pediatric surgeon from Nashville, TN, received the International Surgical Volunteerism Award for his work as clinician and innovator, as well as his decades-long involvement in medical outreach. James A. O’Neill, Jr., MD, FACS, a pediatric surgeon from Nashville, TN, received the International Surgical Volunteerism Award for his work as clinician and innovator, as well as his decades-long involvement in medical outreach. James A. O’Neill, Jr., MD, FACS, a pediatric surgeon from Nashville, TN, received the International Surgical Volunteerism Award for his work as clinician and innovator, as well as his decades-long involvement in medical outreach. James A. O’Neill, Jr., MD, FACS, a pediatric surgeon from Nashville, TN, received the International Surgical Volunteerism Award for his work as clinician and innovator, as well as his decades-long involvement in medical outreach. James A. O’Neill, Jr., MD, FACS, a pediatric surgeon from Nashville, TN, received the International Surgical Volunteerism Award for his work as clinician and innovator, as well as his decades-long involvement in medical outreach. James A. O’Neill, Jr., MD, FACS, a pediatric surgeon from Nashville, TN, received the International Surgical Volunteerism Award for his work as clinician and innovator, as well as his decades-long involvement in medical outreach. James A. O’Neill, Jr., MD, FACS, a pediatric surgeon from Nashville, TN, received the International Surgical Volunteerism Award for his work as clinician and innovator, as well as his decades-long involvement in medical outreach. James A. O’Neill, Jr., MD, FACS, a pediatric surgeon from Nashville, TN, received the International Surgical Volunteerism Award for his work as clinician and innovator, as well as his decades-long involvement in medical outreach.
Practicing surgeons, residents, and medical students were recognized for their contributions to advancing the art and science of surgery. Recipients honored with the Scientific Forum Excellence in Research Awards included the following: Elizabeth J. Lilley, MD, MPH; Mitchell R. Dyer, MD; Alicia E. Snider, MD; Vanagh C. Nikolian, MD; Marina Ibrahim, MD, CM, MSc; David L. Colen, MD; Rebecca Scully, MD; and Matthew A. Hornick, MD.

Ankit Bharat, MD, FACS, assistant professor of thoracic surgery and pulmonary and critical care medicine, Feinberg School of Medicine, Northwestern University, Chicago, IL, received the 12th Joan L. and Julius H. Jacobson II Promising Investigator Award. The award honors outstanding surgeons who engage in research, advance the art and science of surgery, and demonstrate early promise of making significant contributions to the practice of surgery.

The 14th annual ACS Resident Award for Exemplary Teaching was presented to Afif N. Kulaylat, MD, MSc, a fourth-year resident in general surgery at the Penn State Milton S. Hershey Medical Center, Hershey, PA. The ACS Division of Education sponsors the award to recognize excellence in teaching by a resident and to highlight the importance of teaching in residents’ daily lives. Dr. Kulaylat was selected by an independent review panel of the Committee on Resident Education.

The fourth annual Jameson L. Chassin, MD, FACS, Award for Professionalism in General Surgery was presented to Sarah L. M. Greenberg, MD, MPH, a chief resident in general surgery at Medical College of Wisconsin Affiliated Hospitals, Milwaukee. The award recognizes a chief resident in general surgery who exemplifies the values of compassion, technical skill, and devotion to science and learning. The ACS established the award with gifts from the Chassin family, colleagues, and friends of the late Dr. Chassin, who was a skilled surgeon, teacher, and scholar in New York, NY.

Members of the ACS Scientific Forum Committee, including Paula M. Termuhlen, MD, FACS, member; Dennis P. Orgill, MD, PhD, FACS, Vice-Chair; and Mary T. Hawn, MD, FACS, Chair, awarded the Best Scientific Poster of Exceptional Merit to Dani Odette Gonzalez, MD, for Variability in Surgical Management of Benign Ovarian Neoplasms in Children. The coauthors of this poster included the following: Jennifer N. Cooper, PhD; Jennifer H. Aldrink, MD, FACS; Geri D. Hewitt, MD; Peter C. Minneci, MD, MHSc; and Katherine J. Deans, MD, MHSc, FACS.

In addition, the following medical students were honored for their Basic Science Research posters:

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

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

Distinguished Philanthropist Award recipient Dr. McGrath (left) with Amilu Stewart, MD, FACS, ACS Foundation Chair

National Safety Council Award recipient Dr. Kuhls (center), with Raul Coimbra, MD, PhD, FACS, President, American Association for the Surgery of Trauma, and Past Vice-Chair, COT (left), and Ronald M. Stewart, MD, FACS, Chair, COT
The following medical students were recognized for their Clinical and Educational Research posters:

- **First place**: Michael C. Bambad, Yale University School of Medicine: Antibiotic Standardization Decreases Antibiotic-Associated Costs in Pediatric Patients with Appendicitis

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

- **Third place**: Jacob C. Young, University of Chicago, IL: Generation and Characterization of an IL13RA2-Tropic Modified Adenovirus for the Personalized Treatment of Glioblastoma

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

The International Relations Committee (IRC) welcomed the International Guest Scholars (IGS) for 2016 and other guests, including the following: Adewale Oluseye Adisa, MB, BCh, FACS, International Surgical Education Scholar I; Tanveer Ahmed, MB, BS; Wan Mohammed Aldohuky, MB, BCh, FACS, Community Surgeons Travel Awardee; Waddah Badir Al-Refaie, MB, BCH, FACS, Chair, Designated Scholarship Subcommittee; Vivek Bindal, MB, BS, FACS, International Surgical Education Scholar II; Joseph S. Butler, MB, BCH, BOA, Dr. Abdol Islami & Mrs. Joan Islami Scholar I; Yi Chen, MB, BS, PhD, FRACS, ANZ Exchange Fellow; Nai-Chen Cheng, MD, PhD, Elias
Hanna Scholar; Marcello Donati, MD, PhD; Hiba Ezzeddine, MD, Resident Exchange Fellow; Christopher C. K. Ho, MD, MS; Mohammed Kamal, MD, Baxiram S. and Kankuben B. Gelot Community Surgeons Travel Awardee; Manabu Kawai, MD, PhD; Omar Khalaf, MD; Gustavo Kohan, MD, Dr. Abdol Islami & Mrs. Joan Islami Scholar II; Guiseppe R. Nigri, MD, FACS, Chair, Scholarships Subcommittee; Joseph Martin Plummer, MB, BS; Mauricio A. Pontillo, MD, FACS, Murray F. Brennan Scholar; Goran Santak, MD; Anthony Yuen Bun Teoh, MB, BCh, FRCS, PHKAM, PCSHK, Carlos Pellegrini Traveling Fellow; Takeo Toshima, MD, PhD, Japan Exchange Fellow; Dimitrios Tsamis, MD, MSc, PhD, Stavros Niarchos Foundation Scholar; George Velmahos, Chair, ICR; Anubhav Vindal, MB, BS, FACS; and Thilo Welsch, MD, MBA, Germany Exchange Fellow.

The Commission on Cancer (CoC) presented the State Chair Outstanding Performance Award to Ted James, MD, FACS, Vermont; Sharon Lum, MD, FACS, California; and Richard Zera, MD, FACS, Minnesota.

In addition, the CoC held its annual Paper Competition. The three surgical residents who submitted winning papers are as follows: Kendall Keck, MD, University of Iowa Hospitals and Clinics, Iowa City (first place); Ahsan Raza, MB, BS, University of Florida,
Gainesville (second place); and Justin Wilkes, MD, University of Iowa Carver College of Medicine (third place).

Chayanin Musikasinthorn, MD, FACS, general, trauma, and critical care surgeon, Gallup Indian Medical Center, NM, attended Clinical Congress as the recipient of the 2015 Nizar N. Oweida, MD, FACS, Scholarship.

Lastly, the winners of the 2016 Resident and Associate Society (RAS) of the ACS essay contest spoke at the RAS Symposium, the theme of which was Exploring the Limits of Surgeon Disclosure: Where Are the Boundaries? Christopher F. McNicoll, MD, MPH, MS, a second-year general surgery resident, University of Nevada School of Medicine, Las Vegas, was the first place winner for his “pro” essay, and Reema Mallick, MD, an Associate in the ACS Transition to Practice Program, Geisinger Medical Center, Danville, PA, wrote the winning “con” essay.

**Annual Business Meeting**

The ACS Annual Business Meeting of Members convened October 18 with Dr. Townsend presiding. The following officials presented reports: Valerie W. Rusch, MD, FACS, Chair of the Board of Regents; Fabrizio Michelassi, MD, FACS, Chair of the Board of Governors (B/G); David B. Hoyt, MD, FACS, ACS Executive Director; and Michael J. Sutherland, MD, FACS, Chair of the ACS Professional Association political action committee (ACSPA-SurgeonsPAC) Board of Directors.

The election of the ACS President-Elect, Vice-Presidents-Elect, Regents, and Governors also took place at the Annual Business Meeting. Barbara Lee Bass, MD, FACS, the John F. and Carolyn Bookout Distinguished Endowed Chair and chair, department of surgery, Houston Methodist Hospital, TX, and executive director, Houston Methodist Institute for Technology, was elected President-Elect of the ACS. Charles D. Mabry, MD, FACS, a general surgeon, Pine Bluff, AR; associate professor of surgery and practice management advisor to chair, department of surgery, University of Arkansas for Medical Sciences, Little Rock; and medical director of quality, Jefferson Regional Medical Center, Pine Bluff, was elected First Vice-President-Elect. The Second Vice-President-Elect is Basil A. Pruitt, Jr., MD, FACS, FCCM, MCCM, the Dr. Ferdinand P. Herff Chair in Surgery, clinical professor of surgery, department of surgery, trauma division, University of Texas Health Science Center, San Antonio, and professor of surgery, USUHS.

The B/G elected Michael J. Zinner, MD, FACS, a general surgeon, Coral Gables, FL, to serve as Chair of the Board of Regents. Leigh A. Neumayer, MD,
Recipients of the ACS Distinguished Service Award. Front row, left to right (all MD, FACS): Dr. McGrath; LaMar S. McGinnis, Jr.; Dr. Amilu Stewart; Murray F. Brennan; and Jack W. McNinch. Back row: F. Dean Griffen; John A. Weigelt; David B. Hoyt; Patricia J. Numann; J. Wayne Meredith; Frank G. Opelka; and Richard B. Reiling. Dr. Michelassi, then-Chair of the ACS Board of Governors, is at the far right.

CoC State Chair awardees (from left, with awards) Dr. James, Dr. Lum, and Dr. Zera, with (from far left) Otis Brawley, MD, FACP, Chief Medical Officer, American Cancer Society; Mary Milroy, MD, FACS, Chair, Committee on Cancer Liaison; and Peter Hopewood, MD, FACS, Vice-Chair, Committee on Cancer Liaison.

CoC Papers Competition winners, from left: Drs. Raza, Keck, and Wilkes.

Oweida Scholar Dr. Musikasinthorn, with Tyler G. Hughes, MD, FACS (left), and Dr. Richardson.
FACS, a general surgeon, Tucson, AZ, was elected Vice-Chair of the Board of Regents.

The B/G also elected two new Regents: Anthony Atala, MD, FACS, a urologist, Winston-Salem, NC, and Fabrizio Michelassi, MD, FACS, a general surgeon, New York, NY.

The following Regents were reelected: Margaret M. Dunn, MD, FACS, a general surgeon, Dayton, OH (third term); James W. Gigantelli, MD, FACS, an ophthalmologist, Omaha, NE (second term); and Dr. Zinner.

The B/G elected Diana Farmer, MD, FACS, a pediatric surgeon, Sacramento, CA, to serve as Chair, B/G Executive Committee; Steven C. Stain, MD, FACS, a general surgeon, Albany, NY, as Vice-Chair; and Susan K. Mosier, MD, FACS, an ophthalmologist, Topeka, KS, as Secretary. Newly elected to the B/G Executive Committee are S. Rob Todd, MD, FACS, an acute care surgeon, Houston, TX (initial one-year term); and Nicole S. Gibran, MD, FACS, a burn surgeon, Seattle, WA (initial two-year term).

Clinical Congress 2017

Be sure to attend the Clinical Congress 2017, October 22–26, in San Diego, CA. Details regarding the educational program, registration, housing, and transportation will be posted at facs.org.

FOR MORE INFORMATION

This article contains information that is discussed in greater depth in previous issues of the Bulletin, as follows:

September 2016

• Frank G. Opelka, MD, FACS, chosen as 2016 Distinguished Service Award recipient, page 59
• Fellows honored for volunteerism and humanitarianism, page 62

October 2016

• Mary H. McGrath, MD, MPH, FACS, to be honored with Distinguished Philanthropist Award, page 71

November 2016

• RAS-ACS Symposium essays, page 34
• Courtney M. Townsend, Jr., MD, FACS, installed as 97th President of the ACS, page 57
• Inaugural Mary Edwards Walker Award presented to Dr. Maniscalco-Theberge, page 60
• Five outstanding surgeons conferred Honorary Fellowship in the ACS, page 63

December 2016

• Barbara Lee Bass, MD, FACS, is 2016–2017 ACS President-Elect, page 76
• New Regents and Governors elected, page 80

All articles can also be viewed online at bulletin.facs.org.
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This case study was conducted at Stony Brook Medicine, Long Island, NY, and focused on surgical site infection (SSI). SSI is a common complication of colorectal surgery, adding to increased morbidity, readmission rates, and overall costs. In fact, SSIs are responsible for more than $3.5 billion in annual U.S. health care expenditures. Colorectal surgery is consistently associated with SSI rates that are between 5 percent and 45 percent higher than other forms of surgery.

Stony Brook’s ACS NSQIP data from 2006 to 2009 indicated that colorectal surgery was a high outlier for SSI. With the first publication of decile ranks in 2009, our hospital ranked in the 10th (worst) tier. In response to the prevalence of SSIs in colorectal patients, our team designed a multidisciplinary approach to standardize the care and methods involved in managing colorectal patients to determine the impact on SSI rates following colorectal resection.

How was the quality improvement (QI) activity put in place?
Stony Brook Medicine is an academic medical center that encompasses Stony Brook University Hospital, Stony Brook Children’s Hospital, five health sciences schools (dental medicine, health care technology and management, medicine, nursing, and social welfare) and myriad centers, institutes, programs, and clinics. With 603 beds, the University Hospital serves as Suffolk County’s only tertiary care center and regional trauma center. With 106 beds, Stony Brook Children’s offers the most advanced pediatric specialty care in the region. We also are home to a Cancer Center, Heart Institute, and Neurosciences Institute. A Medical and Research Translation (MART) building, dedicated to imaging, neurosciences, and cancer care and research, and a new Hospital Pavilion and Children’s Hospital will open in 2017.

Stony Brook administrators have a vision for quality and patient safety and are working to achieve top decile in all clinical outcomes. Reducing SSI in colorectal surgery ties in with the institution’s goals of providing world-class health care to its patients.

In the development process, ACS NSQIP data from 2006 to 2014 were supplemented with an institutional review board-approved chart review. Patients were divided into three groups: a pre-SSI reduction strategy group (January 1, 2006–June 30, 2009), an SSI reduction strategy group (July 1, 2009–December 30, 2012), and a third group testing the durability of the implemented measures.
(January 1, 2012–September 30, 2014). The SSI reduction strategy was prospectively implemented in a single institution and compared with historical controls (pre-SSI strategy arm).

**What strategies were used to reduce SSI?**

The SSI reduction strategy included preoperative, intraoperative, and postoperative components (see Figure 1, page 51). Patients were given instructions and materials for preoperative procedures, including a chlorhexidine gluconate (CHG) shower. Mechanical bowel preparation without oral antibiotics was used before and after the SSI reduction strategy protocol.

Upon arrival at the hospital, the patient was taken to a preoperative holding area where a member of the colorectal team met the patient and completed a preoperative checklist to evaluate compliance (see Figure 2, page 52). Intraoperative procedures were standardized and included all members of the operative team. The surgical staff implemented wound closure guidelines with well-defined parameters for fascial and skin closure (see Figure 3, page 53) and delayed wound closure (see Figures 4A and 4B, page 54). Upon completion of the operation, a sticker was placed over the surgical dressings, stating that the surgical team was responsible for the initial dressing change, with contact information and instructions in the event that questions arose regarding the integrity or contamination of the dressing (see Figure 5, page 54).

ACS NSQIP data used in the study aided in standardizing our own patient data and the outcome against that of other institutions through their formatted evaluation system. This approach was beneficial in comparing the post-SSI strategy outcome with the pre-SSI value and aided in the study's external validity because ACS NSQIP's standardized definitions of evaluated variables allow for accurate comparison among institutions.

In selecting the processes that were anticipated to reduce the SSI rate, we used a combination of guiding principles, including best practice recommendations and evidence-based medicine. We began developing our strategy by first strengthening the SSI reducing protocols already in place while researching the literature for evidence-based practices that have proven beneficial in colorectal patients. In addition, we adapted and modified select practices that other surgical services had previously implemented in our institution and that had demonstrated beneficial results. In addition, we extrapolated possibilities for improvement by attempting to implement our own possible solutions to the known SSI risks inherent to colorectal resection.

**What resources and skills were needed?**

Before patients arrived at the hospital for their operation, they underwent a standard bowel preparation and took a prescribed enema two hours before leaving home. Patients were instructed to shower from the neck down with chlorhexidine after completion of the bowel prep and after noting clear bowel movements. An antimicrobial scrub brush and solution were provided for the patients' use. On the morning of surgery, the patient underwent a chlorhexidine antimicrobial scrub of the abdomen. At preoperative admission on the day of surgery, the patient was asked a series of questions by trained nursing staff to determine readiness for transfer to the operating room (OR).

Blood glucose was closely monitored, with a preoperative goal of <200 mg/dl. A delay in the OR was considered if the patient had a preoperative glucose of 200–349 mg/dl, and cancellation of the operation was considered if the glucose level was >350 mg/dl. While the patient was in preoperative admission, hair removal by...
**FIGURE 1. SSI REDUCTION STRATEGIES BY PHASE OF CARE**

**PREHOSPITAL**
- Bowel preparation
- Over-the-counter enema two hours before leaving home for hospital
- Neck-down shower with chlorhexidine at completion of prep and after clear bowel movement (BM)
- Chlorhexidine antimicrobial scrub of abdomen morning of operation

**PREOPERATIVE**
- Improved licensed independent practitioner (LIP) questions to determine patient readiness for OR
  - Percent bowel prep consumed
  - Color of last stool
  - Enema two hours before leaving home
  - Neck-down shower with chlorhexidine at completion of prep and after clear BM
  - Chlorhexidine neck-down shower with additional antimicrobial scrub of abdomen morning of operation
- Blood glucose—preoperative holding area check (goal <200)
  - Consider delay of case: ≥200 – 349
  - Consider cancellation of case: ≥350
- Hair removal complete in preoperative holding area before going to OR

**INTRAOPERATIVE**
- Staff will wear surgical masks at all times in the OR
- Staff will minimize traffic and time OR door is left open
- Use of chlorhexidine skin prep unless contraindicated (stoma/allergy)
  - Substitute Betadine when contraindicated: Allow to air dry
- Skin prep area extended from nipple line to knees: side to side
  - Area inclusive of posterior axillary line
- Attending will be present in OR during skin prep to observe staff performing skin prep as per established guidelines
  - Staff will be reeducated at point of care by attending if prep does not meet standard expected
- OR team operating within the sterile field will prepare for the case using chlorhexidine scrub brush for more than two minutes (this includes the scrub nurse)
  - Chlorhexidine/alcohol-based preoperative hand antiseptics will not be considered an acceptable substitute for traditional brush hand scrubbing
- Clean scrubs must be worn at the start of every colorectal case (staff within the sterile field)
- Scrubs worn during a case will not be worn outside of the OR (surgeon)
  - Surgeons will change into clean scrubs before entering or leaving OR
- Prophylactic antibiotic will be administered within 60 minutes of incision time for optimal results
- Place iodine-impregnated incision drape over abdomen
- Put Alexis wound retractor in place
- Before closing the abdominal wall, the OR team operating within the sterile field will:
  - (1) Re-glove
  - (2) Re-prep
  - (3) Re-towel incision area
  - (4) Use reserved clean instrument tray for closing
- Wound closure guidelines to be followed (see Figure 3, page 53)
- Normothermia (SCIP ≥36.0° C); discuss/address patient temperature at debriefing prior to surgeon leaving OR
- Sticker with dressing change instructions placed on dressed wound

**POSTOPERATIVE**
- Do not leave OR in scrubs except when directly walking to and from office to change to street clothes
- Discontinuation of antibiotic within 24 hours (SCIP)
- Foley catheter removal by POD #2 (SCIP)
- Glucose control (SCIP cardiac surgery measure)
- Appropriate hand hygiene/gloves on floor
- Dressing changes using sterile technique
- Prior to patient discharge; attending review of wound
clipping was completed before presenting to the OR.

In the OR, staff was instructed to minimize traffic and the time the OR door was left open to minimize contamination risks. Chlorhexidine skin prep was used unless contraindicated (for example, because of stoma or known allergy). The skin preparation area extended from the patient’s nipple line down to the knees and between bilateral posterior axillary lines. The attending surgeon was present in the OR at this time to observe and confirm proper application of skin preparation. All staff working within the sterile field was required to wear clean scrubs at the start of every colorectal case, and all surgeons were to change into clean scrubs before entering or leaving OR. Hand washing was mandated; alternative hand sterilization methods were deemed an unacceptable substitute in colorectal abdominal surgery cases.

All patients were given a prophylactic antibiotic within 60 minutes of incision time to ensure optimal compliance with Joint Commission Surgical Care Improvement Project (SCIP) measures. An iodine-
impregnated incision drape was placed on the patient’s abdomen, and the surgeon used an Alexis wound retractor to minimize infection risks. Before closing the abdominal wall, the team operating within the sterile field would re-glove, re-prepare the field, and place new sterile towels over the incision area. A new clean instrument tray was used for closing. The surgical team followed the specific wound closure guidelines outlined in Figure 4.

Surgeons worked with the anesthesia team to maintain normothermia (>36.0° C) per SCIP guidelines, which have shown to minimize SSI risk associated with mild hypothermia. After complete wound closure, an adhesive sterile dressing was placed over the site, with the overlying sticker identifying clear instructions for dressing changes. Delayed wound closure was used in patients meeting predetermined parameters.

Delayed wound closure was undertaken prudently due to the associated discomfort and aesthetic impact on the patient. Postoperatively, SCIP guidelines were followed with the discontinuation of prophylactic antibiotics within 24 hours of operation end time and removal of the urethral catheter by postoperative day two. Tight glucose control was maintained for further minimization of SSI. Appropriate hand hygiene and sterile gloves were used on the ward for sterile dressing changes. The attending surgeon evaluated the wound personally before the patient’s discharge.

Essential to the successful implementation of the SSI reduction strategy was the appropriate education and support of all staff involved in the patient’s care. Educational meetings were organized formally to train all OR and ward staff in the rationale and goals of these changes. Perioperative strategies for SSI reduction that were initially developed by the colorectal surgery department were then presented to physician and nursing leadership for review. Discussion and input from all levels were encouraged for the development of this strategy. Frequent multidisciplinary reviews evaluated and guided our strategy. Successful implementation of the goals rested not only on changing patient care, but also on changing the culture of all involved parties. Mandating certain standards of practice in the OR minimized the variability between the surgeons and resident physicians.

**What were the results?**
The strategy used in this study resulted in a 41 percent decrease in SSI rates following colorectal resection over a six-year period, and its durability was demonstrated by continuing improvement over an additional two years. Evaluation of follow-up data was correlated with independent review by the New York State Department of Health, which demonstrated parallel evidence of continual improvement.

Although the most recent ACS NSQIP data have demonstrated increased SSI rates for colorectal surgery, they remain 50 percent lower than when the project began. A multidisciplinary team has been reinvigorated and meets biweekly. Work is being done to hardwire processes through the use of
our electronic health record. The focus has turned to preoperative preparation of in-house surgical patients and comprehensive wound care instructions for patients and caregivers upon discharge.

Using the NSQIP return on investment calculator, Stony Brook has had an average of 22 fewer infections annually, saving the hospital $616,000 dollars per year or a total of $4,928,000 since the inception of our SSI reduction strategy.

**Suggestions for other institutions**

Some guidelines for other institutions considering the implementation of an SSI reduction system as described in this column include the following:

- Convene a monthly SSI committee
- Implement data tracking for process measures and bundle compliance, power plan use
- Institute a root-cause analysis tool with a brief case summary and bundle compliance
- Create a surgical service preoperative power plan and comprehensive wound care discharge order set
- Review real-time data whenever possible, including both Centers for Disease Control and Prevention National Healthcare Safety Network and ACS NSQIP events as discovered ♦

**REFERENCES**

What is it like to be a surgeon in rural America? Many laypeople and even some of our colleagues may have the notion that it is idyllic—perhaps “Doc Hollywood”-like. They may imagine lazy days spent fishing and tending to occasional patient in the hospital—a simple, maybe even boring, life.

However, those of us who have chosen to practice in rural areas will tell you that the life of a rural surgeon can be one of high pressure and professional isolation. As one rural surgeon commented on the American College of Surgeons (ACS) rural surgery listserv, “Non-rural clinicians get only a fraction of this pressure. After 20 years in my community, almost every case now is someone I’ve known or previously treated. No question that this causes us to question every decision we make, and it’s just not the same as when I was a big city doctor. If I could just get a patient over their hospitalization [when I practiced] in the city, it was very unlikely I would ever see them again, compared to my practice now where I never rotate off the service.”

At the same time, rural practice can be incredibly fulfilling. Can this paradox be explained?

Your patients are your neighbors
Some surgeons would consider many aspects of rural surgery to be disadvantages. Rural surgeons know almost all of their patients. A small town affords no anonymity, no ability to leave work at work. The rural surgeon may operate on their grocery clerk or someone else that they see in town every week. In the big city, referrals may depend on insurance networks, one’s professional colleagues, or whoever shows up at the emergency room. In a small town everyone’s mother, brother, and cousin knows you. This can be a good thing or a bad thing. In contrast to life in a bigger city, the rural surgeon truly lives in a fishbowl. Your every move is under scrutiny. As one surgeon noted on the rural surgery listerv:

How about returning to your rural hometown that you grew up in to practice general surgery? Over 20 years of operating on countless friends, classmates, teachers, and so on—making them better, giving them bad news, and dealing with bad outcomes. I have a guy coming in tomorrow who tried to pick a fight with me in high school. I’ve also had people avoid me because of something I did 35 years ago. Forget trying to go out and having a beer. Everyone knows you and watches your every move.

Of course, knowing everyone in town can have its advantages as well. One rural surgeon made the following comment on the listerv: “Just when you think the pressure is too much, someone tells you how much they appreciate you. I had a lady tell me this week that she prays for...”
Those of us who have chosen to practice in rural areas will tell you that the life of a rural surgeon can be one of high pressure and professional isolation.

"You know you’re a rural surgeon when you can’t get through the produce section at the grocery without doing a consult or inspecting a wound...."

"(1) You know you’re a rural surgeon when the family of the kid whose spleen you removed for trauma pays you in cash and blueberry pies (really, really good blueberry pies); (2) You know you’re a rural surgeon when you can’t get through the produce section at the grocery without doing a consult or inspecting a wound; (3) You know you’re a rural surgeon when, before you ask about medications, you ask ‘parlor or stanchion?’ (which, for those of you who didn’t know, are methods of milking cattle); and (4) Lastly, you know you’re a rural surgeon when you go to a garage sale and end up crying with a family over their relative you operated on, but who is gone now. There’s just no greater calling. I am grateful.”

Providing myriad services with limited resources

Another thing about small towns that can make rural practice challenging is that people don’t like to wander away from their homes, farms, or businesses. Rural surgeons are pressured to treat patients in their hospitals, to keep them close to home so their families can avoid traveling to visit and care for them. But the fact is, rural patients are more likely than urban patients to be elderly and poor and to have chronic illnesses, which means they may need more resources than are available at the community hospital.*

Although rural areas often are resource poor, that doesn’t limit the cases that come through the doors. Rural surgeons constantly need to be able to figure out if they can solve a problem with the resources they have or if it would be better for a patient to go elsewhere. The perception at some of the larger referral centers is that rural surgeons ship people out so they can go play golf. Quite to the contrary—rural surgeons do everything they can to keep their patients close to home, but they have to think each problem through to its conclusion and decide whether they have the equipment, skilled nursing staff, anesthesia services, diagnostics, and so on, to complete the job successfully. Many times, the surgeon may have the skills necessary to treat the problem,

but the facility is not equipped to provide high-level recovery and follow-up care. In these cases, it is in the patient’s best interests to be transferred to a better-equipped facility.

24-hour availability
Most rural surgeons are on call every other night or every third night, and some are on call every night. People may think that we are not called very often. However, the potential for interrupted sleep every night can be very stressful. Never being able to turn off the phone or travel more than 30 minutes away from the hospital requires a tremendous commitment on the part of the surgeon, as well as his or her family. Furthermore, our institutions sometimes work from the perception that the more you do, the more you can do. In other words, if you can take call every other night, why can’t you take call every night? Administrators and practitioners who have never taken every-night call don’t understand how stressful it is to always be on. Even if the phone rarely rings, the rural surgeon always has to be available. And inevitably, if you go on vacation, someone you know will get appendicitis, and when you return they will come to you saying, “I was sick and you weren’t here.” Try to go to a movie or a graduation ceremony and not be able to turn off your phone. In bigger cities, where call is one in three or four days, the call day may be busy, but the other three days the phone can be silenced.

Professional isolation
Despite their vital role in treating patients, rural surgeons may feel that their peers overlook or don’t appreciate them. A subtle bias runs through the profession against a surgeon who would choose this life of relative isolation, apparent non-specialized surgery, and overwork in communities with fewer cultural activities and fewer employment options for spouses. Yet rural surgeons are essential to maintaining the health of millions of rural Americans.

A breadth of skills
Another source of pressure is the need for a broad range of skills. In rural hospitals, surgeons must be able to perform a wide variety of procedures and to do them in times of need. A urologist may not be available to provide care if a patient has a bladder or ureter problem. A gynecologist may not be available if a suspected appendicitis turns out to be an ovarian problem. Because the training paradigm for general surgeons is becoming narrower and narrower, rural surgeons often have to develop some of these skills on their own. Graduate medical education programs are configured in such a way as to encourage subspecialization and do not prepare young surgeons adequately for rural practice. This challenge, in addition to work hour restrictions, has made it more difficult to train surgeons who are prepared to practice in rural areas. Gone are the days when general surgery residents came out of residency with a broad set of surgical skills. Mentorship and rural surgery fellowships will become increasingly important as the supply of adequately trained rural surgeons dwindles in the next decade.

It’s the life we love
Those of us who have chosen rural surgery wouldn’t trade it for any other type of practice. We are deeply invested in our communities and find our practices very rewarding. Is the life of a rural surgeon an easy one? Maybe not. Is it a fulfilling one? Absolutely. ♦
Trust: The keystone of the physician-patient relationship

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

Editor’s note: Dr. Pellegrini presented the John J. Conley Ethics and Philosophy Lecture at Clinical Congress 2016 in Washington, DC. Dr. Pellegrini was invited to submit the following column, which highlights the key points he made in that lecture. The address was published online in October 2016 in the Journal of the American College of Surgeons, available at www.journalacs.org/article/S1072-7515(16)31566-6/fulltext.

John J. Conley, MD, FACS, an otolaryngologist, felt that in order to provide the best care to patients, surgeons should be trained in skills that extend beyond the technical aspects of surgery. With this objective in mind, he established the Ethics and Philosophy Lecture at the Clinical Congress of the American College of Surgeons, which now bears his name.

During my years as a surgeon, I realized that my ability to heal and provide comfort to my patients was substantially enhanced when I developed a bond of trust and a strong relationship with them. As I started working on ways to achieve that goal, I recognized the impact that those enhanced relationships had on me as a person and on my colleagues.

**Trust: The keystone of the physician-patient relationship**

I envision the patient-physician relationship, and by extension the relationship that surgeons develop with other members of the team and with themselves, as an arch; the surgeon represents one pillar, and the other party represents the other pillar. Trust is that stone at the top of the arch—the so-called keystone on which the stability and the integrity of the arch is dependent. Indeed, I am convinced that trust is to a relationship like a keystone is to an arch—essential for its integrity.

Trust is defined as “assured reliance on the character, ability, strength, or truth of someone or something.”¹ Trust does not usually result from a single interaction, but instead it is built over time, with repeated interactions through which expectations about a person’s trustworthiness can be tested.

In medicine, our patients expect that we, as physicians, will behave in a certain way. In this relationship, the patient is the trusting party and must have confidence that we will act for their benefit.² This intrinsic trust in the physician is expressed in the discretionary latitude that patients give their physicians to do what is necessary to, hopefully, benefit their well-being.

In the world of medicine, trust results from a number of interactions and the patient’s perception of the physician’s technical competency, interpersonal attributes, and values, as well as the patient’s impression of how the system works, including the reputation of the institution. In addition, medicine emphasizes the affective nature of trust, identifying patient trust as reliance on the physician and the physician’s intent.³ In surgery, our power to heal extends far beyond our technical prowess and is directly influenced by the relationship we establish with our patients. Indeed, studies show that patient trust in a physician increases the likelihood of adherence to...
Just as the patient must be able to trust the physician, the physician needs to have trust in the patient. Mutual trust is an important aspect of the patient-physician relationship with potential benefits for each party. Trust improves cooperation and reduces the need for monitoring.

Communication: A means of developing trust
If trust is a defining element in any interpersonal relationship, then communication is the most effective and efficient means of engendering trust. I am of course talking about communication in a much broader sense than the traditional concept. Most of the communication I refer to is, in fact, nonverbal. To create rich relationships with our patients, team members, and, indeed, ourselves, we must use all communication tools available to us.

Human beings use a wealth of methods to communicate with one another, and the
Although there is substantial evidence in the literature regarding the effects that a positive physician-patient relationship has on patients, very little has been written on the great influence that this bond has on physician well-being.
and that pursue lofty goals in the care of their patients.

Most of us don’t view surgical practice as a job. We view it as a calling. The passion and sense of purpose that drives physicians connects us with our patients in a way that reassures and inspires them. At the same time, it is important to emphasize that clinician well-being and self-awareness have a powerful effect on our ability to communicate better, which in turn will improve the interpersonal relationships that drive patient satisfaction and behavior. A clinician’s mental well-being is a precondition for being effective in the delivery of care and in recognizing and valuing the patient’s perspective as distinct from one’s own.8

**Keeping the arch stable for a rewarding career**

I have described the importance of building trust through communications, primarily in the context of the practice of medicine. In every encounter with our patients, our teams, or for that matter, with ourselves, our own souls, we have a unique opportunity to do good—to make someone feel better or to improve the image of our workplace—and allow us to build trust, no matter how small or how big the opportunity or the result may be. I invite you to reflect on this simple statement, and if you believe it, if you see yourself using each encounter to affix that keystone that ensures the integrity of the arch described earlier, then I say to you: do it. Be present. Seize each opportunity to do what your heart tells you is the right thing to do at every turn of that long, winding road that we call life. That way when you reach the sunset of your career, you will feel as if you lived and as if your life mattered—to you, to your patients, to your team, and to humanity at large. ♦

**REFERENCES**


It is estimated that more than 50,000 women in the U.S. will be diagnosed with ductal carcinoma in situ (DCIS, or preinvasive breast cancer) in 2017, and most of the women who receive this diagnosis will be completely asymptomatic.\(^1\) In DCIS, the neoplastic cells are confined to the breast ducts;\(^2\) thus, in the absence of progression to invasive disease, DCIS has little potential of spreading to distant organs and causing symptoms or death. At present, guidelines recommend that all DCIS be treated with a combination of surgery, radiation, and endocrine therapy—treatments similar to those recommended for patients with invasive cancer. However, it is estimated that without treatment only 20 to 30 percent of DCIS patients will progress to invasive cancer.\(^3\)\(^,\)\(^4\)

The term “overdiagnosis” has been applied in reference to cancerous conditions that are unlikely to cause symptoms or death in a patient’s lifetime.\(^5\) An estimated one in four patients is overdiagnosed with breast cancer as a result of mammographic screening, although the absence of standard definitions of overdiagnosis has led to questions about the accuracy of this estimate.\(^6\)\(^-\)\(^10\) The general consensus, however, is that much of the overdiagnosis burden derives from the treatment of DCIS. For those women who have DCIS that may never have progressed even without treatment, medical intervention can only have harmful effects. And overdiagnosis comes at a financial as well as personal cost—the annual national expenditure incurred by DCIS overtreatment has been estimated to be more than $240 million.\(^11\)

Advances in epidemiology and cancer biology have clearly established that within the group of diseases categorized as cancer are many conditions that vary enormously in biologic behavior. However, the medical treatment of DCIS has not kept pace with scientific discovery. Surgical and medical oncologists must work to develop a treatment strategy based on biologic risk of clinically significant disease, rather than treating all DCIS as one disease.

For DCIS at low risk of progression to invasive cancer, such as low-grade, small, nonpalpable lesions, surgery and radiation may offer no benefit, whereas large, palpable, high-grade DCIS may require more aggressive approaches to halt the likely progression to invasion. Given the long lead time between the development of DCIS and progression to invasive disease, a case can be made for tailoring intervention by age and the presence of competing comorbidities, as is done for prostate cancer.

**COMET study**

In a recent Cancer and Leukemia Group B (CALGB) 40903 clinical trial, postmenopausal patients with DCIS were treated with neoadjuvant letrozole to evaluate the magnetic resonance imaging (MRI) and pathologic response to endocrine therapy. Results from this trial are anticipated in the next six months. The COMET (Comparing Operative to Monitoring and Endocrine Therapy for low risk DCIS) Trial builds upon this previous work, to assess outcomes with a less aggressive approach to the management of DCIS, and to continue to advance the knowledge regarding the biologic behavior of DCIS.

COMET is a prospective randomized trial that will assess the risks and benefits associated with active surveillance (AS) versus...
guideline concordant care (GCC) for patients with low-risk DCIS (see Figure 1, this page). The overarching hypothesis of the study is that management of low-risk DCIS using an AS approach does not yield inferior oncologic or quality of life outcomes when compared with guideline concordant care.

Patient education and close monitoring will be essential components of the study. Endocrine therapy will be encouraged, but not required, in the active surveillance group, and patients will be followed with mammography every six months to assess for invasive progression. The guideline concordant care group will be treated with surgery, radiation, endocrine therapy, or a combination according to usual care guidelines and followed with mammography every 12 months to assess for recurrent disease. Both groups will be monitored for 10 years. The primary outcome will be the proportion of new diagnoses of ipsilateral invasive cancer in the GCC group and the AS group. Secondary outcomes will include assessment of quality of life between the two arms of the study, as well as long-term survival endpoints.

Inclusion in the COMET Trial will be limited to women ages 40 and older who present with a new diagnosis of DCIS grades I/II. DCIS must be estrogen receptor (ER)-positive and/or progesterone receptor (PR)-positive. If human epidermal growth factor receptor 2 (HER2) testing is performed, the DCIS must be HER2 0, 1+, or 2+ by immunohistochemistry (IHC). Male patients, patients with bloody nipple discharge, pregnant patients, or patients with documented history of prior tamoxifen, aromatase inhibitor, or raloxifene use will be excluded. Results from this study will help to determine whether de-escalation of treatment for low-risk DCIS is a feasible approach, and how clinical outcomes and quality of life compare between treatment and surveillance groups.

This trial will recruit 1,200 patients at 100 sites through the Alliance for Clinical Trials in Oncology, with plans to include sites from other national adult cooperative groups. The trial will open for enrollment in February 2017. For more information on the COMET Trial, contact E. Shelley Hwang, MD, MPH, at shelley.hwang@duke.edu.

REFERENCES
J. Marion Sims: Paving the way

by LaMar S. McGinnis, Jr., MD, FACS

Marion Sims, MD, is the most decorated surgeon in American history and the only American surgeon with a life-sized statue in a purely public place. He is considered the father of the surgical specialty of gynecology. Many surgeons are familiar with the Sims position, the Sims speculum, and other innovations in gynecologic surgery that bear his name.

Early influences and contributions
Born in Lancaster, SC, in 1813, Dr. Sims studied for two years at the University of South Carolina, Charleston. Against his parents’ wishes, he chose medicine as a career and apprenticed in the office of a local doctor. At age 20, he attended a three-month course of lectures at the new South Carolina Medical College, now the Medical University of South Carolina, Charleston. In 1833, following a one-week stagecoach ride, he enrolled at the new Jefferson Medical College, Philadelphia, PA, where he received his medical degree and where he was strongly influenced by mentors George McClellan, MD, and Granville Pattison, MD, leading to his focus on surgery.

He returned to Lancaster to practice, but was so dismayed by the deaths of two patients that he physically walked to a new beginning near Montgomery, AL, where he began his practice anew. It was at this new location that Dr. Sims started to bloom with a flourishing practice focused primarily on surgery. A number of slave women were brought to him with the devastating problem of vesico-vaginal fistula caused by prolonged, unattended labor. He attempted to treat the condition with a variety of unsuccessful techniques until a jeweler fashioned silver into wire, at Dr. Sims’ direction, for use in repair for a woman named Anarcha. Thus began his road to fame through a focus on gynecologic surgery. Gynecology was not a recognized specialty at the time, and the use of anesthesia was just evolving.

Pioneering efforts in cancer treatment
In 1853, suffering from unrelenting dysentery and in an attempt to improve the state of his health, he relocated to New York, NY. There, his health improved, his abilities were recognized, and his focus on gynecology flourished.
He established the Woman's Hospital of New York, the first of its kind, which became an incubator for progressive concepts in surgery. Years later—nearing that cancer patients could not be admitted to hospitals due to the misconception that cancer was a communicable disease—Dr. Sims opened the New York Cancer Hospital, which evolved over time into the Memorial Hospital for Cancer and Allied Diseases (now known as Memorial Sloan Kettering).

His reputation continued to grow both nationally and internationally. He operated in the U.S. and in Europe. He was widely decorated and acclaimed, serving as president of the American Medical Association in 1875 and the American Gynecological Society in 1879. He has been recognized as the father of the specialties of gynecology and infertility.

Dr. Sims, who died in 1883, was an inquisitive innovator, an able and talented surgeon, and a humanitarian. It has been said that he advanced surgery as much or perhaps more than any other U.S. surgeon who lived in the 19th century.

Today, there are some health care scholars who may discredit parts of our heritage, largely based on a lack of information. Therefore, when remembering historical pioneers and their achievements, it is important to note the circumstances of that particular period of history. Some have written that because Dr. Sims operated on slave women without anesthesia or proper informed consent, he should be disclaimed rather than applauded. However, that view misses the point of what Dr. Sims accomplished in the mid-19th century. Anarcha and others should be celebrated for their contributions just as Henrietta Lacks—an African-American woman whose cells were unwittingly used to create the first human immortal cell line in the 1950s—has been acknowledged for her role in the evolution of medicine.

**BIBLIOGRAPHY**


Shingleton HM. The lesser known Dr. Sims. ACOG Clin Rev. 2009;14(2):13-16.


Abell I. J. Marion Sims: An appreciation. SMJ. 1933;26(12).
New ACS Foundation board members installed

Editor’s note: The Mayne Heritage Society column is replaced by “ACS Foundation Insights,” a vehicle for updates on all ACS Foundation contributions including, but not limited to, planned gift donations. The ACS Foundation’s mission is to obtain financial support for the charitable and educational work of the College, and it receives donations from Fellows, corporations, foundations and other friends through a wide range of gifts. The column will also update readers on the impact of giving, with reports on the beneficiaries of donors’ generosity.

The American College of Surgeons (ACS) Board of Regents approved three new members of the ACS Foundation Board of Directors for three-year terms beginning in October 2016 at its Annual Business Meeting of Members on October 19, 2016. The new board members, all of whom bring individual philanthropic interests, are Mary O. Aaland, MD, FACS, who advocates for rural surgeons and patients; E. Christopher Ellison, MD, FACS, who urges the continued mentorship and education of young surgeons; and Colonel Kirby Gross, MD, FACS, who endorses the partnership between the ACS and the U.S. Department of Defense Military Health System.

Returning to rural roots
Dr. Aaland, a general and trauma surgeon, knew from childhood that trauma care is critical to life in rural America. “Farming is one of the most dangerous occupations, which I experienced firsthand as a farm girl in North Dakota. During my surgical rotation as a third-year medical student in an inner-city trauma center, I realized that rural Americans were not receiving appropriate trauma care. It was at that moment I decided that I wanted to become a trauma surgeon and help develop trauma systems outside major metropolitan areas,” Dr. Aaland said.

After graduating from medical school at the University of North Dakota (UND), Grand Forks, Dr. Aaland completed her general surgery residency rotations at Yale Affiliates Regional Surgical Residency Programs, University of South Dakota, Vermillion, and at the University of Illinois College of Medicine, Peoria. She eventually returned to North Dakota for her surgical practice, where she is an advocate for meeting the increasing need for rural surgeons and systems, serving as associate professor and director of rural surgery, UND School of Medicine and Health Sciences, department of surgery. In her role as director of the rural surgery support program, Dr. Aaland is working to address rural hospital challenges with surgical coverage recruitment support and continuing education offerings in surgery and trauma.* She also practices surgery in critical access hospitals across the state of North Dakota, including the cities of Devils Lake and Jamestown.

When asked what she enjoys most about being a rural surgeon, she emphasizes the thanks she receives from her patients, who

appreciate the surgical care they receive without needing to travel far from home.

An ACS Fellow since 1995, Dr. Aaland serves on the ACS Board of Governors representing North Dakota and has held leadership roles in ACS chapters. She also supports the College as an ACS Foundation donor, giving back for all she has received from the organization. “Membership in the ACS has been the mainstay of my professional life, even as a nonacademic surgeon. It has given me the opportunity to have access to other members across the world and to have personal contact with key players in the world of surgery.”

Mentoring the next generation
When asked what brings the most satisfaction to his work day, Dr. Ellison is quick to respond that it is teaching and mentoring the next generation of surgeons. “Day to day, I am happiest when I teach a new concept to students and see the light go on in their eyes and they ‘get it,’” he said. “Likewise, the joy of working with residents over years of training and seeing them mature and develop into independent surgeons is meaningful. Teaching spreads my individual contribution to health care onto future providers, and the impact is manifold over what I could accomplish as an individual surgeon.”

Dr. Ellison, a general surgeon, is the Robert M. Zollinger Professor of Surgery, chief executive officer of faculty group practice, and senior associate vice-president for health sciences and vice-dean for clinical affairs, Wexner Medical Center, Ohio State University (OSU), Columbus. Dr. Ellison received his medical degree from the Medical College of Wisconsin, Milwaukee, and completed a general surgery residency at OSU. He has served as ACS Ohio Chapter president, ACS Governor-at-Large, and as the Chair of the ACS Advisory Council for General Surgery.

As a medical student, Dr. Ellison chose a career in general surgery because it afforded him the breadth of patient exposure that he wanted as a young surgeon. Since then, he has valued the opportunity to learn new surgical techniques and evolving treatment paradigms for many surgical diseases. With the joy of teaching such a priority for Dr. Ellison, he is the ideal choice to lead the ACS Transition to Practice Program at Wexner Medical Center. This position allows him to further expand his reach in optimal patient care by helping other surgeons develop their peak potential.

An ACS Fellow for 30 years, Dr. Ellison has found the College beneficial in developing his network of colleagues and for offering access to a variety of educational offerings. He takes pride in the FACS designation. “FACS means something special. It is like the Good Housekeeping Seal of Approval. My patients appreciate the fact the FACS stands for quality and integrity, and it gives them an added sense of confidence in the care they receive,” Dr. Ellison noted.

Giving back as a donor to the ACS Foundation also reinforces Dr. Ellison’s values: “As a not-for-profit organization, the ACS supports many meaningful projects in education leadership.
development, global health initiatives, transition to practice programs, and quality and safety program development. All those who are privileged to have FACS after their name should be proud to contribute to these causes through the ACS Foundation.”

Answering the call to serve
Dr. Gross answered the call to serve in the U.S. military mid-career in 2002. His initial choice of the surgical profession was significantly affected by the faculty, specifically his mentors the late Jay L. Grosfeld, MD, FACS, and James A. Madura, MD, FACS, at Indiana University School of Medicine, Indianapolis. But the events of September 11, 2001, changed his professional direction, and he decided to use his surgical skills to care for members of the U.S. Armed Forces.

Colonel Gross now serves as an officer in the U.S. Army Medical Corps. He will be assuming the role as director of the Army Trauma Training Center at the Ryder Trauma Center, University of Miami, in early 2017. He has deployed seven times to Afghanistan and Iraq, most recently returning to the U.S. in August 2014.

He has been assigned to Fort Campbell, Kentucky; Williams Beaumont Army Medical Center, El Paso, TX; Walter Reed Army Medical Center, Washington, DC; Walter Reed National Military Medical Center, Bethesda, MD; and the Joint Trauma System at Joint Base San Antonio, TX. After two tours of duty in Iraq, he completed a trauma fellowship at Vanderbilt University Medical Center, Nashville, TN. A Fellow since 1989, Colonel Gross has embraced his FACS status with gratitude and pride. “I viewed recognition as a Fellow of the ACS as a career milestone to confirm to myself and to surgical colleagues an attainment of professional achievement and ethics,” he said. “Mid-career, the educational benefits of Fellowship were of great value. Now, as a senior surgeon, Fellowship has provided ready access to colleagues who are subject matter experts and thought leaders on effecting change to positively impact outcomes.”

A regular and generous donor to the ACS Foundation for nearly 25 years, Colonel Gross is a strong supporter of the Military Health System Strategic Partnership ACS. This initiative, established in collaboration between the ACS and the Department of Defense military health system, will use battlefield experiences to provide better care for soldiers and civilians. Part of the partnership's funding will come from ACS Foundation contributions.

“The ACS Foundation serves as a way for Fellows to support their organization, which has consistently and fervently advanced surgical care,” Colonel Gross said. “Even more than the personal benefits from Fellowship, such as educational offerings and career mentorship, the College effectively focuses resources to facilitate improvements in surgical care.”

For more information on the ACS Foundation, contact Shane Hollett, ACS Foundation Executive Director, at 312-202-5506 or shollett@facs.org. ♦
Hospitals in the U.S. continue to make strides in improving patient safety and quality for common conditions, according to America’s Hospitals: Improving Quality and Safety: The Joint Commission’s Annual Report 2016.

The report, released November 7, 2016, presents information on how more than 3,300 Joint Commission-accredited hospitals performed on individual, chart-abstracted measures of patient care during 2015 in comparison to previous years.

Reporting data on these measures is a requirement of Joint Commission-accredited hospitals. A total of 33 measures were described in the report, 29 of which were accountability measures, focused on evidence-based care processes that are closely linked to positive patient outcomes. The measures are relevant for accreditation, public reporting, and pay-for-performance programs that hold providers accountable to external oversight entities and the public.

Measures in the report
The chart-abstracted measures covered in the report pertain to the following:

- Children’s asthma management (one measure)
- Inpatient psychiatric services (seven measures)
- Venous thromboembolism (VTE) care (five measures)
- Stroke care (eight measures)
- Perinatal care (five measures)
- Immunization (one measure)
- Tobacco use treatment (three measures)
- Substance use care (three measures)

Some measures, such as those comprising perinatal care, show significant gains. In 2015, the perinatal care result was 97.6 percent—up from 53.2 percent in 2011, which is an improvement of 44.4 percentage points.

Another is the VTE care result, which came in at 95.2 percent in 2015—up from 89.9 percent in 2011—an improvement of 5.3 percentage points. VTE medicine and/or treatment in an intensive care unit was 94.5 percent in 2011 and 97.4 in 2015—a difference of 2.9 percentage points.

Any improvements, no matter how large or small, are important because they all contribute to better care for patients. As a result of continued excellent performance, three of four individual VTE care accountability measures were retired effective December 31, 2015.

Meanwhile, strong reporting performance led to the retirement of all Surgical Care Improvement Project (SCIP) chart-abstracted measures in 2015. This decision was based largely on the fact that the composite scores were so high, ranging in 2014 from 94.2 percent on the low end (appropriate prophylactic antibiotics for colon surgery) to 99.9 percent on the high end (patients with appropriate hair removal).

Pioneers in Quality recognized
This year’s annual report also recognizes 39 Pioneers in Quality hospitals that are at the forefront of a new era in health care quality reporting—one in which hospitals collect information on the quality of patient care through electronic health records (EHRs).
and report the data to The Joint Commission and the Centers for Medicare & Medicaid Services (CMS). To be recognized as a 2016 Pioneers in Quality organization, a hospital had to meet criteria in at least one of three of The Joint Commission's categories of participation. These categories of participation are as follows:

- **Expert contributor:** Advancing the evolution and use of electronic clinical quality measures (eCQMs) through contributions such as presenting at a Pioneers in Quality webinar or participating in eCQM development in 2016.

- **Solution contributor:** Submitting an eCQM solution or implementation story to The Joint Commission's Core Measure Solution Exchange, a quality improvement tool that promotes the sharing of performance measurement successes among accredited hospitals. To access the database and share your institution's success stories, go to www.jointcommission.org/core_measure_solution_exchange/.

- **Data contributor:** Voluntarily transmitting 2015 eCQM data in 2016.

In 2016, hospitals also will have available to them new eCQMs on surgical care and emergency department measures to report. These electronic (e) SCIP measures are as follows:

- Antibiotics within one hour before the first surgical incision (eSCIP-INF-1a)
- Urinary catheter removed (eSCIP-INF-9)
- Median time from ED arrival to ED departure for admitted ED patients (eED-1a)
- Admit decision time to ED departure time for admitted patients (eED-2a)

“The results featured in The Joint Commission's 2016 Annual Report are important because they show that accredited hospitals have continued to improve the quality of the care they provide, and the data that hospitals collect help them identify opportunities for further improvement,” said Mark R. Chassin, MD, MPP, MPH, FACP, president and chief executive officer, The Joint Commission. “The results also show it’s important to note that where a patient receives care makes a difference. Some hospitals perform better than others in treating particular conditions.”*


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**Disclaimer**

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

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Annual Report 2016: Almost a 10

by Richard J. Fantus, MD, FACS

The Annual Report 2016 of the National Trauma Data Bank® (NTDB®) is an updated analysis of the largest aggregation of U.S trauma registry data ever assembled. The NTDB now contains close to 7.5 million records. The Annual Report 2016 is based on 861,888 records with valid trauma diagnoses from the single admission year of 2015 from 747 facilities, including 239 Level I trauma centers, 263 Level II trauma centers, and 196 Level III or IV trauma centers; 36 are Level I or Level II pediatric centers.

Use of ICD-10 in report development
The International Classification of Diseases (ICD), owned and published by the World Health Organization, is the world-standard diagnostic tool for health management, epidemiology, and clinical purposes. The ICD is used to monitor incidence and prevalence of diseases and other health care problems.* In 2009, the U.S. Department of Health and Human Services published a regulation requiring

The 2016 Annual Report is based on 861,888 records with valid trauma diagnoses from the single admission year of 2015 from 747 facilities, including 239 Level I trauma centers, 263 Level II trauma centers, and 196 Level III or IV trauma centers; 36 are Level I or Level II pediatric centers.

U.S. providers to transition from the ninth edition of the classification system (ICD-9) to ICD-10, which is what the rest of the world was using. ICD-10 has several advantages over its predecessor. Some trauma-related highlights include expanded injury codes, a combination of diagnosis/symptom codes to reduce the number of codes necessary to describe a condition, and two additional characters added along with subclassifications allowing laterality and greater specificity in code assignment. This transition required a significant change in institutional infrastructure throughout the U.S. Consequently, the final date of implementation was delayed until October 1, 2016. As a transitional year, this annual report allows the inclusion of both ICD-9 and ICD-10 codes (see Figure 1, page 71).

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

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

Throughout the year, we will be highlighting these data through brief reports that are published monthly in the Bulletin. The NTDB Annual Report 2016 is available on the ACS website as a PDF file at facs.org/quality-programs/trauma/ntdb. In addition, information is available on the 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.

The American College of Surgeons (ACS), and indeed all of surgery, lost one of its champions October 19, 2016, with the passing of Jay L. Grosfeld, MD, FACS. His contributions to surgery and in particular to his beloved specialty, pediatric surgery, for more than 50 years were extraordinary. He served the ACS in many roles over the years, most recently as First Vice-President (2014–2015).

Dr. Grosfeld was born in New York, NY, May 30, 1935. He grew up in New York, graduating from Midwood High School in Brooklyn and New York University (NYU) subsequently. He attended medical school at NYU and completed his general surgery training at NYU and Bellevue Hospitals (1961–1966).

**Pioneering pediatric surgeon**
He served two years as a Captain in the U.S. Army Medical Corps and then trained in pediatric surgery at Nationwide Children’s Hospital at the Ohio State University, Columbus, under the mentorship of William Clatworthy, MD, FACS. After completing his pediatric surgery training in 1970, he returned to New York as an assistant professor of surgery at NYU, but was promptly appointed professor and chief of pediatric surgery at Indiana University School of Medicine, Indianapolis, in 1972. He was the first surgeon-in-chief at the Riley Children’s Hospital and remained in Indianapolis for the rest of his career.

Dr. Grosfeld was a pioneer in pediatric surgery as it was emerging as a discipline, and he established the specialty of pediatric surgery in Indianapolis and, indeed, in the state of Indiana. He established the pediatric surgery training program in Indianapolis, and in 1985 he was appointed chairman of the department of surgery at Indiana University School of Medicine. He was the first pediatric surgeon in the U.S. to chair a department of surgery.

Dr. Grosfeld stepped down from his leadership positions at Indiana University in 2003 but remained actively engaged at the institution and in surgery in many important roles. He was the Lafayette F. Page Professor and Chairman Emeritus of Pediatric Surgery, department of surgery, at the Indiana University School of Medicine at the time of his death.

**Recognized leadership**

He held leadership positions in virtually all of the professional organizations in which he was active. He was secretary and chairman of the Section on Surgery of the American Academy of Pediatrics, president of the American Pediatric Surgical Association, president of the Halsted Society, chairman of the American Board of Surgery, and president of the American Surgical Association. He also served as president of the Central Surgical Association and the Western Surgical Association, as well as president of the World Federation of Associations of Pediatric Surgeons.

In 1998 he was awarded the Denis Browne Gold Medal by the British Association of Paediatric Surgeons, in 2002 he received

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**In memoriam:**

Jay L. Grosfeld, MD, FACS, champion for pediatric surgery patients

by Keith T. Oldham, MD, FACS
Dr. Grosfeld was a pioneer in pediatric surgery as it was emerging as a discipline, and he established the specialty of pediatric surgery in Indianapolis and, indeed, in the state of Indiana.

the William E. Ladd Medal from the American Academy of Pediatrics, and in 2011 he was awarded the Fritz Rehbein Medal from the European Pediatric Surgical Association. Each of these represents the highest honor these associations bestow on an individual.

Dr. Grosfeld lectured worldwide and was an honorary member of 15 international surgical societies, including the Royal College of Surgeons of England and Ireland, as well as the Royal College of Physicians and Surgeons, Glasgow. He received the Solomon A. Berson Medical Alumni Achievement Award in 2008 from NYU.

He was editor-in-chief of the Journal of Pediatric Surgery, Seminars in Pediatric Surgery, and the most widely used pediatric surgery textbook, Pediatric Surgery. He remained active as chairman of the board of directors of the American Pediatric Surgical Foundation and as vice-president of the American Surgical Association Foundation until his death.

Dr. Grosfeld’s service to essentially all of the major organizations in American surgery, including the ACS, is evident. Less apparent, but perhaps more noteworthy, is the fact that he used each opportunity to change and improve individual programs and organizations.

In addition to his many professional accomplishments, Dr. Grosfeld was the patriarch of a wonderful and loving family. He is survived by his wife Margie, to whom he was happily married for 54 years and with whom he shared his professional and personal journeys; his sister Claire Zucker; children Alicia Thorn, Dalia Maheu, Janice Kaefer, Jeffrey Grosfeld, and Mark Grosfeld; as well as 17 grandchildren.

Dr. Grosfeld was an influential leader, a role model, a mentor, an important investigator, and a masterful surgeon beloved by his patients, their families, and his colleagues. He made a difference for all of us who knew him and for all the pediatric surgeons who have followed in his path. He will be greatly missed.

Dr. Grosfeld was a pioneer in pediatric surgery as it was emerging as a discipline, and he established the specialty of pediatric surgery in Indianapolis and, indeed, in the state of Indiana.
Important changes made in the 
**AJCC Cancer Staging Manual, Eighth Edition**

by David J. Winchester, MD, FACS

The American Joint Committee on Cancer (AJCC) recently released the eighth edition of the *AJCC Cancer Staging Manual*. This edition incorporates significant changes in a manual that is now approximately 1,000 pages in length. The AJCC member organizations worked together to devise a comprehensive format revision to provide consistency throughout an expanded list of chapters, and new organ sites have been added to the text, as well. Several chapters introduce additional non-anatomic prognostic variables into staging schemes to increase the relevancy of the stage with regard to prognosis and defining optimal therapy.

**New implementation postponed**

Coordinating the implementation for a new staging system is critically important to ensure that all partners in patient care and cancer data collection are working in synchrony. Implementation was originally scheduled for January 1, 2017. However, to ensure that the cancer care community has the necessary infrastructure in place to successfully implement the new standards, compliance with the eighth edition cancer staging system has been delayed until January 1, 2018. The decision to delay implementation resulted from discussions between the AJCC Executive Committee, the National Cancer Institute, Centers for Disease Control and Prevention, the College of American Pathologists, the National Comprehensive Cancer Network, the National Cancer Database, and the Commission on Cancer.

The time extension will allow all partners to develop and update protocols and guidelines and for software vendors to develop, test, and deploy their products in time for the data collection and implementation of the eighth edition. Clinicians will continue to use the most recent information for patient care, including scientific content in the latest manual.

**Rationale for changes in the manual**

The eighth edition attempts to more fully synthesize stage groupings with relevant variables identified from multiple data sets based on registries and clinical trials. For example, after reviewing hundreds of publications, the Breast Expert Panel decided to include estrogen receptor and progesterone receptor status, HER-2 status, and grade into the...
The eighth edition attempts to more fully synthesize stage groupings with relevant variables identified from multiple data sets based on registries and clinical trials.

creation of a prognostic stage, combined with traditional tumor, node, and metastases (TNM) variables as defined in Anatomic Stage. Information from multi-gene panels was incorporated for patients with T1-2N0M0, ER-positive, HER2-negative tumors. With these eight variables (T, N, M, grade, ER, PR, HER-2, and multi-gene panel score), the complexity of staging increased, creating several hundred possible combinations. Other noteworthy changes included the elimination of lobular carcinoma in situ as a breast cancer diagnosis.

As a consequence of including biomarkers in the staging of breast cancer, more than 40 percent of patients with stage I–III disease were reclassified into a different stage than if seventh edition criteria had been applied, with a nearly equal split between those patients who were up-staged (20.0 percent) and down-staged (20.6 percent). Maintaining consistent definitions of in situ and distant metastatic disease with other organ sites, stage reassignment was excluded for patients with stage 0 and stage IV disease.

Within the remaining stage groupings, 9.8 percent of patients were reassigned more than one stage higher or lower than according to seventh edition criteria. These stage changes reflect the significant impact of prognostic variables that clinicians have long recognized as important in determining prognosis and therapy. Although this model provides a much more robust categorization of stage, it is essential to recognize that the derivation of these survival figures and stage assignments assumes that patients and clinicians follow treatment guidelines. As an example, a patient with a T2N1M0, Grade 3, ER-positive, PR-positive, HER2-positive breast cancer is assigned to Stage IB, as the survival with proper treatment for such a patient is similar to that of smaller and node-negative cancers. However, without appropriate treatment, including chemotherapy, pertuzumab, trastuzumab, endocrine therapy, surgery, and radiation therapy, this patient would be at high risk of cancer-related mortality.

Accommodating diverse resources
The AJCC remains committed to serving cancer patients throughout the world. Many geographic regions lack the resources needed to define the aforementioned variables. In this case, anatomic stage will continue to be used in the absence of biomarkers. In contrast, in developed countries where biomarkers are routinely used and available, it will be expected that physicians and registrars alike will be committed to using prognostic stage with complete entry of all prognostic variables as stipulated in respective chapters.

As the complexity of staging increases beyond the traditional TNM work laid out in the previous editions of the AJCC Cancer Staging Manual, staging calculators and electronic health record software will be necessary to achieve accurate and consistent implementation of stage into the patient’s care. In addition, careful and complete entry of staging variables will help provide critical information to develop future staging algorithms, likely to consist of rolling updates; to reflect advancing knowledge and improvements in patient care; and to show progress and establish priorities in cancer control and prevention. ♦
The American College of Surgeons (ACS) is now accepting applications for the 2018–2020 Clinical Scholar in Residence positions. Applications are due April 3, 2017.

About the program
The ACS Clinical Scholars in Residence Program is a two-year fellowship in surgical outcomes research, health services research, and health care policy performed on-site at ACS headquarters in Chicago, IL. It was initiated in 2005 for the purpose of advancing the College’s quality improvement initiatives and to offer opportunities for residents to work on ACS quality improvement programs. More specifically, ACS Clinical Scholars in Residence perform research relevant to ongoing projects in the ACS Division of Research and Optimal Patient Care.

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

In addition, participants earn a master’s degree in health services and outcomes research or health care quality and patient safety from Northwestern University, Chicago. This aspect of the program prepares clinicians to become effective health services...
The ACS Clinical Scholars in Residence have presented their findings at national meetings and in high-impact, peer-reviewed publications, in addition to having contributed a great deal to the ACS quality improvement programs. Furthermore, scholars have gone on to gain prestigious fellowships in several fields, including surgical oncology and pediatric surgery.

Past successes
Surgical residents from throughout the U.S., including California, Colorado, Connecticut, Illinois, Kansas, Louisiana, Michigan, and Ohio, have participated in the ACS Clinical Scholars in Residence Program since its inception. These individuals report excellent, productive experiences that have been useful in launching their careers in the field of academic surgery. In all, 12 scholars have completed the program, and four scholars are currently participating. The ACS Clinical Scholars in Residence have demonstrated great dedication to outcomes research and the improvement of the quality of surgical care.

Apply now
The 2018–2020 scholars will begin their work on July 1, 2018. Applicants are required to have funding through their institution or other grant mechanism. For more information about the program and the application requirements, go to facs.org/clinicalscholars, or send an e-mail to clinicalscholars@facs.org.
ACS NSQIP honors 60 hospitals for meritorious outcomes in surgical care

The American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP®) recognized 60 of 603 hospitals participating in the adult program for meritorious outcomes in surgical patient care in 2015. Participating hospitals track the outcomes of in- and outpatient surgical procedures and analyze the results. The hospitals were notified of this recognition through a poster announcement at the ACS Clinical Congress 2016. A list of the 60 hospitals is available at facs.org/~/media/files/quality%20programs/nsqip/meritoriousoutcomes2016.ashx.

The hospitals achieved this distinction based on their composite quality score, which is determined through a weighted formula combining outcome performances related to patient management in the following eight clinical areas:

- Mortality
- Cardiac: Cardiac arrest and myocardial infarction
- Pneumonia
- Unplanned intubation
- Ventilator less than 48 hours
- Renal failure
- Surgical site infection (SSI): superficial incisional SSI, deep incisional SSI, and organ/space SSI
- Urinary tract infection

Risk-adjusted data from the July 2016 ACS NSQIP Semiannual Report, which presents data from the 2015 calendar year, were used to determine the hospitals with meritorious outcomes.
The number of close races in the last election cycle illustrates the importance of a strong political action committee (PAC) focused on the concerns of surgical patients and professionals. Every campaign contribution, fundraiser, or independent expenditure could represent the difference between a win and a loss. As the American College of Surgeons (ACS) Washington, DC, office reprioritizes its legislative efforts, prepares for the transition to a new presidential administration, and welcomes the 115th Congress, it is critical that the ACS Professional Association political action committee (ACSPA-SurgeonsPAC), strengthen relationships with returning members of Congress and educate new legislators about the issues that could affect the delivery of quality surgical care.

Supporting Fellows, physicians, and surgical champions
During the 2015–2016 election cycle, the ACSPA-SurgeonsPAC disbursed more than $1.2 million to more than 150 congressional candidates and incumbents, including two ACS Fellows and 14 other physicians members of Congress, several physician and dentist candidates, and congressional leadership PACs and political campaign committees. In line with congressional party ratios, 58 percent of the funds were given to Republicans and 42 percent to Democrats. To learn more about SurgeonsPAC disbursements, visit surgeonspac.org/disbursements.

In addition, ACSPA-SurgeonsPAC staff and the federal legislative team attended or hosted more than 350 fundraisers, candidate meetings, and health care industry events to help leverage relationships with key physician champions in Congress.

New physician members of Congress
Although there are relatively few physician members of Congress, ACSPA-SurgeonsPAC plays a key role in engaging interested physician candidates around the country, particularly Fellows and surgeons. Two key races that SurgeonsPAC supported in the last election cycle include the following:

• Rep. Neal Dunn, MD, FACS (R-FL-02): To raise awareness about Dr. Dunn’s candidacy, the ACS Washington office organized a physician community briefing with more than 25 health professional groups in attendance. On November 8, Dr. Dunn, a urologist, won his election, capturing more than 67 percent of the vote.

• Rep. Roger Marshall, MD (R-KS-01): ACSPA-SurgeonsPAC partnered with other physician organizations to support Dr. Marshall, who unseated incumbent Rep. Tim Huelskamp (R-KS), in the Republican primary. Dr. Marshall, an obstetrician-gynecologist, went on to win the general election with 66 percent of the vote.

ACSPA-SurgeonsPAC candidate successes
• Dr. Dunn (R-FL-02)
• Drew Ferguson, DMD (R-GA-03)
• Raja Krishnamoorthi (D-IL-08)
• Dr. Marshall (R-KS-01)

ACSPA-SurgeonsPAC-supported physician and dentist candidates
• Scott Angelle (R-LA-03, lost December 10 runoff)
• Dr. Dunn (R-FL-02)
• Dr. Ferguson (R-GA-03)
• Pam Galloway, MD, FACS (R-IN-03, lost May 3 Republican primary)
During the 2015–2016 election cycle, the ACSPA-SurgeonsPAC disbursed more than $1.2 million to more than 150 congressional candidates and incumbents, including two ACS Fellows and 14 other physicians members of Congress, several physician and dentist candidates, and congressional leadership PACs and political campaign committees.

Physicians in the 114th Congress supported by SurgeonsPAC

U.S. House of Representatives

• Matt Heinz, MD (D-AZ-02, lost general election to incumbent Rep. Martha McSally)

• Dr. Marshall (R-KS-01)

• Dena Minning, MD, PhD (D-FL-09, lost August 30 Democratic primary)

• Rep. Dan Benishek, MD, FACS (R-MI-01), member, Committee on Veterans Affairs

• Rep. Ami Bera, MD (D-CA-07), liability reform champion

• Rep. Michael Burgess, MD (R-TX-26), member of the Committee on Energy and Commerce; founder, Congressional Health Caucus; and strong ally in the repeal of the sustainable growth rate formula

• Rep. Larry Bucshon, MD, FACS (R-IN-08), member, Committee on Energy and Commerce

• Rep. John Fleming, Jr., MD (R-LA-04), vice-chair, GOP Doctors Caucus

• Rep. Andy Harris, MD (R-MD-01), member, Committee on Energy and Commerce and the Committee on Appropriations

• Rep. Jim McDermott, MD (D-WA-07), member, Committee on the Budget and Committee on Ways and Means

• Rep. Tom Price, MD, FACS (R-GA-06), Chairman, Committee on the Budget, and member, Committee on Ways and Means, nominated in December by President-Elect Donald Trump to serve as secretary of the U.S. Department of Health and Human Services

• Rep. Phil Roe, MD (R-TN-01), member, Committee on Education and the Workforce and Committee on Veterans Affairs

• Rep. Raul Ruiz, MD (R-CA-36), member, Committee on Veterans Affairs

• Rep. Brad Wenstrup, MD (R-OH-02), member, Committee on Veterans Affairs

U.S. Senate

• Sen. Bill Cassidy, MD (R-LA), member, Committee on Appropriations; Committee on Health, Education, Labor, and Pensions; and Committee on Veterans Affairs

• Rep. Charles Boustany, Jr., MD, FACS (R-LA), candidate for U.S. Senate, member of the House Committee on Ways and Means

• Rep. Joe Heck, Jr., DO (R-NV), candidate for U.S. Senate, member of the House Committee on Education and the Workforce

In early October, the ACSPA-SurgeonsPAC launched independent expenditures in support of the elections of Congressman Bera and Dr. Heck’s Senate race, both staunch supporters of the physician community. Although Dr. Heck lost his race, strong ACSPA-SurgeonsPAC support assisted in re-electing Dr. Bera, a top Democratic liability champion on Capitol Hill. Dr. Bera’s victory is one example of how PACs can affect tight races for candidates who support the needs of surgeons and surgical patients.

For more information about ACSPA-SurgeonsPAC fundraising and disbursement activities, visit surgeonspac.org. ♦
The 2017 Nominating Committee of the Fellows (NCF) and the Nominating Committee of the Board of Governors (NCBG) will select nominees for leadership positions in the College as follows.

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

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

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

• Nominees must have demonstrated leadership qualities, such as service and active participation on ACS committees or in other components of the College

• The ACS encourages consideration of women and underrepresented minorities for all leadership positions

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

Further details
Entities such as surgical specialty societies, ACS Advisory Councils, and ACS chapters that want to make a nomination must provide a description of their selection process and the total list of applicants reviewed.

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

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

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

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

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

• Nominees must have demonstrated leadership qualities, such as service and active participation on ACS committees or in other components of the College.

• The ACS encourages consideration of women and underrepresented minorities for all leadership positions.

• The NCBG recognizes the importance of the Board of Regents representing all who practice surgery, including surgeons in academic and community practice, regardless of practice location or configuration.

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

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

All nominations must include:

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

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

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

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

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

Visit web4.facs.org/ebusiness to purchase official FACS-branded lab coats, surgical caps, and more!
The American College of Surgeons (ACS), in association with Pfizer, Inc., is accepting nominations for the 2017 Surgical Volunteerism Award(s) and Surgical Humanitarian Award. All nominations must be received by February 28, 2017.

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

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

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

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

The following conditions apply to the nominations process:

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

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

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

• Demographic information about the nominee and nominator.

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

• Completion of narrative sections requesting detailed information
American College of Surgeons Official Jewelry & Accessories
designed, crafted and produced exclusively by Jim Henry, Inc.

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<td>Maroon</td>
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<tr>
<td>Blazer Buttons (Not Shown)</td>
<td>#21</td>
<td>Gold Electroplated (set of 9)</td>
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<td>Extra long add $5.00</td>
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<tr>
<td>Women's Scarf - Silk (Not Shown)</td>
<td>#22</td>
<td>36&quot; x 36&quot; cream</td>
<td>$35</td>
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<td></td>
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<td>w/ dark blue and maroon border</td>
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Shipments/Handling: Insurance Domestic (48 contiguous states) $20
Alaska, Hawaii, Puerto Rico $35
Foreign $45

Shipping/Handling/Insurance
Domestic (48 contiguous states) $20
Alaska, Hawaii, Puerto Rico $35
Foreign $45

**Please use model # and item description when ordering**
- Include payment with order
- VISA, American Express, & MasterCard accepted
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- Illinois residents add 8% sales tax
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JAN 2017 BULLETIN American College of Surgeons
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 October 15 at the Marriott Marquis Hotel in Washington, DC. The following is a summary of their discussions and actions.

ACSPA
As of October 15, 2016, the ACS Professional Association’s political action committee, ACSPA-SurgeonsPAC, raised a total of $1,081,165 from more than 2,100 College members and staff. In addition, the PAC also had disbursed more than $1,044,000 to more than 160 congressional candidates, leadership PACs, and party committees. In line with congressional party ratios, 58 percent of the disbursements went to Republicans and 42 percent to Democrats. The ACSPA does not contribute to presidential campaigns.

ACS
In addition to reviewing reports from the ACS division directors, the Board of Regents reviewed and approved new policy approval and dissemination principles and a white paper on the ACS database integration project.

Division of Advocacy and Health Policy
The Division of Advocacy and Health Policy has established a Quality Payment Program (QPP) Resource Center, which contains several tools that are available to help surgeons understand the new payment system being implemented under the Medicare Access and CHIP (Children’s Health Insurance Program) Reauthorization Act (MACRA). Videos are available on the ACS website to explain the four components of the QPP’s Merit-based Incentive Payment System (MIPS)—Quality, Resource Use, Advancing Care Information, and Clinical Practice Improvement Activities.

The ACS also is working with colleagues at Brandeis University, Waltham, MA, and Brigham & Women’s Hospital, Boston, to develop alternative payment models for use in the QPP. A redesigned ACS Surgeon Specific Registry (SSR) will be available this month. The SSR is a useful means for surgeons to report their outcomes data to the Physician Quality Reporting System and will be useful in responding to the MIPS Quality mandates.

Division of Education
The 2016 Clinical Congress program comprised 24 Tracks, 128 Panel Sessions, 18 Didactic Courses, 14 Skills Courses, 45 Meet-the-Expert Luncheons, and 18 Town Hall Meetings. Three Special Sessions were offered on Firearm Injury Prevention, ACS Strong for Surgery, and Global Engagement.

In addition, the Division of Education collaborated with the Division of Integrated Communication on a targeted e-mail campaign to surgeons in 14 states, recommending courses that might help them fulfill their respective states’ maintenance of licensure requirements.

Division of Integrated Communications
The Division of Integrated Communications played a major role in the creation of Bleedingcontrol.org, a new website that highlights the Stop the Bleed program developed through a collaboration between the ACS Committee on Trauma, the White House, the U.S. Department of Homeland Security, and other federal agencies.

After 100 years as a print publication, the Bulletin is transitioning to an online-only publication beginning January 1. The member magazine is available in the following three digital formats: a website, bulletin.facs.org; an interactive version that replicates the print edition; and an app.

The Division of Integrated Communications was responsible
for the development of two video series, which are posted on the ACS website. One video series centers on the value of ACS Fellowship and the other on the value of ACS educational programs.

The ACS Communities are now in their third year as a forum to discuss topics of interest to ACS Fellows. At present, there are 106 active ACS Communities.

Division of Member Services
The College had a record number of Initiates in 2016, a total of 1,823, with 1,256 from the U.S. and its territories, 21 from Canada, and 546 from 69 other countries. The B/R accepted resignations from four Fellows: two cardiothoracic surgeons, one general surgeon, and one ophthalmic surgeon. The B/R also approved a change in status from Active (dues paying) to Retired for 49 Fellows, and from Senior (non-dues paying) to Retired for 28 Fellows, for a total of 77 Fellows. In all, the College had more than 80,000 members at the end of October 2016.

The Initiate classes of 1966 and 1991 received special recognition at the Convocation Ceremony at Clinical Congress 2016. Special invitations and a recognition website were created to support this event.

The Realize the Potential of Your Profession campaign continued this year with young surgeon networking events in Sacramento, CA; Seattle, WA; and New York, NY. Non-member surgeons were invited to these events to meet ACS leaders and learn about the benefits of College membership.

Four new videos were released this past year highlighting key areas of member involvement—Advocacy, Leadership, Influence, and Engagement. These videos are displayed on the ACS website and were distributed through various College e-newsletters and social media outlets.

In addition to member recruitment and retention, the Division of Member Services has purview over the ACS Advisory Councils, Archives, Board of Governors, and Chapter Services.

Advisory Councils
The Advisory Councils have been restructured to include Advisory Council pillars aligned with the values of the College—Membership, Communications, Advocacy, Quality, and Education. The Advisory Council pillars now meet at the Leadership & Advocacy Summit and again at the Clinical Congress.

Archives
More than 32 new accessions were accepted into the Archives this past year, including the records of Past-Executive Director Thomas R. Russell, MD, FACS; minutes of the Annual Meetings of the Fellows at the Clinical Congress 1910–1951; minutes of the Annual Meeting of the Fellows 1912–1984; extensive Commission on Cancer (CoC) American Joint Committee on Cancer (AJCC) records; and trauma publications. Improvements have been made to the new Archives online database, including the addition of a module to support College publications and a search by subject feature.

The College also hired a new full-time Archivist, Meghan Kennedy.

Board of Governors
The following three specialty societies have been approved for representation on the ACS Board of Governors:

• American Society of Maxillofacial Surgeons
• The International Society for Minimally Invasive Cardiothoracic Surgery
• The Society of Black Academic Surgeons

Chapters
Chapter Services continues to provide guidance and assistance to the College’s 109 Chapters, 67 of which are Domestic and 42 of which are International. The Trinidad & Tobago Chapter received approval from the Board of Regents earlier this year, and a surgeon in Kuwait petitioned the College for a Governor with the intention of forming a new
chapter soon. Other Chapter Services updates are as follows:

- The ACS President and other Officers have attended 22 domestic and international chapter meetings as keynote speakers, providing updates on College activities or presentations on leadership or clinical topics of interest.

- The first Chapter Officer Leadership Program will take place in March 2017. This program is designed exclusively for domestic chapter officers and will provide participants with the skills they need to help their chapters build sustainable success.

- A new Chapter Administrator Learning Event will take place in conjunction with the 2017 Leadership & Advocacy Summit.

- The Chapter Guidebook has been completely revamped and was distributed to all Chapters following the Clinical Congress. A new Chapter Meeting Toolkit has been developed and will be integrated into the Guidebook.

- A total of 15 webinars have been held this year to provide chapter leaders with strategies and tools to run a successful chapter.

2017 Leadership & Advocacy Summit
The 2017 Leadership & Advocacy Summit will take place May 6–9, 2017, at the Renaissance Hotel, Washington, DC.

**Division of Research and Optimal Patient Care**
The Division of Research and Optimal Patient Care (DROPC) encompasses the area of Continuous Quality Improvement and ACS research and accreditation programs.

**ACS NSQIP**
A total of 754 hospitals participate in the ACS National Surgical Quality Improvement Program (ACS NSQIP®), 662 of which participate in the adult option. Following is the breakdown of participating sites by ACS NSQIP category:

- Small and rural: 64
- Procedure targeted: 280
- Essentials: 318
- Pediatric: 92

The 2016 ACS NSQIP Annual Conference took place in San Diego, CA. Nearly 1,500 individuals attended, representing 690 medical institutions and 14 countries.

**MBSAQIP**
A total of 813 surgery centers participate in the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP)—725 of which are fully accredited, and 51 of which are initial applicants. The remaining 37 are data collection centers that were originally American Society for Metabolic and Bariatric Surgery (ASMBS) provisional centers that chose to continue with data entry but did not complete the process to meet full accreditation status.

**Educational course**
The Health Services Research Methods Course (HSRM), previously the Outcomes Research Course, took place December 8–10, 2016, at ACS headquarters in Chicago, IL. The three-day course, led by Arden M. Morris, MD, MPH, FACS, and Caprice C. Greenberg, MD, MPH, FACS, was redesigned in 2016 for clinical and health services researchers with varying degrees of experience. The program included didactic lectures and skills-based labs, and participants were able to select modules appropriate to their skill levels and interests. The methods focus was on quantitative, qualitative, and mixed method, and implementation science.

**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 policy. This program offers surgery residents a unique opportunity to work with College leaders and Quality Programs (see related story, page 77). Scholars and their major projects are as follows:

- **Julia Berian, MD**, is a general surgery resident at the University of Chicago Medical Center and is in her third year as a Clinical Scholar and her second year as the ACS-John A. Hartford Foundation (JAHF) James C. Thompson Geriatric Surgery Research Fellow. Dr. Berian has continued her work on the JAHF-funded Coalition for Quality in Geriatric Surgery.

- **Kristen Ban, MD**, is a resident in the department of surgery, Loyola University Medical Center, Maywood, IL, and a second-year ACS Clinical Scholar in Residence. Her interests include health services and quality improvement research.

- **Jason Liu, MD**, is a general surgery resident at the University of Chicago Medical Center. His research focuses on outcomes within general surgical oncology, particularly hepatopancreatobiliary operations.

- **Melissa Hornor, MD**, is a general surgery resident at The Ohio State University Wexner Medical Center, Columbus. She is in her first year as a Clinical Scholar and as an ACS-JAHF James C. Thompson Geriatric Surgery Research Fellow. Her research focuses on outcomes in acute care surgery and trauma, specifically among geriatric patients.

- **Ryan Ellis, MD**, will be joining the ACS Clinical Scholars in Residence program in July 2017. Dr. Ellis is a general surgery resident at Northwestern University McGaw Medical Center. In the coming years, Dr. Ellis hopes to further his career as a practicing surgical oncologist and a health services and outcomes researcher, with his time evenly split between research and clinical practice.

**Cancer Programs**

At present, the Commission on Cancer (CoC) accredits 1,519 cancer programs.

The resource booklet, *National Cancer Database Tools, Reports, and Resources*, was recently revised and will be shared with the Cancer Liaison Physicians, staff at accredited programs, attendees at CoC education programs, and CoC surveyors. The booklet also will be distributed at the meetings where the CoC and National Cancer Database exhibit.

**Committee on Trauma**

As of September 20, 2016, a total of 530 hospitals participate in the Trauma Quality Improvement Program (TQIP); a total of 442 trauma centers have ACS Verification. Since its launch in January 2016, more than 650 participants have completed the online TQIP course.

**ACS Foundation**

The ACS Foundation had a strong year, obtaining financial support for the educational and outreach programs of the College. Examples of support in 2016 include:

- More than 50 international guest scholarships, research fellowships, and other traveling scholarships for young surgeons. The ACS Foundation is tracking the career progress of its past scholarship recipients to show the long-term impact that funding can have on surgical careers and patient care.

- Funding to provide Advanced Trauma Life Support training in Mongolia and Kenya.

- Support to Operation Giving Back in its strategic planning for greater outreach. ♦
Editor’s note: Media around the world, including social media, frequently report on American College of Surgeons (ACS) activities. Following are brief excerpts from news stories covering research and activities reported from the ACS Clinical Congress 2016, October 16–20, in Washington, DC. To access the news items in their entirety, visit the online ACS Newsroom at facs.org/media/acs-in-the-news.

Trauma: A neglected US public health emergency
The Lancet, October 29, 2016
“In the USA, the leading cause of death in those younger than 45 years is trauma, accounting for over half of deaths in that age group. Trauma costs the USA up to $600 billion [U.S.] each year, and yet despite these sobering figures, this epidemic goes largely unrecognized. Last week, at their 2016 Clinical Congress, the American College of Surgeons (ACS) announced a commitment to achieving zero preventable deaths from trauma. If realized, this goal would save one in five civilians and a quarter of military personnel currently killed by trauma, an estimated 30,000 lives per year in the USA alone.”

Weight-loss surgery may lower risk of pregnancy complications
“According to study co-author Brittanie Young, a medical student at the Philadelphia School of Osteopathic Medicine, ‘If the child is less at risk of being very large for its gestational age, the woman is less likely to have a C-section.’ The findings were presented recently at the Clinical Congress of the American College of Surgeons, in Washington DC. Research presented at meetings should be viewed as preliminary until published in a peer-reviewed journal.”

Follow-up imaging lacking for many after breast cancer surgery
Medscape, October 27, 2016
“About one third of US women who receive surgical treatment for breast cancer are not receiving appropriate follow-up, new research suggests. Findings from the National Cancer Database were presented here at the American College of Surgeons Clinical Congress 2016 by surgery resident Taiwo Adesoye, MD, MPH, from the University of Wisconsin, Madison.”

Tweet of the week: Surgeons look like
MedPage Today, October 23, 2016
“Surgeons spun #WhatADoctorLooksLike from last week into an opportunity to highlight gender disparities among surgeons during the annual gatherings of the Association of Women Surgeons (#AWS2016) and [the] American College of Surgeons (#ACSCC16).”

Trauma patients not to blame for opioid epidemic: Study
HealthDay, October 19, 2016
“Almost 75 percent of major trauma patients who were prescribed narcotic painkillers such as OxyContin and Percocet had stopped using them a month after leaving the hospital. And only 1 percent were still taking the drugs on a prescription basis a year later, researchers found. ‘We were really surprised by how low the numbers were for long-term opiate use,’ study senior investigator Dr. Andrew Schoenfeld said in an American College of Surgeons news release.”
**Why don’t more women of color have reconstruction after breast cancer?**
*Philadelphia Inquirer, October 25, 2016*

“[Paris Butler, MD, MPH,] who specializes in plastic and reconstructive surgery, has documented the problem nationally and investigated the role of private vs. public insurance in determining which patients receive reconstructive surgery. While his work has found that insurance status and geographic availability to plastic surgeons likely play a role in the disparities, ‘we strongly believe it’s something about patients’ race and ethnicity that goes beyond insurance status and access to care.’ Recently, we asked him a few questions about his work, which he presented to the American College of Surgeons in DC on October 20th.”

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**Minimally invasive surgery a safe option for major liver cases, UW study finds**
*Seattle Times, October 17, 2016*

“The odds of serious complications or death in patients who had surgeries known as major hepatectomies using minimally invasive techniques were about half those of patients who had conventional surgeries, according to an analysis by Dr. Lucas Thornblade, a UW Medicine general-surgery resident, and colleagues. ‘We are encouraged by the results,’ said Thornblade, lead author of the study presented Monday at the 2016 Congress of the American College of Surgeons.”

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**Wearable fitness tracker monitors patients’ postoperative functional recovery at home**
*Surgical Products, October 21, 2016*

“A new way for surgeons to know how well their patients are regaining physical function after a major abdominal operation could be as simple as patients wearing a fitness wristband to count their steps. Results of a new study, presented at the 2016 Clinical Congress of the American College of Surgeons, show that monitoring patients’ postoperative functional recovery using a commercially available, wireless activity tracker is feasible, and strongly correlates with patients’ reported postoperative complications.”

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**Rates of preventive mastectomy doubled in a decade, and fear is a factor**
*United Press International, October 18, 2016*

“Fear of cancer recurrence seems to be a primary reason why breast cancer patients choose to have their cancer-free breast removed at the same time as their affected breast, a new study finds...The study is to be presented Tuesday at a meeting of the American College of Surgeons (ACS) in Washington, D.C.”
The Board of Governors of the American College of Surgeons (ACS) has announced the availability of the Nizar N. Oweida, MD, FACS, Scholarship for surgeons who serve small communities. The Oweida Scholarship provides up to three awards of $5,000 each to subsidize the participation of a Fellow or Associate Fellow serving a small community at the ACS Clinical Congress 2017 in San Diego, CA; alternatively, applicants may propose a plan for additional training or research appropriate to a rural surgeon. Applications are due to the ACS Scholarship Administrator no later than March 1, 2017.

Requirements
The Oweida Scholarship is available to an ACS member in any surgical specialty who meets the following requirements:

• Is a Fellow or Associate Fellow under age 55 on the date the application is filed

• Is serving a small town or rural community in the U.S. or Canada

Financial support
Successful applicants will receive the sum of $5,000, to be used to defray expenses for attendance at the ACS Clinical Congress or for the approved training or research opportunity. Cost categories include travel expenses, lodging and per diem, registration, and course fees. Scholars will make their own travel arrangements.

The Executive Committee of the Board of Governors will select awardees following review and evaluation of the applications received. Applicants must submit a single PDF document with the following items, in this order:

• A one- to two-page essay discussing the following specific topics:
  − The opportunity for which the applicant is applying (Clinical Congress, or a personal training or research project)
  − The applicant’s reasons for submitting an application
  − The applicant’s qualifications for the scholarship
  − The applicant’s current practice in a rural or small community.

• Execute a well-defined proposal for travel or research to improve a rural surgeon’s performance

• A copy of the applicant’s current curriculum vitae, no more than 10 pages in length

Scholars and alternates will be selected and all applicants will be notified of the outcome of the selection process by May 1, 2017. The Oweida Scholars must attend the meeting or pursue their project in the year for which the scholarship is designated; the award may not be postponed.

Oweida Scholars will provide a narrative and financial report of their experiences at the conclusion of their awarded activity. These final reports are due by March 1, 2018.

Submit applications for this scholarship via e-mail to scholarships@facs.org. Direct questions to the ACS Scholarships Administrator at scholarships@facs.org or 312-202-5281, or visit facs.org/member-services/scholarships/special/oweida. ✦
Apply through February 15 for International ACS NSQIP Scholarships 2017

The American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP®) and the International Relations Committee offer International ACS NSQIP Scholarships for two surgeons from countries other than the U.S. or Canada who demonstrate a strong interest in surgical quality improvement. Applications for the 2017 scholarships are due February 15, 2017.

The scholarships, in the amount of $10,000 each, provide the scholars with an opportunity to attend the 2017 ACS NSQIP Annual Conference, July 21–24 in New York, NY, and meet with program leadership and surgeon champions from ACS NSQIP participating hospitals. Following the ACS NSQIP conference, the scholars are encouraged to visit one or two hospitals with strong quality programs that reflect the candidate’s clinical interests.

Criteria
The International ACS NSQIP Scholarship requirements are as follows:

- Applicants must be medical school graduates.

- Applications will be accepted for processing only when the applicants have been in surgical practice, teaching, or research for a minimum of one year at their intended permanent location, following completion of all formal training (including fellowships and scholarships).

- Applicants must be under 55 years of age at the time of application.

- Applicants must have demonstrated a commitment to surgical quality improvement.

- Applicants must submit a fully completed online application form available on the ACS website. Applicants must prepare the application and accompanying materials in English. Submission of a curriculum vitae only is not acceptable.

- Applicants must provide information regarding their work setting, including their hospital and the patients they see, as well as their participation in quality improvement activities in this setting. They also must indicate their career goals, specifying how they plan to transfer their newly acquired learning to their current situation.

- Applicants must submit letters of recommendation from three colleagues. One letter must be from the chair of the department of their hospital or an institution in which they hold academic appointment, or a Fellow of the American College of Surgeons residing in their country. The chair’s or the Fellow’s letter must include a specific statement detailing the nature and extent of the applicant’s involvement with quality improvement. The individuals making the recommendations must submit the letters of recommendation.

- Applicants are required to submit a curriculum vitae of no more than 10 pages.

- The International ACS NSQIP Scholarships must be used in the year for which they are designated. They may not be postponed.

- Applicants who are awarded scholarships will submit a full written report of the experiences provided through the scholarships upon completion.

- An unsuccessful applicant may reapply only twice and only by completing and submitting a current application form provided by the College, together with new supporting documentation. The scholarships provide successful applicants with the privilege of participating in the ACS NSQIP Annual Conference. The ACS will...
The scholarships, in the amount of $10,000 each, provide the scholars with an opportunity to attend the 2017 ACS NSQIP Annual Conference, July 21–24 in New York, NY, and meet with program leadership and surgeon champions from ACS NSQIP participating hospitals.
Congratulations to the Associates who successfully completed the Transition to Practice (TTP) Program in General Surgery in 2016

Samar F. Alami, MD
Anne Arundel Medical Center

Emily Ament, MD
University of Texas Health Science Center
at San Antonio, University of Texas
School of Medicine

Ritha M. Belizaire, MD
Montefiore Medical Center

Anne Kuritzky, MD
Alpert Medical School of Brown University

Phillip A. Letourneau, MD
Oregon Health & Science University

Catherine L. Loflin, MD
Wake Forest University School of Medicine

Priscilla G. Thomas, MD
Mercer University School of Medicine

Tanveer Zamani, MBBS
Geisinger Health System

Welcome to the following TTP Associates participating in 2016–2017

Larissa Chiulli, MD
Alpert Medical School of Brown University

Elisha M. Collins, MD
University of Florida/St. Vincent’s
Health Center

Travis L. Holloway, MD
University of Texas Health Science Center
at San Antonio, University of Texas
School of Medicine

Naveen Kumar, MD
Surgery South

Reema Mallick, MD
Geisinger Health System

Mandy R. Maness, MD
Wake Forest University School of Medicine

Juliette Moore, MD
Oregon Health & Science University

Cindy-Marie O’Neal, MD
Mercer University School of Medicine

Joshua S. Rickey, MD
Wake Forest University School of Medicine

Nathan J. Roberts, MD
Loyola University Medical Center

Rachael Springer, MD
Wake Forest University School of Medicine

Michael Tran, MD
Anne Arundel Medical Center

Lauren I. Wikholm, MD
Oregon Health & Science University
**Calendar of events**

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

### JANUARY

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

**2017 ACS Surgical Coding Workshop**
- January 26–27
- Las Vegas, NV
- Contact: Jan Nagle, jlmdata@aol.com

**Montana-Wyoming Chapter and Idaho Chapter**
- January 27–29
- Teton, WY
- Contact: Cyan Sportsman, cSPORTSMAN21@outlook.com, squ.re/2dK13CI

### FEBRUARY

**South Florida Chapter**
- February 1
- Fort Lauderdale, FL
- Contact: Bill Bouck, bill@bouckmgmt.com, www.sfc-acs.org

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

### APRIL

**Minnesota Surgical Society: A Chapter of the ACS**
- April 7–8
- Minneapolis, MN
- Contact: Janna Pecquet, janna@mnSURGICALSOCIETY.ORG, mnsurgicalsociety.org

**Indiana Chapter**
- April 21–22
- French Lick, Indiana
- Contact: Tom Dixon, tdixon@ismanet.org, www.infacS.org

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

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

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

### MAY

**Australia and New Zealand Chapter**
- May 1
- East Melbourne, Australia
- Contact: Monique Whear, Monique.Whear@surgeons.org

**West Virginia Chapter**
- May 11–13
- White Sulphur Springs, WV
- Contact: Sharon Bartholomew, www.wvacs.labs.net

**Ohio Chapter**
- May 12–13
- Cleveland, OH
- Contact: Emily Maurer, emaurer@facs.org, www.ohiofacs.org

**Metropolitan Philadelphia Chapter**
- May 22
- Philadelphia, PA
- Contact: Robbi-Ann M. Cook, rcook@pamedsoc.org, www.metrophilasurgeons.org

### FUTURE CLINICAL CONGRESSES

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

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

- **2019**
  - October 27–31
  - San Francisco, CA