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The Bulletin of the American College of Surgeons

by David L. Nahrwold, MD, FACS, co-author of A Century of Surgeons and Surgery: The American College of Surgeons 1913-2012

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Published by the American College of Surgeons.
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Looking forward

by David B. Hoyt, MD, FACS

In the February 2016 issue of the Bulletin, I noted that the American College of Surgeons (ACS) was engaged in an effort with QuintilesIMS to seamlessly link our clinical databases under a single platform and build the ACS registry of the future.* This vision begins coming to fruition with the launch of a reimagined ACS Surgeon Specific Registry (SSR). Although some users had indicated that they were experiencing difficulties with the new system at press time, the ACS leadership anticipates that the next generation SSR will be an invaluable tool for surgeons seeking to comply with regulatory mandates, improve their performance, and provide the highest quality surgical services to their patients. We are working to address any functionality issues and are providing regular updates on enhancements to the system.

Background on the SSR
The SSR originated as the ACS Case Log system under the leadership of Ajit K. Sachdeva, MD, FACS, FRCSC, Director, ACS Division of Education, and the late Thomas R. Russell, MD, FACS, Past-Executive Director of the College. The Case Log system was created as a repository for surgeons seeking to maintain an electronic record of their operations. This information could then be transmitted readily to the American Board of Surgery (ABS) to meet requirements for board certification, recertification, and the fledgling Maintenance of Certification (MOC) program.

The Case Log system evolved into the SSR with guidance from Clifford Y. Ko, MD, MS, MSHS, FACS, Director, ACS Division of Research and Optimal Patient Care. The SSR has served as an online software application and database that allows surgeons to track their cases and outcomes in a convenient, easy-to-use manner from their computer or mobile devices. The SSR enables surgeons not only to log and track their cases, but also to participate in an increasing number of government regulations facing the individual health care professional.

In recent years, the SSR has supported ABS MOC Part 4 mandates, which call for ongoing participation in a local, regional, or national outcomes registry or quality assessment program. In addition, the ACS has worked closely with the Centers for Medicare & Medicaid Services (CMS) to achieve and maintain recognition of the SSR as both a Qualified Registry and a Qualified Clinical Data Registry for the Physician Quality Reporting System (PQRS), a quality reporting program that provides payment incentives to eligible professionals (EPs) and group practices that report positive outcomes for certain quality metrics. Providers that fail to report or that do not measure up to CMS’ standards face financial penalties.

How it works
The new ACS SSR has many enhanced features. Under the new registry platform, a single data system will house all quality registry data. As a result, users eventually will be able to share relevant quality data across individual ACS Quality Programs, such as the National Surgical Quality Improvement Program (ACS NSQIP®) and the Trauma Quality Improvement Program (TQIP®), and move these data into the SSR. The ability to move the electronic health record (EHR) into the SSR is in development, and, at present, data from an office practice or a clinic can be uploaded into the SSR as well, thereby minimizing the data entry burden for surgeons. The new ACS SSR also features enhanced reporting capabilities, a mobile device-friendly interface, delegate-level access to enter data, and the ability to add custom fields to collect additional variables relevant to a surgeon’s practice efforts to provide quality care.

Changing regulatory challenges
The new SSR has launched at a time when the Medicare physician payment system is undergoing a significant transformation. This year, CMS begins the transition to the Quality Payment Program (QPP) established under the Medicare Access
Under the new registry platform, a single data system will house all quality registry data. As a result, users eventually will be able to share relevant quality data across individual ACS Quality Programs, such as ACS NSQIP and TQIP, and move this data into the SSR.

and CHIP (Children’s Health Insurance Program) Reauthorization Act (MACRA). Under the QPP, most physicians, at least initially, will be reimbursed for Medicare services through the Merit-based Incentive Payment System (MIPS). MIPS comprises four components: Quality (formerly PQRS), Advancing Care Information (ACI, formerly EHR meaningful use), a new Clinical Practice Improvement Activities (CPIA) component, and Cost (formerly the Value-based Payment Modifier).

Just as the SSR was approved for use with the PQRS, the new ACS SSR has been approved as a QPP MIPS-Qualified Entity for 2017. As a result, surgeons will be able to fulfill the Quality and CPIA MIPS requirements.

Moreover, surgeons may use the SSR to qualify for an ACI registry bonus because of the SSR’s ability to receive clinical data from EHR systems in a manner that is consistent with MIPS requirements. To receive this Public Health and Clinical Data Registry bonus in payment year 2019—based on 2017 reporting—surgeons will need to create an account within the SSR and maintain a record of their registration for at least 10 years in case of audit. Go to qpp.cms.gov/measures/aci to learn more about the ACI performance category.

In addition, the new SSR will make meeting board certification and Part 4 MOC requirements simpler than ever. Reporting functions will allow users to analyze their own data and compare it with ACS NSQIP compiled data.

**KEY STAFF INVOLVED IN DEVELOPMENT AND LAUNCH OF THE NEW SSR**

- David B. Hoyt, MD, FACS, Executive Director, ACS
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- Amy J. Sachs, ACS Registry Operations Senior Manager
- Ulrike Langenscheidt, SSR Program Manager
- Michael Bencur, Continuous Quality Improvement and Measures Project Manager
- The QuintilesIMS team

**Improved ability to deliver patient-centered care**

The new SSR is designed to help ACS members not only keep pace with changes in the regulatory demands, but also to provide more patient-centered care in an easy-to-use, more fully integrated format.
The new SSR is designed to help ACS members not only keep pace with changes in the regulatory demands, but also to provide more patient-centered care in an easy-to-use, more fully integrated format.

Because of the new SSR’s enhanced capacity for customization, it is a tool that surgeons eventually will be able to use at the point of care, along with the ACS NSQIP Surgical Risk Calculator and evidence-based guidelines to assist in shared decision making.

Moreover, office staff will be able to upload a surgeon’s records and spreadsheets to your individual registry through a document template provided by the SSR. This will reduce the time you must spend on administrative tasks, so you can spend more time providing care.

In addition, users will be able to track patients through all phases and domains of care, including the preoperative consultation and evaluation, the immediate preoperative, the intraoperative, the postoperative, and the postdischarge stages. For those of you familiar with the College’s history and the contributions to surgical quality of one of the organization’s founders—Ernest Amory Codman, MD, FACS—this functionality represent a major milestone in fulfilling the end result idea.

The College hosted a series of webinars throughout the first half of April to help surgeons prepare for the switch to the new SSR. For those of you who were unable to participate in April, these webinars will continue throughout the summer and as the need arises. Much of the information in these programs is available at facs.org/quality-program/ssr/news. This site is updated regularly. In addition, the new SSR will be described more completely in an upcoming feature article in the Bulletin.

**Accountability is paramount to success**

Accountability is paramount to success. We are at the dawn of an age of accountability. In health care, accountability will be linked with performance data. The ACS recognizes that some surgeons believe that the new expectations associated with MIPS, MOC, and so on add to a laundry list of already overwhelming administrative burdens. The SSR responds to this concern, making data collection relatively painless. We are excited to offer this tool that will enable our members to objectively reflect on their practice patterns and improve the care provided to the surgical patient.

I can’t overstate how important it is that you participate in these efforts to maintain the financial viability of your practice, to improve your ability to offer patient-centered care, and to help surgery maintain its reputation as a profession that polices itself for the good of society. Your thoughts and recommendations on how the ACS leadership can help you satisfy these objectives are always welcome.
Italian training program in Cameroon: A model for developing cultural competence

by
Antonino Cavallaro, MD, FACS; Giulio Clodio Mariani, MD; Eleonora Guaitoli MD; Gianluca de Vito, MD; Antonio V. Sterpetti, MD, FACS; and Sergio Stipa, MD, FACS
Due to its geographic position in southern Europe, with miles of coastline on virtually all sides of the peninsula, Italy has often represented a “first approach” for people emigrating from North Africa and the Middle East to Europe and North America. Italy’s role as an international gateway means health care professionals in the country must be trained in cultural awareness to meet the needs of individuals representing a spectrum of backgrounds and ethnicities. To this end, the department of surgery at Pietro Valdoni, Sapienza University of Rome, Italy, has long supported a small rural hospital in the pluvial forest of South Cameroon located in Central Africa. Saint-Luc, a not-for-profit hospital, is part of the Mission Catholique de Bimengue, and our surgical residents do voluntary rotations at this facility.

Surgical rotations in Central Africa
The training program, started in 1988 with leadership from then-chief of surgery and a co-author of this article, Prof. Sergio Stipa, MD, FACS, provides residents with a six-month experience in an African mission hospital. Soon after the first residents began their rotations, they indicated that they found it to be a positive experience. In fact, residents have played a significant role in promoting the benefits of this particular rotation, which has developed a strong reputation for preparing hospital staff to administer care to people from different cultural backgrounds.

Saint-Luc hospital
Saint-Luc hospital is situated in Bimengue, which is part of the Cameroon forest (see Figure 1, page 13). The facility is surrounded for 70 miles by wilderness, which provides some protection from the urban violence that is a common problem in many major cities in Central Africa. Saint-Luc hospital is an eight-hour trip from the nearest airport, and the road to the mission—built by German colonizers at the end of the 19th century—is unpaved and full of holes. With just 30 beds, Saint-Luc is a small facility that serves a population of about 20,000 people. No other medical facility is available to the people living in the small villages and tribal communities within the forest. The mission and the hospital were built more than 40 years ago by a Catholic priest of the Spiritan Congregation from Como, Italy. The priest manages all of the organizational and economic affairs of the mission, except for the hospital, which is managed by the not-for-profit organization Don’t Forget Africa (DFA).

Care is provided to patients presenting with a variety of medical issues. Abdominal, obstetric, and urological surgery are routinely performed on patients in need. Patients suffering from other medical problems, such as marsh fever and illness related to intestinal parasites, also receive care at Saint-Luc.

It is difficult to comprehend how the local population received medical care before Saint-Luc was built. Most likely, local midwives and nonmedical individuals functioned as primary caregivers.
Resident selection
For each of the 30 years since the program launched, the fourth- and fifth-year general surgery residents (typically 10 residents) have been given the option to commit a six-month period of their training to providing care at Saint-Luc. The residents themselves determine who will volunteer for this opportunity, and to date 42 residents have participated in this program. Before traveling to Africa, the selected residents spend six months rotating in anesthesia, urology, and obstetrics and gynecology, all of which are key areas of need outside of general surgery for patients living in Cameroon.

Prior to travel, all residents receive the required vaccination against yellow fever; no other vaccination is required. None of the residents have reported significant health problems during or after this experience. A few residents have suffered from short episodes of mild diarrhea (probably bacterial in origin), and from short episodes of fever of unknown origin. At a mean follow-up of 10 years, none of the residents has reported health problems related to his or her experience in Africa.

All resident participants have reported a high level of satisfaction with the experience at Saint-Luc, both from a professional perspective, including improved performance and confidence levels, and from a humanitarian point of view. Participants reported high levels of interaction with the local population, engaging in such social activities as...
sharing meals, playing soccer, exchanging articles of clothing, and so on.

After participating in conversations with the residents, the staff at the University of Rome noted that these physicians appear more mature after their rotations. Before going to Africa, one of the most important expectations for the residents was achieving a large income. After returning from Africa, the major priority for these residents shifted to less finance-driven goals, specifically an interest in helping other people. Luxurious cars, dinners in sophisticated restaurants, or lavish holidays lost their allure in comparison with developing personal relationships and providing optimal care to patients.

The staff of the hospital also has observed a significant improvement in the residents’ clinical abilities, as well as enhancements in their observational and communication skills, which are essential for providing quality care no matter the environment.

Approximately 20 percent of the residents have voluntarily returned to the mission hospital for periods of two to six months in order to provide surgical care to those in need, as well as to help mentor other residents working in the region. Funds for their renewed mission work are provided by DFA.

Gianluca de Vito, MD, the first surgical resident to journey to Saint-Luc (and a co-author of this article), decided to remain and work in Africa. He married a journalist from Holland who also was working in the region. Dr. de Vito has spent more than 25 years providing medical care to people in remote regions of Africa.

The residents’ role
Resident participants live in the mission and are on duty virtually 24 hours a day. Residents see all the admissions and visits to Saint-Luc, and they rely on local nurses to assist in communicating with patients and their families. Because Cameroon became a French colony after World War I, many Cameroonians speak broken French peppered with many dialectal phrases. Nurses also help participants enhance their knowledge base regarding some of the more common diseases affecting the local population, which were described earlier in this article.

Each resident member of the program (mean age 28 years) has performed an average of 50 major and 80 minor operations. The complication rate has been very low—less than 3 percent. The low complication rate is generally attributed to the young age and good health of the individuals who are able to make the journey to Saint-Luc.

Local nurses have assisted in the delivery of babies, about 20 deliveries per month. Residents are involved in deliveries only if complications arise or if a cesarean section is needed (5 percent of the cases). Typically, the residents see an average of 500 patients in the outpatient clinic during the six-month period. Most of the surgical procedures relate to
ITALIAN RESIDENTS IN CAMEROON

draining of abscesses, repair of trauma wounds, bone fractures, hernia, thyroidectomy, hysterectomy, and bowel obstruction. Most are elective or semi-elective procedures, but a number of urgent operations for strangulated hernia or bowel obstruction also have been successfully performed.

The residents follow up with all patients in the hospital on daily rounds. They are typically the only physicians on site, so they must provide care for all medical problems. All commonly used drugs, such as oral and intravenous antibiotics, intravenous fluids, analgesics, aspirin, proton pump inhibitors, cortisone, quinine, artemesumate, and so on, are available at Saint-Luc. Each resident also brings a supply of pharmaceuticals and other supplies, such as suture materials and meshes for hernia repair.

No anesthesiologists are on site, so the resident administers anesthesia in addition to performing the operation. The local nurses have experience with intravenous analgesia, such as morphine and fentanyl. Most operations are performed using local anesthesia. For more difficult cases—strangulated hernia, hysterectomy, thyroidectomy, and bowel obstruction—intravenous analgesia is added to local anesthesia.

Patient satisfaction
The local people have been very satisfied with the care they have received from the residents at the Saint-Luc hospital. Patients typically show faith in the residents
and are thankful for the care they receive. Much of this positive relationship is a result of the continuous social contact the residents have with the local population living around the mission.

The people involved in this work agree that this is a rewarding experience, one that reminds us of the meaning and the beauty of being a surgeon and what a privilege it is to take care of people in need. A smile or the gift of a wild fruit is often more memorable than a monetary reward.

Italy remains a gateway to the Western world for many immigrants from North Africa and the Middle East. In fact, the number of immigrants from these regions has increased in recent years due to the political instability of both regions. This phenomenon has resulted in various Italian hospitals recognizing the need to address the cultural differences of these immigrant populations.

Future challenges: Funding and rotation decline
Unfortunately, securing funding for our missionary work in Cameroon continues to be a challenge as DFA, our sponsoring organization, relies on private donations. A notable exception is the Italian Episcopal Committee, which recently offered support for a program aimed at improving maternity and infant care. Since the implementation of this program, mortality rates for pregnant women have been dramatically reduced, and there have been no recorded cases of infant mortality.

In addition to funding hurdles, the program faces other challenges related to a reduction in resident participation. Residents have expressed a decreasing interest in the Saint-Luc rotation, which may be attributed to a couple of factors, including the Ebola epidemic of 2014–2015, even though Cameroon was unaffected; the continuous political unrest in the region; and the retirement of Professors Stipa and Cavallaro, co-authors of this article and a leading force behind the success of the Saint-Luc hospital resident rotations. Upon Dr. Cavallaro’s retirement from his academic position in 2010, he joined Alberto Scamplicotti, a photographer with the University of Rome, in giving renewed support and energy to a small project initiated by the first residents who worked at the mission. This humanitarian organization continues to work to secure funding to continue this rotation in Africa.

While many debates regarding the ongoing role of Italian physicians who provide care for immigrant populations continue to have a presence in the media, the hospitals and physicians continue to work to meet the needs of these patient populations, with little regard for the patient’s social, economic, and religious background. Our experience in Cameroon continues to serve as a reminder that differences in culture can be overcome by knowledge and friendship. ♦
Although budget bills are the only legislation that state lawmakers must pass this year, many state legislatures opened their 2017 sessions with a flurry of bills on a range of public policy issues. Furthermore, political uncertainty is casting a pall over some state legislatures, likely stemming from the change of power in Washington, DC. The impact of policy positions that were at the heart of Republican campaigns in the last election—such as repeal and replace of the Affordable Care Act, tax reform, and trade policy such as a border adjustment tax—will have an impact on the state budgets and available funding for state health care programs.

The State Affairs staff in the American College of Surgeons (ACS) Division of Advocacy and Health Policy monitors bills and resolutions introduced at the beginning of the legislative calendar in an effort to identify policy trends that affect the ability of the surgical community to provide safe, quality care for patients. This article describes the bills and legislative trends that the College is monitoring in 2017.

Budget impact on health policy

Passing a state budget is mandatory for state legislatures. Reductions in revenues collected by states and growing liabilities, including state employee pensions, are forcing many lawmakers to re-examine priorities, which often can lead to restricted services for Medicaid or other state health care-related programs. The pressure to pass a budget can become a distraction that diverts attention away from other legislative priorities, including those important to the College, or could result in the passage of laws that could adversely impact patient safety in order to save the state money.

Two states in particular—Mississippi and Ohio—are facing significant budget shortfalls in the 2017 fiscal year.* These budget challenges
are affecting state health care programs and patient access to care.

At the close of the 2016 legislative session, the Mississippi legislature passed a budget bill that swept funds from state programs with dedicated financing and redirected the monies into the state’s general revenue fund. The Mississippi Trauma Care System was one of many state programs affected by the act. While state officials have indicated that the trauma system will be funded at the same level through the state’s Department of Health annual budget, the rerouted fees earmarked for the trauma system will continue to go into the state’s general revenue fund. Critics have noted that the Department of Health’s budget will not be reduced or increased. Adding the funding for the state trauma system is likely to pull funding from other health programs funded by the Department of Health.

Some states are considering policies to improve their revenues through increased or new taxes on products and services. Some tax increases, such as an increase on tobacco, can have a positive impact on health outcomes.

More than a dozen states, including Arizona, Connecticut, Indiana, Kansas, Montana, New Jersey, New Mexico, New York, Ohio, Oregon, Rhode Island, Virginia, Vermont, and Wyoming, have proposals to increase the sales tax on tobacco products or add electronic cigarettes (vapor) to existing tobacco tax laws. Conversely, tax policy can have a potentially negative impact on access to care, such as a proposal in Ohio to tax cosmetic surgery.

In Ohio, Gov. John Kasich (R) supports a tax reform proposal that would add cosmetic procedures to the state’s sales tax. The proposal also seeks to increase the sales tax rate to 6.25 percent. The governor’s state budget estimates that the cosmetic surgery tax will generate up to $25 million annually. New Jersey implemented a similar tax in 2004. New Jersey eventually repealed the tax because it did not collect the projected amount of revenue and instead cost the state money to administer the tax, while patients went out of state for cosmetic and reconstructive procedures. The ACS highlights New Jersey’s experience with this issue to discourage other states from considering a similar tax.

While state budget challenges may affect health care services, opportunities still exist to advocate for increased funding of state programs. The Georgia Society of the ACS, at its 2017 state lobby day in February with the Georgia Trauma Foundation, advocated for $1 million from the state’s Super Speeder Law fund to install bleeding control kits in all public schools. To support their lobby day efforts, the Georgia Society conducted a bleeding control simulation for legislators, staff, and others in the state capitol building, and secured passage of a resolution in the House and Senate declaring February 7 as Trauma Awareness Day at the Georgia Capitol.

**Priority legislative activities**

Despite political uncertainty and fiscal challenges, the regular order of business has not stopped in the state legislatures. Several ACS state legislative priorities remain active, including the following: limiting scope-of-practice expansion initiatives by nonphysician providers; clarifying the definition of surgery; and supporting legislation on distracted driving, motorcycle safety, cancer prevention, and tanning bed use.

**Scope of practice**

Working closely with other surgical specialty associations, the ACS has been engaged in advocacy efforts in several states to stop legislation that would expand the scope of practice for optometrists. Alaska, Florida, Georgia, Iowa, North Carolina, Maryland, and Nebraska have introduced bills that would expand optometrists’ scope of practice to allow them to perform surgical procedures. The ACS Florida Chapter, the Georgia Society, and the North Carolina Chapter engaged in campaigns to encourage their legislators to oppose the legislation. As a result of the Georgia
Despite political uncertainty and fiscal challenges, the regular order of business has not stopped in the state legislatures.

Society’s efforts, the Georgia bill died in committee. Additionally, the ACS sent a letter and engaged in a grassroots campaign in Maryland. At press time, legislation that would expand optometrists’ scope of practice continues to remain active in Alaska, Florida, Iowa, North Carolina, Maryland, and Nebraska.

**Definition of surgery**

The Connecticut Chapter of the ACS is advocating for legislation that would establish a definition of surgery. In November and December 2016, the Connecticut Chapter participated in a Department of Public Health roundtable discussion along with other physician and nonphysician groups about a definition-of-surgery report presented to the state legislature. At present, no bill has been introduced in the legislature to define surgery in Connecticut state statutes. Members of the Connecticut Chapter discussed the importance of the legislation with lawmakers at their lobby day on March 16. But as the deadline for the legislature to adjourn is June 7, and state budget negotiations remain tense between the governor and the legislature, the probability of a bill being introduced and considered in 2017 becomes less likely.

**ANP independent practice authority**

Advanced nurse practitioners (ANPs) continue to seek independent practice authority, introducing legislation to this effect in Arkansas, Connecticut, Illinois, Oklahoma, and Tennessee. The ACS sent a letter to the Arkansas legislature opposing a bill to remove a requirement that physicians supervise certified nurse anesthetists.

**Balance billing/out of network**

Patient protections from unexpected out-of-pocket expenses for medical care are a continuing issue for state legislatures. Georgia, New Jersey, Rhode Island, and Washington have introduced bills to address surprise billing through either dispute resolution using third-party data (Georgia and Rhode Island) or limiting out-of-network payments to providers at in-network facilities to a percent of Medicare (New Jersey and Washington).

**Trauma prevention and systems**

As of late March, nearly 50 distracted driving bills were under consideration in state legislatures. Arizona, California, Colorado, Florida, Kansas, Montana, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, Texas, Vermont, and Washington have bills that either prohibit using mobile devices for texting, making calls, and using the Internet or strengthen clarifications on current policy. Four states are seeking an increase in penalties for violating distracted driving laws. Colorado is seeking to raise the first-time offender fine to $500 from $50; Maine is proposing to suspend an offender’s driver’s license for 90 days; New Mexico is looking to increase the fine by $100; and New Jersey legislators are working to elevate the charge of distracted driving to vehicular homicide if it results in a death. Iowa and Kansas have bills to remove restrictions on police officers, which would enable them to enforce distracted driving laws. Conversely, policymakers in New Hampshire have proposed legislation to remove laws prohibiting the use of electronic devices while driving.

Five states, Connecticut, Delaware, Florida, Hawaii, and Iowa have introduced bills that would require all motorcycle operators and passengers to wear helmets. Despite the Connecticut bill being sponsored by the Chair of the Transportation Committee and a statement of support from the Connecticut Chapter, the committee decided not to advance the legislation any further. Similarly, in Delaware, after ACS Fellows along with transportation safety advocates testified in support of the universal helmet bill, the House Public Safety and Homeland Security Committee voted to table the legislation.

Conversely, bills have been introduced in four states to create exemptions to existing universal helmet laws. Specifically, Nebraska, New York, Oregon, and West Virginia would exempt operators and passengers ages 21 and older. Meanwhile, bills introduced in Missouri would mandate that operators and passengers ages 18
and younger must wear helmets while another would allow adults 21 years or older who provide proof of health insurance to ride without a helmet.

An Arizona proposal would establish a helmet waiver permit to operate a motorcycle without a helmet. The state currently only requires riders 17 years old and younger to wear a helmet. The fee for the permit would go toward the Arizona Highway User Revenue Fund. Motorcycle operators riding without a helmet and without a permit would be fined $500, of which $200 will go to the highway fund and $300 to the Spinal and Head Injuries Trust Fund.

In Florida, a bill would provide the state Department of Health with the authority to designate trauma centers and publish a statewide trauma plan. The legislation would remove the existing cap on the number of trauma centers in the state, following through on the call from Gov. Rick Scott (R) to move to a market-based approach.

The North Texas and South Texas Chapters of the ACS incorporated the bleeding control campaign as part of their 2017 lobby day and annual meeting in February. The chapters included an exhibit at their annual meeting to promote the campaign and demonstrate how to use tourniquets. A resolution recognizing the campaign and encouraging Texans to participate in the initiative was adopted by the state’s House of Representatives in March 2017.

Cancer prevention
The Arizona, Rhode Island, and Washington Chapters of the ACS are collaborating with state coalitions to support legislation clarifying contradictory rules related to students having or using over-the-counter sunscreen at school and school events. School districts around the country have broad policies that ban “medication” in schools without a physician’s note. The schools follow U.S. Food and Drug Administration guidelines that classify sunscreen as an over-the-counter medication, while the U.S. Centers for Disease Control and Prevention policy recommends students apply sunscreen while at school. Additionally, legislation was introduced in Arizona, Arkansas, Iowa, Mississippi, Montana, New Mexico, New York, Oklahoma, and Virginia that prohibits access to tanning beds for individuals under 18 years of age.

Only two states, New York and Mississippi, have introduced legislation to close the loophole for colorectal cancer screening tests. Currently, many health insurers require cost-sharing for patients who need a colonoscopy following a positive stool test, claiming the colonoscopy is a diagnostic procedure rather than a screening procedure. Under the Affordable Care Act, patients are not required to pay out-of-pocket expenses for screening procedures. Kentucky introduced a resolution urging Congress to amend the Social Security Act to include coverage for colorectal screenings. It is too soon to tell what impact efforts to repeal and replace the Affordable Care Act will have on mandates that health insurers provide coverage for this and other cancer-related screening tests.

Get involved
Active participation in ACS advocacy efforts is one of the most effective ways members of the College can influence public policy that specifically affects patient safety and quality health care outcomes. The College provides several resources to help surgeons get involved in advocacy initiatives, including responding to ACS Action Alerts, participating in your state chapter’s annual lobby day, and hosting a tour of your practice for a member of Congress.

The ACS State Affairs team is available to answer questions and to provide members with pertinent information regarding specific state issues and policy programs. ACS state advocacy resources are available on the College’s website at facs.org/advocacy/state. For more information, e-mail state_affairs@facs.org or call 202-337-2701.
Health care leaders develop strategies 

for improving access to surgical care in Latin America

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Centered on the vision of universal access to surgical and anesthesia care as articulated by The Lancet Commission on Global Surgery (LCoGS), the field of global surgery has achieved large advances through academic and political efforts in sub-Saharan Africa, south and east Asia, and the islands of the central and south Pacific, commonly known as Oceania.1-5

During a regional meeting on December 7, 2016, in São Paulo, Brazil, a diverse group of health care leaders from eight Latin American countries also demonstrated a commitment to systematically improving access to safe and affordable surgical care through a symposium titled Global Surgery Latin America: Findings, Recommendations, and Implementation of The Lancet Commission on Global Surgery (see Figure 1, this page). This group was composed of 55 individuals, including regional leaders in acute care, colorectal, gynecologic, oncologic, pediatric, plastic, trauma, and vascular surgery, as well as anesthesia professionals and members of the American College of Surgeons (ACS).

Through prepared comments, interactive panels, and focused small-group discussions, participants identified priorities in Latin America for providing safe surgical care, conducting research, and driving policy. They identified challenges that are common to many regions of the world, as well as issues that are specific to Latin America (see photos, page 23). Notably, during the meeting clinicians and policymakers in Latin America resolved to implement change and improve access to surgical care.

This article summarizes the contents of the symposium and describes strategies for further
action. It is intended to serve as a call to action for members of the ACS, as well as for other health care providers to become more engaged in the global surgery movement.

Summary of symposium presentations
The opening comments at the symposium focused on core concepts in global surgery, including the surgical access gap, indicators for benchmarking progress, and a framework for evaluating and improving surgical systems. They pointed to the need to dedicate global resources to addressing surgical care as a public health concern. A summary of presenters and their topic areas are as follows:

- **Robert Riviello, MD, MPH, FACS**, director of global surgery programs at the Center for Surgery and Public Health, associate surgeon, division of trauma, burns and surgical critical care, Brigham and Women’s Hospital; and assistant professor of surgery, Harvard Medical School, Boston, MA, presented the key messages of the LCoGS, providing specific data on the surgical access gap and the resources needed to close it.

- **Walter D. Johnson, MD, MPH, MBA, FACS**, program lead, emergency and essential surgical care, World Health Organization, Geneva, Switzerland, discussed the World Health Assembly Resolution 68.15, which calls for “strengthening essential and emergency surgery as a component of universal health care.”

- **John G. Meara, MD, DMD, MBA, FACS**, chair, LCoGS, spoke of the need for national surgical planning on a state, national, and regional level to ensure coordination of efforts.

- **Nobhojit Roy, MD, MPH**, of LCoGS–India, an organization that promotes global surgery in a large, disparate, emerging economy similar to Brazil or Mexico, provided another international perspective. Dr. Roy highlighted the role of the “essential surgeon,” which he defined as a health care provider who is equipped to take care of a broad array of surgical disease in austere environments—an idea that is being practiced in some regions of Latin America and North America.

Financial challenges in Latin America
A key topic of discussion among conference attendees was the harsh economic conditions of Latin America. Brazil in particular is struggling with difficult economic policies—for example, the government recently passed constitutional amendment PEC.55, Novo Regime Fiscal, which will cap social spending (with adjustments for inflation) for the next 20 years. Unlike Africa’s need for a large-scale infrastructure investment, Latin America’s greatest financial
challenges relate to freezes on or a decline in public sector spending. Maureen Lewis, PhD, an economist and chief executive officer of Aceso Global, a not-for-profit organization committed to improving health care delivery and management in emerging markets, spoke on the need to prioritize effective management, efficiency, and quality reforms in order to do more, and to do better with less (see photos, this page).

Dr. Lewis noted that quality and efficiency extend well beyond the walls of the operating room and highlighted the need to address the continuum of surgical patient care from initial presentation to follow-up. Symposium participants concluded that three pillars should underpin efficiency efforts: strong management, appropriate incentives, and robust data.

The issue of strong management was of particular importance, and some delegates were concerned that management professionals in Latin America’s complex health care domain are under-trained for the role they serve.

The second pillar requires a restructuring of appropriate incentives for quality measures at both the facility and staff level. As an example of misaligned incentives, participants spoke of public systems throughout the region in which providers receive below-cost reimbursements. As a result, if the hospital takes on more volume it actually loses money because the per procedure reimbursement is less than the per procedure cost.

The third pillar, data, was referenced repeatedly throughout the day as a major barrier to efficient and effective surgical practice. Although health care data are regularly collected in Latin America—even digitally, in some cases—the quality and management of these data varies and they are rarely leveraged for systems level decision making. As a result, participants called for the establishment of a basic, consensus-driven, streamlined set of minimum data requirements. All delegates agreed that the most important part of collecting data is leveraging it to guide management decisions.

Surgical workforce maldistribution
Another broad challenge for global surgery is how the surgical, anesthesia, and obstetrics (SAO) workforce can adequately meet the demands of underserved populations. Mário Scheffer, PhD, from the Departamento de Medicina Preventiva, Universidade de São Paulo, Brazil, and a co-author of this article, highlighted the maldistribution of health care professionals in Brazil. Although the national average of SAO specialists meets the LCoGS’ target of 20 to 40 SAO professionals per 100,000 patients, there are marked disparities between the well-served south and the underserved north and northeast areas of Brazil (see Figure 2, page 25).8,9

Referring to 2014 data, Dr. Scheffer noted that most Brazilian physicians work in the private sector (78.4 percent, with 26.9 percent working exclusively in the...
private sector), whereas only 25 percent of the population receives its care in the private sector. He also observed that while women are making gains in the health care workforce in Brazil (43 percent of physicians are women), the surgical professions have been less successful in attracting women; only 16 percent of surgeons and 37 percent of anesthesiologists are women (see Figure 3, page 26).

To address workforce geographic maldistribution, symposium delegates offered several solutions, including a program tested at the Universidade do Estado do Amazonas (UEA), where students from remote areas are recruited into “quota” seats. In accepting these university seats, students agree to one year of service in their home town after graduation. The first cohort of 16 students is scheduled for graduation later in 2017.

Surgical workforce shortages, particularly in resource-poor environments, often lead to health care providers performing procedures without adequate training. José Emerson dos Santos Souza, MD, of the UEA and co-author of this article, described his research carrying out an on-the-ground evaluation in the Brazilian state of Amazonas. He described a situation in which nonsurgeons routinely practice surgery and non-physicians perform procedures, often without adequate training or supervision. Likewise Sandra Leal, MD, an anesthesiologist from El Salvador, noted a lack of training among the nonphysician providers who are often tasked with delivering anesthesia care in El Salvador.

Telemedicine is one viable strategy for improving the skills of under-trained staff, as is telementoring. Cleinaldo Costa, rector/chancellor of UEA, noted that telemedicine should start as a means to support physicians in the periphery through continuing professional development of these surgeons. Professional development, a low-risk and less logistically complicated activity, would be a first step in telementoring, before progressing to assistance with triage or even live surgical training. Another delegate described the experience of using neurosurgical teleconsultations at a trauma hospital in São Paulo, with remote neurosurgeons evaluating computed tomography scans in order to minimize patient transfers to higher care.

Implementing change in Latin America

Although symposium participants discussed key barriers to providing surgical care in the region, they also identified strategies that can address these challenges, including the following:

- Continued collaboration at the regional level, including regular meetings to share ideas and progress
- Dissemination of global surgery data and research by engaging with national, state, and municipal governments and professional societies
• New or improved mechanisms for surgical data collection at the facility and national level

• Expansion and formalization of global surgery research within Latin America to develop effective policy

At a state level, in Amazonas, Brazil, Dr. dos Santos Souza and Rodrigo Vaz Ferreira, MD, a co-author of this article, plan to bring the results of an on-the-ground surgical capacity assessment to the state government later this year. This initiative would demonstrate how surgical systems research can create potential for health care improvement even at the grassroots level.

At the national level, participants from Operation Smile and Nicaragua described the early phases of a partnership with the government of Nicaragua. Jordan Swanson, MD, a plastic surgeon working with Operation Smile, explained the goal of increasing access to quality and timely surgical care for patients, in particular underserved patients who live in communities away from large urban centers. This proposal includes a plan to improve rural emergency and essential surgery, nurse training, and the development of a framework for scale-up of surgery.

Beyond the national level commitments, symposium participants reached consensus on the value of regional collaboration and agreed that the global surgery Latin America group should reconvene approximately one year after the symposium, possibly in Mexico City, Mexico, in November. The goals of reconvening are to move beyond the broad overview of global surgery, transition from individual to collective efforts in the region, measure progress, and share ideas.

Organizational support

For these efforts to succeed, institutions and networks across Latin America need to be leveraged. Paulo Corsi, MD, president of the Colégio Brasileiro de Cirurgiões, pledged his organization’s support. An invitation was extended to present the findings of the LCoGS at the Congreso Latinoamericano de Cirugía General in March 2017 in Lima, Peru. These opportunities could attract broader participation and may lead to policy development and position statements from professional societies.

Recognizing the role of universities in creating global surgery research centers outside of the U.S. and Europe also is a way to help promote global surgery efforts; in fact, a symposium participant initiated a proposal to develop the first global surgery research center at UEA in Manaus, Brazil. These centers will enhance the sustainability of global surgery efforts by allowing trainees to build longitudinal careers in global surgery and to act as hubs that support surgeons.
GLOBAL SURGERY LATIN AMERICA

MEETING ATTENDEES REPRESENTING EIGHT LATIN AMERICAN COUNTRIES

in the periphery. Additionally, by using global surgery research projects as part of work toward advanced degrees—for example, toward earning a doutorado in Brazil—global surgery research can be recognized and incentivized.

Through this symposium, Latin America has joined Europe, North America, Africa, Asia, and Oceania in uniting and committing to systematically improving access to safe and affordable surgical care—a goal that the ACS supports. The connections made via this meeting will spark new initiatives and collaborations in the region and will ideally inspire continued support from members of the College. (See photo, this page.)

Acknowledgement

The symposium was made possible through contributions from Johnson & Johnson Medical Innovation Institute, Globomed, Mending Kids, the Program in Global Surgery and Social Change at Harvard Medical School, and Rutgers Global Surgery. Industry and not-for-profit sponsors did not have input into the academic or other content of the symposium.

REFERENCES

A new subspecialty of general surgery is emerging: acute care surgery, which encompasses trauma, critical care, and emergency care, with general surgery at its core. Because acute care surgery has gained such prominence, in 2016 we surveyed the 274 members of the B/G on the potential impact of this growing specialty on patients and health care providers.

**Acute care surgery timeline**

In 2003, the ACS Committee on Trauma (ACS COT), the American Association for the Surgery of Trauma (AAST), the Eastern Association for the Surgery of Trauma, and the Western Trauma Association established the Committee to Develop the Reorganized Specialty of Trauma. This collaborative effort led the AAST to create the Acute Care Surgery Committee in 2005, which established the training and practice parameters for the new specialty. Since then, acute care surgery has grown as a specialty and now has a major presence throughout the U.S.* Jerry Jurkovich, MD, FACS, past-president of the AAST, in a 2007 column wrote that the acute care surgeon should “be responsible for managing acute general surgical problems, covering emergency general surgical and specialty services, providing surgical critical care, and managing acute trauma.”†

Respondents’ general perceptions
U.S. surgeons accounted for 81 percent of the respondents to the 2016 ACS Governors Survey, Canadian surgeons accounted for 5 percent, and international surgeons for 14 percent. Specialists made up 50 percent of survey respondents, 14 percent were general surgeons, and 36 percent identified as both (see Figure 1, this page).

With respect to practice type, 49 percent of the respondents were in full academic practice, 23 percent in private practice, and 15 percent were hospital employed; the rest were employed at government agencies or other institutions. Most ACS Governors (84 percent) work in academic institutions or community hospitals with more than 250 beds. In all, 68 percent of the respondents indicated that they work in hospitals that have an acute care surgery service (see Figure 2, this page).

Of the respondents who work at a hospital that has an acute care surgery program, 79 percent indicated that the acute care surgery program had been in place for at least five years. However, only 26 percent of the surgeons who participated in an acute care surgery program were full-time acute care surgeons (see Figure 3, this page).

Of the surgeons who served on an acute care surgery service, most had little or no formal training (23 percent and 46 percent, respectively) in acute care surgery.
Effects of acute care surgery

The Governors also sought to evaluate specific acute care-related issues, such as the efficiency of care delivery, emergency room (ER) coverage, and costs since the development of an acute care surgery program. Table 1, this page, shows the overall responses to the effect of these programs on health care delivery, and Table 2, page 31, identifies the responses to the same questions from acute care general surgeons as compared with all other surgeons. For most of these issues, the percentage of positive answers was higher among the acute care general surgeons than among all other surgeons.

The Governors also wanted to determine the positive effects of an acute care surgery service on patient and provider well-being based on responses from acute care general surgeons as compared with all other surgeons (see Table 3, page 31). Again, for most of these issues, acute care surgeons were more likely than other surgeons to answer in the affirmative.

The survey also sought to determine perceptions of the intermediate or negative effects of an acute care surgery service from the acute care surgeon perspective versus all other surgeons (see Table 4, page 32). Since the development of acute care surgery services, 26 percent of the survey respondents reported a decrease in the number of surgical cases done by general surgeons who were not involved in the acute care surgery program (see Figure 4, page 32). In addition, 79 percent reported no significant change in income (see Figure 5, page 32).

Tables 5 and 6 (see page 33) show income variability based on the specialty of the respondent. For all types of surgeons, most noted no significant change in income. More general surgeons (17 percent) noted an increase in their income than a decrease in earnings (9 percent).

We also asked the Governors to describe any negative developments that have emerged since their hospital developed an acute care surgery service. These responses can be combined into six categories, which are listed below in order of the frequency of the response:

- Fragmented care/poor continuity of care: 10 responses
- Negative effects on the call schedule: seven responses
- Decreased quality of care due to less experienced acute care surgeons: six responses
- OR access issues due to acute care surgery cases needing to be scheduled urgently/emergently: four responses
- Conflicts/controversy between acute care surgeons and community surgeons: four responses
- Devaluation of the general surgeon: Two responses

continued on page 32
### TABLE 2. EFFECTS OF ACUTE CARE SURGERY PROGRAMS ON HEALTH CARE (acute care surgeons vs. other surgical specialists)

<table>
<thead>
<tr>
<th>Issue</th>
<th>Acute care surgery</th>
<th>All other specialists</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>ER patients that need a general surgery consult are seen more quickly</td>
<td>64%</td>
<td>22%</td>
</tr>
<tr>
<td>Inpatients that need a general surgery consult are seen more quickly</td>
<td>62%</td>
<td>27%</td>
</tr>
<tr>
<td>It has been easier for our hospital to provide ER general surgery coverage</td>
<td>65%</td>
<td>27%</td>
</tr>
<tr>
<td>Patients with nontraumatic surgical emergencies get to the OR more quickly</td>
<td>59%</td>
<td>19%</td>
</tr>
<tr>
<td>The length of stay for patients with nontraumatic surgical emergencies has decreased</td>
<td>39%</td>
<td>28%</td>
</tr>
<tr>
<td>Care of patients with nontraumatic surgical emergencies has improved</td>
<td>69%</td>
<td>17%</td>
</tr>
<tr>
<td>Care of patients in the surgical ICU has improved</td>
<td>44%</td>
<td>31%</td>
</tr>
<tr>
<td>The cost of care for emergency surgical patients has decreased</td>
<td>19%</td>
<td>33%</td>
</tr>
<tr>
<td>General surgeons are happy that they no longer have to take ER general surgery call</td>
<td>53%</td>
<td>19%</td>
</tr>
<tr>
<td>Surgical specialists are happy that they no longer have to take ER general surgery call</td>
<td>44%</td>
<td>28%</td>
</tr>
<tr>
<td>General surgeons now have a more predictable lifestyle with less interruption of scheduled surgery days and office days</td>
<td>61%</td>
<td>17%</td>
</tr>
<tr>
<td>Surgical specialists now have a more predictable lifestyle with less interruption of scheduled surgery days and office days</td>
<td>51%</td>
<td>26%</td>
</tr>
<tr>
<td>Patients prefer the acute care surgery model over the traditional model</td>
<td>14%</td>
<td>20%</td>
</tr>
<tr>
<td>The nursing staff prefers the acute care surgery model over the traditional model</td>
<td>40%</td>
<td>11%</td>
</tr>
</tbody>
</table>

### TABLE 3. POSITIVE EFFECTS OF AN ACUTE CARE SURGERY SERVICE ON PATIENT AND PROVIDER WELL-BEING

<table>
<thead>
<tr>
<th>Issue</th>
<th>Acute care surgery</th>
<th>All other specialists</th>
</tr>
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<tr>
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<td>17%</td>
</tr>
<tr>
<td>Patients with nontraumatic surgical emergencies get to the OR more quickly</td>
<td>59%</td>
<td>19%</td>
</tr>
<tr>
<td>General surgeons are happy that they no longer have to take ER general surgery call</td>
<td>53%</td>
<td>19%</td>
</tr>
<tr>
<td>Surgical specialists now have a more predictable lifestyle with less interruption of scheduled surgery days and office days</td>
<td>51%</td>
<td>26%</td>
</tr>
</tbody>
</table>
Although overall, 70 percent of survey respondents could foresee no significant change in their income if their hospital developed an acute care surgery program, 65 percent of the responders would prefer not to develop such a program. When analyzed by type of surgeon, a substantial majority—73 percent of general surgeons and 54 percent of other surgeons—are opposed to the development of an acute care surgery service.

**ER call**

Among the Governors who participated in the study, 57 percent reported that they take ER call. Of those who take ER call, general surgeons are most likely to do so (76 percent) versus other surgical specialists (31 percent). Furthermore, 100 percent of the general surgery respondents said they feel comfortable taking ER call versus 78 percent of all others. Compensation for ER call is provided to 48 percent of the respondents.

In total, 48 percent of survey participants said they would consider it a negative change if their hospital developed an acute care surgery service and they no longer were able to take ER general surgery call. In fact, the survey participants who indicated such a move would be a negative change were largely general surgeons (52 percent) compared with all other surgeons (33 percent).

**Career choices**

When asked whether they believe acute care surgery will become a popular career choice for medical students and surgical residents in the future, 52 percent of the respondents answered yes and 18 percent said no. In addition, 42 percent of the respondents said they

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**TABLE 4. INTERMEDIATE OR NEGATIVE IMPACT OF AN ACUTE CARE SURGERY SERVICE**

<table>
<thead>
<tr>
<th>Issue</th>
<th>Acute care surgery</th>
<th>All other specialists</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Care of patients in the surgical ICU has improved</td>
<td>44%</td>
<td>31%</td>
</tr>
<tr>
<td>Surgical specialists are happy that they no longer have to take ER general surgery call</td>
<td>44</td>
<td>28</td>
</tr>
<tr>
<td>The nursing staff prefers the acute care surgery model over the traditional model</td>
<td>40</td>
<td>11</td>
</tr>
<tr>
<td>The length of stay for patients with nontraumatic surgical emergencies has decreased</td>
<td>39</td>
<td>28</td>
</tr>
<tr>
<td>The cost of care for emergency surgical patients has decreased</td>
<td>19</td>
<td>33</td>
</tr>
<tr>
<td>Patients prefer the acute care surgery model over the traditional model</td>
<td>14</td>
<td>20</td>
</tr>
</tbody>
</table>
believe that acute care surgery will be a more attractive career choice for medical students and residents than trauma surgery or critical care surgery. This perceived preference could be related to the need for a better defined work schedule, more predictable work hours, and an expectancy for an improved quality of life.

Therefore, it is possible that because the presence of an active acute care surgery service could make the practice lifestyle of a general surgeon (one who is not a member of the acute care surgery service) more predictable, 60 percent of the ACS Governors indicated that more medical students and residents may choose general surgery if they knew they could forgo call responsibility.

Overall, 50 percent of the respondents agree that the development of acute care surgery services should be supported across the U.S. (see Figure 6, this page). However, this sentiment varies depending on whether the respondent’s hospital already has an acute care surgery program and if this individual is a general surgeon or a surgical specialist (see Tables 7 and 8, page 34).

**Summary and implications of findings**

Acute care surgery is a relatively new field that will continue to evolve. Our 2016 survey of the members of the ACS B/G shows that most hospitals (68 percent) have an acute care surgery program. Of these programs, 79 percent have been in place for at least five years.
TABLE 7. INSTITUTIONS WITH ACUTE CARE SURGERY PROGRAM: Should acute care surgery programs be instituted across the U.S.?

<table>
<thead>
<tr>
<th>Category</th>
<th>Yes</th>
<th>No</th>
<th>I’m not sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>General surgeons</td>
<td>59%</td>
<td>15%</td>
<td>26%</td>
</tr>
<tr>
<td>Other non-acute care surgeons</td>
<td>49%</td>
<td>13%</td>
<td>38%</td>
</tr>
<tr>
<td>Acute care surgeons</td>
<td>84%</td>
<td>8%</td>
<td>8%</td>
</tr>
</tbody>
</table>

TABLE 8. INSTITUTIONS WITHOUT ACUTE CARE SURGERY PROGRAM: Should acute care surgery programs be instituted across the U.S.?

<table>
<thead>
<tr>
<th>Category</th>
<th>Yes</th>
<th>No</th>
<th>I’m not sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>General surgeons</td>
<td>29%</td>
<td>34%</td>
<td>37%</td>
</tr>
<tr>
<td>Other non-acute care surgeons</td>
<td>53%</td>
<td>18%</td>
<td>29%</td>
</tr>
<tr>
<td>Acute care surgeons</td>
<td>0%</td>
<td>0%</td>
<td>100%</td>
</tr>
</tbody>
</table>

These programs are usually a mix of full-time acute care surgeons, or both general surgeons and acute care surgeons. However, at most, 31 percent of the surgeons in an acute care service are fellowship trained.

The general surgery respondents who are presently in an acute care surgery program express an overall positive attitude toward their experience. Likewise, respondents indicate that the presence of an acute care surgery service has a positive effect on patient care.

General surgeons and other surgeon specialists have seen 30 percent and 24 percent decreases, respectively, in the number of cases since the development of acute care service programs. However, overall income has not changed significantly for 79 percent of the survey respondents. Interestingly, 17 percent of general surgeons saw an increase in income.

Negative developments that hospitals with acute care surgery services have experienced include fragmentation of care, negative effects on the call schedule, and decreased quality of care due to acute care surgeons with less experience in caring for certain conditions compared with their general surgeon counterparts.

Overall, of respondents who work in hospitals that have yet to develop an acute care surgery program, 65 percent would prefer that their hospital refrain from developing such a service. This sentiment is even more common among general surgeons (73 percent). However, if their institutions did develop an acute care surgery service, 70 percent of the respondents thought their income would remain relatively stable, although general surgeons were most likely to express concern that their income would decline (37 percent versus 17 percent).

In all, 57 percent of ACS Governors take ER general surgery call, and 95 percent feel capable and comfortable doing so. Of those who do take call, 48 percent receive compensation for it. Interestingly, 47 percent of Governors in hospitals that do not have an acute care surgery program had a negative response to the possibility of no longer taking ER call. This reaction was more common among general surgeons (52 percent) than all other surgeons (33 percent). It’s possible that being compensated for taking ER general surgery call might influence whether surgeons would want their hospitals to develop an acute care surgery program.

Most Governors believe that acute care surgery will become a popular career choice for medical students and surgical residents, even more so than trauma surgery and/or critical care. Likewise, it is possible that the appeal of acute care surgery programs may encourage medical students to pursue general surgery as a career since they would not be expected to be on call as frequently.

Despite the limitations of the survey—specifically, the limited response number, as only B/G members were surveyed—these responses suggest that acute care surgery is an important and growing area of concentration, and that the development of programs across the U.S. should be encouraged.
The American College of Surgeons is dedicated to improving the care of the surgical patient and to safeguarding standards of care in an optimal and ethical practice environment.

—ACS Mission Statement

Editor’s note: The American College of Surgeons (ACS) Health Policy and Advocacy Group updated the 2009 ACS Statement on Health Care Reform and has developed the following 2017 Statement on Health Care Reform. The ACS Board of Regents reviewed and approved the statement at its February meeting in Chicago, IL.

The ACS is the largest surgical organization in the U.S., representing more than 80,000 members from all states and surgical specialties. The ACS was founded in 1913 and is dedicated to high-quality, safe surgical care delivered in a compassionate, ethical manner. Surgeons perform approximately 30 million operations annually in the U.S. Although the ACS appreciates the challenges facing the U.S. health care system, the organization also emphasizes that many aspects of surgical health care in the U.S., including surgical education and training, are the best in the world.

The ACS strongly supports efforts to ensure that individuals have universal access to patient-centered, timely, affordable, and appropriate health care, while maintaining that surgeons are an integral and irreplaceable component of quality health care.

To this end, in any health care reform bill, the ACS strongly supports four core principles:

• Quality and safety
• Patient access to surgical care
• Reduction of health care costs
• Medical liability reform

Achieving these goals and building a better health care delivery system will require all stakeholders to work together.
Quality and safety

The ACS has a multifaceted approach to enhancing quality and safety in health care worldwide. The cornerstone of this effort focuses on our clinical registries and our educational efforts to drive quality improvement and safety. Scientific evidence shows that providing safe and effective quality surgical care will help to reduce the cost of health care delivery. Cost reductions must be linked to quality improvement efforts.

The ACS registries are built with scientific rigor, using standards and critical audit functions to ensure that surgeons and patients have valid, reliable information upon which to base health care decisions and drive improvement. College registries include the ACS National Surgical Quality Improvement Program (ACS NSQIP®) and clinical databases focused on pediatrics, bariatrics, breast disease, cancer, trauma, as well as the Surgeon Specific Registry. The ACS education, improvement, and verification programs are broadly applied using the registries for their supporting infrastructure.

ACS NSQIP, for example, represents a nationwide effort to use risk-adjusted tools to improve surgical care and cut costs. This program helps to prevent thousands of surgical complications each year, which, in turn, reduces costs. These achievements have been recognized by the National Academy of Medicine, the National Quality Forum, and The Joint Commission.

Physician quality data

The Centers for Medicare & Medicaid Services (CMS) quality programs have evolved under the Medicare Access and CHIP (Children’s Health Insurance Program) Reauthorization Act (MACRA) into two major programs: the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs). The ACS maintains that performance measurement is important in establishing value-based care for patients in both payment programs. Performance measurement should focus more on patient safety than on surgeons adequately attaining participation thresholds in CMS payment programs. The ACS supports CMS and all payors in their efforts to align their quality programs with individual patient needs and goals of care. The ACS sent a cautionary message to CMS with regard to the use of outcome measures. Outcome measures are an invaluable tool in driving improvement, but they lack the statistical capabilities for discerning differences among individual surgeons for the purposes of payment differentiation or public reporting. Outcome measures, when used, should be risk adjusted and stratified and used to assist in developing quality improvement initiatives.

The ACS supports defining performance measurement within episodes of care using phases of care to define the foci for measurement. For example, the surgical phases of care are as follows: surgical preoperative evaluation and preparation, immediate preoperative readiness, perioperative, intraoperative, postoperative, and postdischarge. The ACS recommends use of high-value process measures and directed patient-reported outcome measures that are consistent with the goals of surgeons and their patients for each specific episode of care.

The ACS supports quality, safety, and related performance measurements that meet the following standards:

- Is actionable, reliable, and voluntary
- Seeks to reduce the administrative burden of data collection from physicians
- Provides positive incentives for participation
- Provides access to data in a timely manner
- Has a reasonable appeals process

Furthermore, the ACS believes that Congress should:
• Publicly release quality reports only after further evaluation and improvements occur to ensure that the reports are valid.

• Provide additional federal funding to assist in the development of clinical data registries and other quality improvement tools.

Patient access to surgical care

The ACS has a longstanding policy of supporting universal access to affordable, high-quality, safe surgical care delivered in a timely and appropriate manner. Achieving universal access to such care requires that our nation maintain a well-trained and available surgical workforce to meet the needs of all surgical patients. The shortage of surgeons in several surgical specialties in many areas of the country jeopardizes patient access to timely, high-quality surgical care.

Surgical workforce and access to surgical care

• Existing legislation should be modified to allow for growth of surgical and other specialties as demand for service dictates. For more detailed recommendations, see the January 2017 ACS Policy and Position Paper on Graduate Medical Education Reform.*

• Deliberate efforts should be undertaken to increase the number of women and minorities training in graduate medical education programs.

• Nonphysician providers may serve as extenders to augment and facilitate the efforts of surgeons but cannot and should not replace them.

• Congress should include those surgical specialties with documented workforce shortages, such as general surgery, in the loan forgiveness programs of the National Health Service Corps.

Medicaid

• The expansion of Medicaid provides coverage for millions of previously uninsured Americans. Any further efforts directed at health care reform must ensure that these Americans keep their coverage and that the safety net upon which they depend is preserved.

• Medicaid is the single largest children’s health insurance program, covering more than one in four children. It must continue to support these vulnerable children.

• Medicaid should reimburse physicians at levels equal to those of Medicare.

Ensuring equal access to quality surgical care for children

• Funding for the Children’s Health Insurance Program expires in September of 2017. The reauthorization and appropriation of funds for this program is vital to ensuring that eligible children have coverage and access to surgical care.

Insurance reform

• The ACS supports preserving coverage for those individuals with pre-existing conditions.

• The ACS supports continuing to preclude lifetime maximums on coverage policies.

• Reforms must address issues of reducing costs, improving coverage, and relieving administrative burdens.

Ensuring responsible physician ownership

• Physicians should have the right to responsibly own, either individually or through a joint venture (with

hospitals and/or other physicians), facilities (including hospitals), equipment, and services that provide appropriate, high-quality care for patients.

• Congress should remove the restriction on physicians owning and expanding such ventures. Physicians should be obligated, however, to disclose this ownership information to the public.

• Physicians should be able to continue to own, operate, and refer patients to in-office imaging services as provided in the Stark in-office ancillary exception.

Reduction of health care costs

Provision of appropriate, high-quality, safe, and cost-effective patient care should begin with defining unwarranted, unnecessary, high-cost care. Surgeons should reduce unwarranted variation in order to preserve quality while optimizing resource use. Efforts to promote value-based risk models linking quality and optimal cost should encourage rewards and limit penalties. Further, optimal care should encourage patient engagement in shared decision making. Patients require education and support in fulfilling their individual role in the maintenance of health and well-being. These efforts should promote access to appropriate and compassionate care for all.

Advanced APMs

• The ACS supports efforts (including MACRA provisions) aimed at allowing more physicians to voluntarily participate in APMs such as shared savings programs, bundled payments, accountable care organizations, and episode-based payments where containment of cost is linked to improvements in care.

• The ACS has expended significant time and resources to ensure that surgeons have viable opportunities to participate in these models, including the development of the ACS-Brandeis Advanced APM, which was recently submitted to the Physician-Focused Payment Model Technical Advisory Committee.

• All payment programs should ensure sustainable business models to preserve a viable surgical workforce by providing fair and appropriate reimbursement for surgeons.

• If implemented, participation in value-based payment programs should be tied to quality, involve voluntary participation, possess fair and attainable upside risks and limits on downside risks, and not unduly restrict patient choice.

• Congress must amend the Stark physician self-referral laws and the federal antitrust laws and/or regulations to allow for provider collaboration and flexibility in the development of APMs.

Commitment to evidence-based guidelines for surgical care

• Clinical practice guidelines (CPGs) based on the best available evidence and recommendations from clinical experts are valuable resources to assist surgeons in implementing evidence-based practice.

• Surgeons need CPGs so that patients can be assured that the best possible outcomes of care will be achieved.

• Well-developed CPGs can be used to eliminate waste and inefficiency wherever possible, including overuse, underuse, and misuse of services.

• Development of CPGs is an expensive and a labor-intensive process that requires periodic revision to ensure accuracy and dependability.

• The ACS is committed to the assessment, development, and promulgation of guidelines that will lead to the best outcomes and the most cost-effective care for patients with surgical disease, so that the full spectrum of care is optimized and coordinated.
Independent Payment Advisory Board
The ACS supports the repeal of the Independent Payment Advisory Board. The ACS maintains that Medicare payment policy should remain the primary purview of Congress rather than delegated to an unelected, unaccountable governmental body that may minimize input from stakeholders and citizens. Any binding mandates promulgated from such a body that affect reimbursement should be fairly constructed, spread across the spectrum of all health care interests, and not directed at any one sector, such as surgery.

Process for valuing codes under the physician fee schedule

• The ACS opposes the creation of a duplicative process for determining code values.

• The surgical community supports maintaining the role of the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC) as the entity through which medical services are valued.

• The RUC continues to be a dynamic body, which makes recommended increases and decreases in the value of codes reimbursed under the Medicare physician fee schedule.

• The RUC has maintained budget neutrality.

• The ACS opposes reassignment of 10-day and 90-day global codes to 0-day, where stakeholder specialties have not requested a change in global codes.

• The ACS opposes use of a reverse building block methodology to revalue codes, which would subtract work values for changes in postoperative visits, unless clear documentation is available to show that the code value was created using the building block methodology.

• The ACS supports code valuation that uses magnitude estimation to appropriately align codes relative to one another.

Medical liability reform
In accordance with the “Statement on medical liability reform” developed by the ACS Legislative Committee and approved by the Board of Regents in October 2014, the ACS actively supports the following:

• Reforms based on safety, quality, and accountability

• Continued advocacy for traditional reforms where appropriate and feasible

• Legislation that eases structural barriers to implementation of patient-centered reforms, specifically with respect to National Practitioner Data Bank reporting requirements and apology laws

• Culture change among hospitals and providers to embrace swift adoption of alternative patient-centered reforms, including communication and resolution programs (CRPs)

Meaningful medical liability reform would reduce health care costs and improve patient access to care, as demonstrated by the following examples:

• Before taking legislative action in 2008, Texas ranked 48th out of 50 states in terms of physician workforce, averaging 152 physicians per 100,000 population in contrast to the national average of 196.

• After passing strong medical liability reforms in 2008, Texas received more than 4,000 physician licensure applications compared with 2,500 received in 2002.

Included were 162 orthopaedic surgeons and an additional 49 neurosurgeons.

• A report by the Congressional Budget Office concluded that a medical liability reform package, including a $250,000 cap on noneconomic damages would reduce federal budget deficits by roughly $57.1 billion over the next 10 years.

• The medical liability crisis has contributed to a maldistribution of physicians.

The ACS maintains that our nation’s medical liability system is broken and that it fails both patients and physicians. Less than 3 percent of patients who sustain medical injury sue for monetary compensation. Furthermore, in 37 percent of all closed liability claims, no error was discovered. In addition, the present liability system costs an estimated $100 billion annually. The system is costly, inefficient, and the process of compensating injuries related to medical errors is inaccurate.

The mission of the ACS is to improve the care of the surgical patient, safeguard standards of care, and create an ethical practice environment. The College is a proven leader in patient safety through initiatives such as ACS NSQIP. The failing medical liability process jeopardizes the public’s trust in the health care system and threatens to undermine the successes that the ACS has achieved. Therefore, the ACS will continue to lead the way by advancing practical reforms that improve patient safety and provide quality health care.

Beyond traditional legislative remedies, the medical liability system is in need of transformative change that focuses less on monetary reparations and more on patient safety, quality care, and provider accountability. Adverse events should be approached with open communication and recognition that an unfortunate outcome is not synonymous with negligence. Compensation for injured patients, monetary or otherwise, should be fair and timely without the unnecessary delay commonly associated with the current tort process. Hospitals should pursue system-level changes that assure patients of quality care and that prevent event recurrences. Ultimately, negligent providers should be held accountable.

Alternative, patient-centered solutions to liability reform have received varying degrees of attention. Health courts, enterprise liability, and alternative dispute resolution can be crafted around patient-centered principles and also provide excellent opportunities for reform. However, on balance, disclosure and offer programs, otherwise known as CRPs, show great promise for promoting a culture of safety, quality, and accountability; restoring financial stability to the liability system; and requiring the least political capital for implementation. Whereas any of these alternatives would represent an improvement over the status quo for both patients and providers, they should be explored through additional research and advocacy. In addition, structural barriers to implementation, such as obsolete reporting requirements to the National Practitioner Data Bank and inconsistent apology protections, must be addressed.

Thus, the ACS believes that incorporating medical liability reform is essential in any comprehensive health care reform effort and supports the following:

• Provisions modeled after the laws in California (specifically the Medical Injury Compensation Reform Act, also known as MICRA) or Texas, which include reasonable limits on noneconomic damages

• Alternatives to civil litigation, such as health courts, arbitration, early disclosure, and compensation offers

• Protections for physicians who follow established evidence-based practice guidelines, such as safe harbors

• Protections for physicians volunteering services in a disaster or a local or national emergency situation ♦
Practice changes lower rates of transfusion, superficial SSI, and morbidity

by Kori Wolcott, RN, BSN

Editor’s note: Hospitals that participate in the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP®) use the program’s data and reports to improve performance and surgical outcomes. Sites are invited to share their experiences at the annual ACS Quality and Safety Conference (formerly the ACS NSQIP Conference) through abstract submissions for poster and panel presentations. Hospitals also are encouraged to share their quality improvement (QI) initiatives, so other institutions can learn from their experience and develop their own QI programs.

The “ACS NSQIP best practices case studies” column is an ongoing look at these experiences. These case studies, which have been edited to comply with Bulletin style, provide a description of the clinical problem being addressed, the context of the QI project, the planning and development process, a description of the activity, the resources needed, the results, and suggestions for developing other case studies.

Surgical site infections (SSIs) remain a substantial cause of morbidity, mortality, increased length of stay, and increased hospital costs. Blood transfusions also have been found to contribute to increased morbidity and mortality due to negative reactions to transfusion, over-transfusion, transfusion-related acute lung injury (TRALI), and transfusion-associated circulatory overload (TACO). Alloimmunization (immune response to foreign antigens after exposure to genetically different cells and tissues) and immunomodulation (any process in which an immune response is altered to a desired level) also are both possible reactions that can occur when receiving blood transfusions.

Why was the QI activity initiated?
Golisano Children’s Hospital (GCH), University of Rochester, NY, is a 124-bed facility that serves as the referral center for all seriously ill or injured children in the 17-county Finger Lakes region. With more than 200 pediatric specialists, GCH provides a spectrum of care that spans more than 40 specialty areas and serves more than 85,000 children and their families annually. Approximately 21,300 operations are performed each year, covering numerous subspecialties. Furthermore, GCH offers pediatric cardiac surgery and has the largest pediatric intensive care unit (ICU) in western and central New York, which averages 825 admissions annually.

According to the 2013 ACS NSQIP Pediatric Semiannual Report (SAR) released in July 2014, GCH had a high outlier status in the following categories: all morbidity (12.95 percent observed/8.86 percent expected), abdominal-neonate morbidity (41.43 percent observed/27.45 percent expected), and general morbidity (15.40 percent observed/10.95 percent expected). As a result of these findings, which indicated that GCH was above the NSQIP benchmark, GCH’s pediatric surgery QI group (PSQIG) began analyzing the morbidity data. Superficial SSIs and transfusions in the pediatric general and pediatric orthopaedic surgery patient populations were identified as two of the main contributors to the morbidity high outlier status. Pediatric general and pediatric orthopaedic superficial SSIs accounted for 12/18 (67 percent) of superficial SSIs with 25/28 (89 percent) of cases meeting excessive transfusion criteria (>25ml/kg).

How was the QI activity put in place?
The PSQIG began meeting in August 2013 and included representatives from infection prevention, pharmacy, pediatric quality, multiple pediatric surgery divisions (orthopaedic, general, urologic, and cardiac surgery), neonatal intensive care, and infectious disease. The group continues to grow, most recently adding representatives from the pediatric surgical suite, which includes the nurses who work in that area.
After the orthopaedic bundle and pediatric general surgery bundles were finalized and a launch date selected, the pediatric surgical quality assurance/performance improvement specialist provided in-services to the pediatric surgical suite, as well as to pediatric units where these patients would be admitted.

One of the responsibilities of the PSQIG is to review the ACS NSQIP data and identify areas for quality improvement. After the release of the 2013 SAR in 2014, the PSQIG analyzed the following data published in that report:

- **Orthopaedic SSI bundle:** At the time of the SAR’s release, the original orthopaedic bundle, a group of evidence-based practices that have shown to reduce the risk of SSIs, had already been launched and was in the process of being audited. The audit results were shared with members of the PSQIG on a monthly basis, and areas for improvement were identified. After reviewing the data, the PSQIG made the decision to split the orthopaedic SSI bundle into low- and high-risk bundles to provide the best possible care to each patient population.

- **Pediatric general surgery SSI bundle:** In August 2014, the PSQIG began a bundle comparison to identify components of the orthopaedic bundle that could be used in the pediatric general surgery bundle. Once agreement was reached, the pediatric general surgery bundle was launched and auditing initiated.

- **Pediatric surgery transfusion protocols:** ACS NSQIP blood transfusion data were presented at the September 2014 PSQIG meeting. ACS NSQIP criteria were discussed, and patients receiving ≥25ml/kg were identified. Discussion regarding development of blood transfusion protocols began at this time. Key stakeholders were identified and the first meeting to discuss pediatric transfusion protocols took place March 2015. Current protocols were identified, with discussions on using these protocols as templates for division-specific protocols.

- **Methicillin-resistant staphylococcus aureus (MRSA) screening:** Performed on pediatric orthopaedic patients at their preoperative appointment with the orthopaedic nurse practitioner (NP) entering the order for preoperative vancomycin if indicated.

- **CHG wipes:** Pediatric orthopaedic patients receive CHG baths the day before and the day after an operation. The CHG wipes for the day before bath are distributed to the family with instructions by the NP/resident at the preoperative appointment, and this transaction is documented in the patient’s medical record. For pediatric general surgery patients, the CHG wipes are used to clean the surgical site. This task is performed on all patients ages two months and older. All CHG bath information is documented in the patient’s medical record by the nurse in the preanesthesia unit.

- **Betadine nasal swabs:**
  - Used to decolonize the nares of staphylococcus aureus preoperatively
  - Performed by anesthesia professionals on all pediatric orthopaedic patients in the operating room before the operation begins

**What did the QI activity involve?**

After the orthopaedic bundle and pediatric general surgery bundles were finalized and a launch date selected, the pediatric surgical quality assurance/performance improvement specialist provided in-services to the pediatric surgical suite, as well as to pediatric units where these patients would be admitted. An in-service in this context is an educational meeting to teach staff involved in the care of these patients what their involvement in the bundle compliance will be, such as performing chlorhexidine gluconate (CHG) bathing on inpatients prior to surgery.

The pediatric orthopaedic and pediatric general surgery bundles included many evidence-based practices, which follow:
ACS NSQIP BEST PRACTICES CASE STUDIES

TABLE 1. TRANSFUSION BEFORE AND AFTER INTERVENTION

<table>
<thead>
<tr>
<th></th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total cases</td>
<td>569</td>
<td>566</td>
<td>583</td>
</tr>
<tr>
<td>Excessive transfusion</td>
<td>25 (4%)</td>
<td>11 (2%)</td>
<td>18 (3%)</td>
</tr>
</tbody>
</table>

FIGURE 1. TRANSFUSION BEFORE AND AFTER INTERVENTION

What were the results?
A total of 569 pediatric general and pediatric orthopaedic cases were performed in 2013, and 566 were conducted in 2014. In comparison with 2013, the frequency of cases receiving transfusion significantly decreased in 2014 (17 percent versus 11 percent, p<0.01, see Figure 1, this page) and fewer met criteria for excessive transfusion (25 versus 11, see Table 1, this page). In comparison with 2013, superficial SSIs have been reduced from 12 (2 percent) to eight (1 percent) in 2014, and a continued decline has been noted for 2015 (see Table 2 and Figure 2, page 44). Observed cases for all morbidity, abdominal-neonate, and general morbidity categories have decreased from 107 to 65, 29 to 14, and 67 to 37, respectively, from 2013 to 2014. Each category had a decrease in decile from 10 to six, eight, and five, respectively, with concomitant improvement in odds ratios.

Setbacks were largely logistical, such as scheduling meetings with limited staff availability. No revisions were

- Normothermia:
  - Preheat operating room to at least 78° Fahrenheit for infants up to six months old and at least 75 degrees for all other pediatric patients
  - Maintain patient normothermia between 96.8° and 100.4° Fahrenheit

- Standardized wound dressing:
  - Pediatric orthopaedics: Gauze and tape dressing, tegaderm used with any incision at risk for contamination, and prineo +/- gauze and nonadherent dressing for spine operations
  - Pediatric surgery: Standardized intraoperative application of wound dressing

- Blood transfusion protocols: A pediatric surgery transfusion protocol was developed and shared with representatives of all pediatric surgery specialties. After the transfusion protocol was reviewed by all pediatric surgery specialties, it went to

  GCH’s quality council, which approved the standard for use with pediatric surgery patients. The next step will be to have the electronic health record builders integrate the protocol into the transfusion order set.


What resources were needed?
The PSQIG reviewed the bundles as well as the transfusion protocols. Pediatric surgical suite, operating room, and anesthesia staff are key stakeholders in implementing bundle components and maintaining compliance.

  No costs beyond normal hospital operations were necessary, although value analysis approval was needed for the purchase of CHG wipes and betadine nasal swabs; no additional funding was necessary.
made in the original QI plan as a result of limitations encountered during the process; however, a revision was made in the orthopaedic SSI bundle after the original launch date due to an identified need to divide the bundle into high- and low-risk.

**Recommendations for reducing morbidity and mortality due to transfusions and SSI complications**

- Obtain value analysis approval for additional supplies, which can sometimes be a challenge. Knowing who to contact to initiate, process, and complete additional supply requests in a timely manner may help the process run more smoothly.

- Identify champions from each area of participation and include topics/projects that are important to everyone in the group.

- Encourage all members of the group to participate in the PSQIG meetings and quality assurance and QI projects. Contributing to the process and sharing successes engages the group and encourages continued group participation to work toward improving patient care.

- Identify a strong leader who is able to engage all participants throughout the process.

**BIBLIOGRAPHY**


Principles of leadership for the young surgeon

by Paula Ferrada, MD, FACS

The Resident and Associate Society of the American College of Surgeons (RAS-ACS) recently presented a webinar on leadership development for surgical trainees and young surgeons. With the annual Leadership & Advocacy Summit scheduled to take place in Washington, DC, this month, it is worth taking this opportunity to summarize key points of information from the training session.

Understanding your power

It is impossible to discuss leadership without discussing power. Leaders are inherently in positions of power and use their status to stimulate changes. The word “power” sometimes has negative connotations, perhaps because as a society we typically define it as the ability to control others. But the true definition of power is the capacity to influence the behavior of those around us and together reach a common goal.

Influential surgeons have the ability to help a health care institution to grow, to improve resident education, and to bring about the changes necessary to produce better patient outcomes.

Empowered individuals have the confidence to exert their authority when it is needed, to develop partnerships with likeminded individuals, and to ensure fairness and transparency in our professional environment. When we understand our power and its impact, we can better see that leadership in surgery is not a privilege but a duty in which we serve our institutions, our patients, and our profession.

Leadership is a choice, not a rank

Productive leadership is every surgeon’s responsibility. Leading a team and advocating for our patients are examples of how we use our leadership skills in daily clinical activities and interactions. Effective leadership is a skill that can be learned and enhanced by understanding the following five key concepts.

Find your purpose

As a leader you must know what you want to accomplish, and strong leaders typically feel passion for a particular goal or project. Passion is a strong emotion that can sometimes overtake logical thinking, but if these intense feelings can be focused, they can help support a project. A leader’s mission can be an extension of his or her passion and refers to what we are meant to accomplish in the long term.

Understanding the difference between a surgeon’s profession and their vocation is important when defining your purpose and mission. A profession can refer to an individual’s paid occupation, while a vocation refers to a strong suitability for a particular profession such as surgery, along with a moral obligation based on personal principles to provide optimal care for the patient. Taking the time to conduct a self-assessment to determine where our passion, mission, vocation, and profession intersect is critical to defining a clear purpose for a surgeon leader.

Once your purpose is defined, it is important to communicate your vision with pathos (an appeal to emotion), logos (understanding the logic), and ethos (always taking into account ethics and integrity) to your team in order to convey credibility in your role as a leader. Your team’s commitment to helping you fulfill your goals depends on your ability to show them that change is necessary and that they have an important role in the process.
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Reciprocity
Leaders know the value of paying it forward. They know that they build goodwill by extending opportunities to the rest of the team, allowing them to move ahead. These opportunities must be offered in a way that is ethical and authentic.

Authority
Leading with authority is not about exerting force, but rather about being a trusted expert on a specific area. Excellent clinical performance is of the highest importance on the path to leadership in surgery.

Scarcity
Human nature seems to suggest that individuals sometimes desire things that are available in limited quantities. One of the best examples of using scarcity to demonstrate value can be found in sales, where advertisements indicate a product is available in limited supply or for a limited time only. As a health care provider, scarcity—or rather, your availability—can be a marker of your value as a team leader. Successful surgeon leaders excel at time management. Maintain control over your time commitments and devote yourself to a limited but meaningful number of activities.

Consensus
Leaders are consensus builders. They understand that having the support of stakeholders, or at least having them understand the leader’s point of view, can support the message and, hopefully, lead to better results. Aligning your goals with the goals of your institution and your team will allow for a successful outcome for all parties involved.

Presenting your best self
Leaders exude and inspire confidence in those around them. Although confidence comes from within, there is some evidence that small interventions can affect how we feel about ourselves and our ability to lead with assurance.

In humans and other mammals, testosterone levels rise in individuals who hold situational power. These levels also increase in anticipation of a competition and as a result of a win; conversely, they drop following a defeat. Cortisol levels tend to increase in people who feel less powerful and capable. Carney and colleagues have shown cortisol levels drop and testosterone levels rise in healthy volunteers who hold power poses for 90 seconds or more. The same study showed increased cortisol in those individuals holding low-power poses. Power poses may be a quick fix to empower yourself and perform better under stress. However, building courage to take on difficult situations is a lifelong challenge. Being confident and appearing confident to others might be connected, but they are not the same. Being able to see a situation from a broad perspective and without feeling defensive is part of an ever-evolving mindset.

The role of the ACS
The ACS is committed to providing surgeons with the skills they need to be successful leaders. The RAS-ACS provides all members in training and the early stages of their careers with opportunities to get involved in the activities of the College; to serve on various standing committees of the organization; and to participate in educational programs, including free admission to the ACS Clinical Congress to those who register in advance. Membership in the RAS-ACS provides trainees and Associate...
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Fellows with access to career planning resources, networking situations, advocacy training and resources, and fellowship and scholarship programs. In addition, the College offers the Residents as Teachers and Leaders course to help young surgeons and trainees develop leadership skills.

The ACS Young Fellows Association (YFA) represents the interests of surgeons ages 45 and younger and provides a forum for them to shape the future of the organization and their specialty. The YFA provides opportunities to serve on committees and to lead courses and sessions at the Clinical Congress and locally through the ACS chapters. YFA members may serve on one of four workgroups (Advocacy, Communications, Education, and Member Services) and have opportunities to serve as a leading voice on advocacy and health policy issues. These groups work during the entire year to help all members getting involved in the national Clinical Congress program and all other ACS activities.

For surgeons interested in additional leadership development, the ACS offers the Surgeons as Leaders: From Operating Room to Boardroom course, which includes a week of intense training and networking.

The College also organizes the annual Leadership & Advocacy Summit mentioned at the beginning of this month’s column. This meeting provides a forum for surgeons to advocate to improve health care, meet with influential policymakers, network with ACS leaders, become more engaged in the organization, learn innovative ways to meet leadership and surgical challenges, and enhance leadership skills.

**Conclusion**

Leadership is a learned skill that allows surgeons to exert positive influence in their work environment. As surgeons, we are responsible for leading our teams. We serve as trusted authorities and advocates for our patients. It is important that we develop and maintain leadership skills throughout our careers. The ACS has programs in place to aid in the development of surgeon leaders starting early on in our careers.

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**BIBLIOGRAPHY**


An estimated 160,000 men are diagnosed with prostate cancer annually in the U.S.¹ Once diagnosed, these patients are left with the perplexing decision of whether or not to undergo an operation. Imperfect evidence, professional biases, and quality of life trade-offs make such treatment decisions difficult.

Complicating factors
Urologic surgeons face increasing challenges in counseling these patients. Recent declines in prostate cancer screening following the U.S. Preventive Services Task Force recommendation against routine PSA (prostate-specific antigen)-based screening for prostate cancer may be leading to an increase in the incidence of more clinically aggressive prostate cancer.²⁻⁴ Furthermore, minority patients have higher morbidity and disparate outcomes, making these choices even more challenging for them. In fact, minority men experience worse outcomes, as measured in terms of mortality as well as quality of life after prostate cancer treatment. We recently published data demonstrating that minority males have limited access to robotic surgery.⁵ African-American, Native American, and Alaska-Native men, in particular, are more likely to have more aggressive prostate cancer and worse survival rates.⁶ African-American men are more vulnerable to receiving low-quality medical care, particularly when receiving primary therapy for localized disease.⁷⁻⁸ Social determinants of health status, biased health care systems, and complexity of follow-up care for populations lacking social support may contribute to this overall problem.

Addressing the complexities
To address these challenges and complex choices, clinical practice guidelines encourage shared decision making to ensure that newly diagnosed patients are familiar with all of the available treatment options and their associated risks and benefits. Having this information available allows them to better weigh their treatment modalities against their personal preferences to inform the decision-making process.

Decision aids can facilitate shared decision making by enabling patients to better comprehend the available evidence, comparative trade-offs, and how their values fit into the decision-making process.

Some decision aids for prostate cancer do not incorporate individualized risk and patient-specific disease severity, nor do they address health care-related quality of life and life expectancy. None of these decision aids have been tested in a manner that samples sufficient minority populations to infer their effects in these populations. Our conversations with prostate cancer survivors have convinced us that having decision support tools available at the point of care with urologists may be critical when providing care to minority populations.

A191402 trial design
The A191402 trial, Decision Aids for Prostate Cancer in Minority Men, is designed to improve treatment decisions for minority men diagnosed with localized prostate cancer. The study will enroll 168 men over a two-year time period and will include a culturally sensitive decision aid for use by clinicians during their consultations with newly diagnosed prostate cancer patients. This decision aid, called the Prostate Cancer Choice tool (see Figure 1, page 49), along with another out-of-visit tool developed by the Agency for Healthcare Research
and Quality, Knowing Your Options, will be tested during the trial (see Figure 2, this page).

The A191402 study will oversample African-American, Native American, and Alaska-Native men with half of the enrollment slots reserved for this population. We have identified strategic partner sites to help us achieve these demographic recruitment targets. The aim of the study is to test the impact of the two different decision aids, alone and in combination, on patient knowledge and one-year quality of life in comparison with usual care.

We will use a “cluster-randomized” design, which assigns institutions to different intervention arms. As a result, all patients and physicians at a given site will get the same interventions. We will use statistical methods to ensure that site-to-site differences are accounted for, while making certain that “contamination” across study arms is minimized.

Planning for this trial began in 2012. Since then, we have been privileged to establish collaborations with national leaders in prostate cancer survivorship as well as with many colleagues in the urologic oncology community through the National Cancer Institute’s Community Oncology Research Program. The trial opens this month. For more information, contact Simon P. Kim, MD, MPH at simkim@me.com, or Jon C. Tilburt, MD, MPH, at tilburt.jon@mayo.edu.

REFERENCES

Pediatric surgery approaches a 100-year milestone in 2017. December 6 marks the centennial of the maritime disaster off the coast of Nova Scotia known as the Halifax Explosion. On that date in 1917, the French munitions ship Mont-Blanc, carrying wartime explosives, collided with the Imo, a Dutch relief vessel, in Halifax harbor. Within a half hour the Mont-Blanc detonated, with a blast that leveled buildings within a two-square-mile area. So powerful was the explosion that the six-ton anchor of the Imo was found in a ruined building nearly two miles from the harbor.1 Historians estimated that it was the most powerful man-made explosion in recorded history until the Trinity atomic bomb test of 1945.2 Many locals watched the conflagration from their windows, their morning routines interrupted by the spectacle. Thousands of bystanders, including hundreds of children, were killed or maimed by the explosion. Glass shattered into the faces of onlookers in their homes, leaving approximately 200 completely blind and another 500 with serious eye injuries. A radiologist noted more than 226 fractures in his log. In all, an estimated 2,800 people died as a result of the Halifax Explosion.3

With local health care facilities destroyed and the surviving physicians and nurses undersupplied and overwhelmed, Canadian authorities struggled to bring relief to the devastated city. A medical convoy of 40 physicians and nurses from Boston, MA, led by 37-year-old William Ladd, MD, FACS, traveled by train through a blizzard, arriving in Halifax two days after the disaster. A damaged but still serviceable building at Saint Mary’s College was converted into an infirmary, where the team treated victims maimed and blinded by shards of wood and glass. The medical convoy remained on-site for nearly a month, through the winter holidays.1

The “father” of pediatric surgery
Legend has it that the experience inspired Dr. Ladd to devote his surgical career to the care of children. Robert E. Gross, MD, FACS, Dr. Ladd’s successor as surgeon-in-chief at The Children’s Hospital (now called Boston Children’s Hospital) in Boston, was among those who believed the origin of the specialty began in Halifax. In fact, Richard Goldbloom, MD, FACS, a pediatric surgeon in Halifax, had a chance encounter with Dr. Gross in 1976, where
the latter reportedly said, “I suppose you know that Halifax was the birth place of pediatric surgery as a specialty.” The folklore surrounding the origin of pediatric surgery was so pervasive that it continued to be retold even by the leading authorities in the field. However, Dr. Ladd had set the record straight some 13 years earlier in 1963 in a letter to Gerald Zwiren, MD, FACS, a pediatric surgeon in Atlanta, GA, who had asked him to verify the story. “I fear I will have to make many alterations [to the story],” Dr. Ladd wrote. He had made the decision to focus on pediatric surgery nearly a decade earlier, when he completed his training at the Boston City Hospital in 1908 before joining the visiting staffs at The Children’s Hospital and the Infant’s Hospital in Boston. (The two hospitals merged officially in 1961.) “The Children’s was [my] very first and most permanent love,” Dr. Ladd wrote. “As soon as it became feasible after the first World War, I devoted myself exclusively to pediatric surgery and have never regretted it.”

Dr. Ladd’s place as the father of pediatric surgery is secure, even though the historical narrative linking the Halifax disaster and the origin of pediatric surgery turned out to be false. Dr. Ladd ascended to the position of surgeon-in-chief of Boston Children’s Hospital in 1927. His clinical work defined the specialty and inspired a generation of trainees who came under his mentorship. In 1997, 80 years after the Halifax Explosion, nearly three-fourths of pediatric surgery program directors and two-thirds of all practicing pediatric surgeons in the U.S. and Canada could trace their training lineage to Dr. Ladd. In the decades that followed the Halifax Explosion, thousands of surgeons have continued his devotion to the surgical care of children.

Acknowledgment
The author acknowledges the diligent support and invaluable assistance of Amy M. Duncan, librarian, Sacred Heart Hospital, Pensacola, FL, in the preparation of this article.

REFERENCES
Safety culture is the sum of what an organization does to provide optimal patient care. The Patient Safety Systems (PS) chapter of The Joint Commission accreditation manuals defines safety culture as the product of individual and group beliefs, values, attitudes, perceptions, competencies, and patterns of behavior that determine the organization’s commitment to quality and patient safety.1 The PS chapter asserts that organizations with a robust safety culture are characterized by the following:

• Communication based in mutual trust
• Shared perceptions of the importance of safety
• Confidence in the efficacy of preventive measures

The Joint Commission described behaviors that undermine a culture of safety in a July 2008 issue of Sentinel Event Alert, which was followed by another Alert published the following year emphasizing the benefits of a leadership standard that requires leaders to create and maintain a culture of safety.2,3 In January 2017, the PS chapter was expanded to include critical access hospitals, ambulatory care, and office-based surgery settings. And most recently, in March of this year The Joint Commission released a new Sentinel Event Alert that updates the 2009 Alert, and which clarifies the essential role of leadership in developing a safety culture.4

Surgeon leaders play a fundamental role in ingraining safety culture strategies into the core of an organization. The Joint Commission’s accreditation manual glossary defines a leader as “an individual who sets expectations, develops plans, and implements procedures to assess and improve the quality of the organization’s governance, management, and clinical and support functions and processes.”4

The board and chief executive officer (CEO)—key leadership roles in any organization—must emphasize with their every action that communication of unsafe conditions is an obligation of every person working in the organization. According to the Sentinel Event Alert published March 1, 2017, strong leaders understand that “systemic flaws exist and each step in a care process has the potential for failure simply because humans make mistakes.” These human errors, sometimes referred to as “latent” holes or weaknesses, may be present in any culture of safety.4

The best way to communicate these unsafe conditions is to develop mechanisms that allow identification of safety threats, correction of those threats, and recognition that the threat has been adequately addressed. These actions convey to those working in a health care organization that safety is important in the minds of their leaders.

Preventing future harm
Developing a culture of safety begins with incorporating lessons learned from adverse events and near misses in order to prevent future harm. This
The Joint Commission’s accreditation manual glossary defines a leader as “an individual who sets expectations, develops plans, and implements procedures to assess and improve the quality of the organization’s governance, management, and clinical and support functions and processes.”

Environment does not rely on a punishment model to correct these unsafe conditions or behaviors because most adverse events are related to unintended systems or human failures. This approach does not mean that individuals are not being held accountable for their behaviors, but the focus is on preventing future adverse events rather than punishment.

Failure on the part of leadership to create an effective culture of safety has been identified as a contributing factor to adverse events, such as wrong site surgery and delays in treatment. The March Sentinel Event Alert emphasizes the commitment to a culture of safety as equally important to the resources devoted to financial stability, system integration, and productivity, according to Ana Pujols McKee, MD, executive vice-president and chief medical officer of The Joint Commission.

In addition to contributing to adverse events, an underdeveloped culture of safety leads to adverse outcomes, according to the Joint Commission Center for Transforming Healthcare, including the following:

- Insufficient support of patient safety event reporting
- Lack of feedback or response to staff and others who report safety vulnerabilities

**FIGURE 1. 11 TENETS OF A SAFETY CULTURE**
Failure on the part of leadership to create an effective culture of safety has been identified as a contributing factor to adverse events, such as wrong site surgery and delays in treatment.

- Allowing intimidation of staff who report events
- Refusing to consistently prioritize and implement safety recommendations

Promoting everyday safety
Competent and thoughtful leaders contribute to improvements in safety and organizational culture because they understand that systemic flaws can lead to latent threats to safety and that humans make mistakes. Preventing those mistakes by reinforcing the system and developing ways to recognize and address failures when they happen is the key to a safety culture.

According to a Health Foundation report published in May 2012, a safety culture is supported by leaders who “consistently and visibly support and promote everyday safety measures.” An enduring commitment to a culture of safety is the “product of what is done on a consistent daily basis.” An organization’s commitment to culture should be determined “by what leaders do, rather than what they say should be done.”

To promote consistent, everyday safety measures, The Joint Commission recommends that leaders take specific actions to establish and continuously improve safety culture. These 11 action items, defined by Mark R. Chassin, MD, FACP, MPP, MPH, president and CEO of The Joint Commission, and Jerod M. Loeb, PhD, are described in the March 2017 Sentinel Event Alert (see Figure 1, page 53). These actions include establishing a transparent, nonpunitive approach to reporting adverse events and incorporating safety culture team training into quality improvement projects.4,7

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

REFERENCES
Every second of every day, an older adult falls.* Hip fractures are one of the most serious injuries resulting from falls among elderly patients. Each year, more than 300,000 elderly patients ages 65 and older are hospitalized for hip fractures.† Of these fractures, 95 percent are a result of a same-level fall that usually occurs by falling sideways. Almost three-quarters of hip fractures occur in women, although the chance of breaking one’s hip, regardless of gender, increases with age.‡ These fractures often lead to a loss of physical independence and lower quality of life.

The proximal femur comprises the femoral head, the femoral neck, and the trochanteric region, which includes the greater and lesser trochanters. Three types of hip fractures occur in the trochanteric region. The first type is an intertrochanteric fracture that occurs between the greater and lesser trochanter; the second type is a sub-trochanteric fracture that occurs distal to the trochanters; and the third type of fracture is proximal to the trochanters, called a femoral neck fracture. The femoral neck has a fragile vascular supply and, therefore, is susceptible to poor outcomes of avascular necrosis and nonunion.‡

**Age is a key factor**

Patients with femoral neck fractures fall into one of two evidence-based groups based on their physiologic, rather than their chronologic, age. The “young” patients often sustain injuries as a result of high-energy mechanisms. These young patients may have associated traumatic injuries but have strong physiologic reserves and few comorbidities. Furthermore, their bones can tolerate internal fixation.

On the other side of the spectrum are the “old” or “elderly” patients, who sustain femoral neck fractures as a result of low-energy trauma (same-level falls). These elderly patients present with isolated injuries and have fewer functional demands, poor bone quality, multiple medical comorbidities, and decreased functional reserve. This group

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is more likely to require a hip arthroplasty (replacement).‡

To examine the occurrence of femoral neck fractures, medical records contained in the National Trauma Data Bank® (NTDB®) research dataset for admission year 2015 were searched using the International Classification of Diseases, Ninth Revision, Clinical Modification codes. Specifically searched were records that included a diagnosis code of 820 (fracture of neck of femur).

A total of 67,094 records were found, of which 62,312 contained a discharge status, including 14,859 patients discharged to home, 14,798 to acute care/rehab, and 30,811 sent to skilled nursing facilities; 1,844 died. Of these patients, 62 percent were women, on average 73.6 years of age, had an average hospital length of stay of 6.6 days, an intensive care unit length of stay of 5.4 days, an average injury severity score of 10.5, and were on the ventilator for an average of 5.9 days. Of those tested for alcohol, almost 28 percent (2,447 out of 8,863) tested positive. Most of these injuries (61 percent) occurred in the home and only a minority of patients (approximately one-quarter) were discharged to home (see Figure 1, this page).

Helping patients avoid hip fractures
Elderly adults can avoid hip fractures by taking a few precautions. First, they should take steps to strengthen their bones and prevent falls. This patient group should also ask their physicians to review their medications to see if any may result in sleepiness or dizziness; assess for possible Vitamin D deficiencies; and screen for osteoporosis. Patients should have their vision checked annually.

Elderly patients should be encouraged to make their home safer by eliminating items that could produce a fall, such as loose throw rugs, and by adding grab bars around the tub, shower, and toilet. Installing railings on both sides of all stairs is a great precautionary measure, as is ensuring the living space features adequate lighting. After all, no one wants to fall and break one’s (femoral) neck.

Throughout the year, we will be highlighting these data through brief monthly reports in the Bulletin. The NTDB Annual Report 2016 is available on the American College of Surgeon’s website at facs.org/quality-programs/trauma/ntdb. In addition, information is available on our website about how to obtain NTDB data for more detailed study. If you are interested in submitting your trauma center’s data, contact Melanie L. Neal, Manager, NTDB, at mneal@facs.org.

Acknowledgment
Statistical support for this article was provided by Chrystal Caden-Price, Data Analyst, NTDB.

ACS Board of Regents approves new Foundation officers  

by Sarah B. Klein, MPA

The American College of Surgeons (ACS) Board of Regents approved new officers of the ACS Foundation Board of Directors at the Regents’ February meeting in Chicago, IL. The new officers, who began their two-year terms in February, are Chair Mary H. McGrath, MD, MPH, FACS, professor of surgery, University of California, San Francisco (UCSF); Vice-Chair Charles E. Lucas, MD, FACS, professor of surgery, Wayne State University, Detroit, MI; and Secretary Ruth L. Bush, MD, JD, MPH, FACS, deputy director, the Center for Innovations in Quality, Effectiveness and Safety, a partnership between the Baylor College of Medicine and the Michael E. DeBakey Veterans Affairs (VA) Medical Center, Houston, TX.

Dr. McGrath

Dr. McGrath is a graduate of St. Louis University School of Medicine, MO, and completed her general surgery residency at the University of Colorado Medical Center, Denver. She then trained in plastic surgery at Yale University School of Medicine, New Haven, CT, and has made outstanding clinical and academic contributions to the field of plastic surgery, especially in the areas of breast and hand surgery, wound healing, introduction of new technology, and workforce issues.

Dr. McGrath’s career as an academic surgeon started at Yale in 1978 with a position as assistant professor of surgery in the school of medicine’s division of plastic and reconstructive surgery. In 1980, she attained the position of assistant professor of surgery, division of plastic and reconstructive surgery, Columbia University College of Physicians and Surgeons, New York, NY. In 1984, she moved to the George Washington University Medical Center, Washington, DC, where she began as chief, division of plastic and reconstructive surgery, and director, residency training program, ultimately ascending to professor of surgery. She has held her present position at UCSF since 2003. She has served in many national positions in plastic surgery and is the present president of the American Association of Plastic Surgeons.

A Fellow of the College since 1983, Dr. McGrath has provided exceptional service to the ACS and has served for 25 years in leadership roles, including First Vice-President (2007–2008); Vice-Chair, Board of Regents (2005–2006); member, Executive Committee, Board of Regents (2002–2006); Regent (1997–2006); and Chair, Committee on Ethics (2003–2006). She served on the Board of Governors (B/G) Executive Committee and as a Governor-at-Large representing the District of Columbia.

In 2009, the ACS appointed her to serve on the Board of Commissioners of The Joint Commission. She is
currently serving her third term in this capacity.

For this remarkable record of service, Dr. McGrath received the College’s highest honor, the Distinguished Service Award, in 2011. She received the ACS Foundation’s Distinguished Philanthropist Award in 2016 for her generous contributions to the College and service to the larger philanthropic community.

Dr. Lucas

A native of Detroit, Dr. Lucas has dedicated his surgical career to his hometown. He earned his undergraduate degree from the University of Detroit and his doctor of medicine degree from Wayne State University (WSU). After completing his residency at WSU, he accepted a position on the WSU surgical faculty, specializing in trauma and surgical critical care.

Dr. Lucas conducted his clinical and academic activities at Detroit General Hospital until its closure in 1980. He then moved to the Detroit Medical Center (DMC), practicing at the new Detroit Receiving Hospital (DRH), the Harper University Hospital (HUH), the Hutzel Hospital, and the Karmanos Cancer Hospital. A renowned trauma surgeon, Dr. Lucas was instrumental in securing DRH as the first ACS-verified Level I trauma center in the U.S. He has trained hundreds of medical students and residents, and his research efforts have resulted in the publication of more than 400 peer-reviewed articles, books, and book chapters.

An ACS Fellow since 1970, Dr. Lucas has served in several ACS volunteer roles for more than 35 years, including member, B/G (1984–1990, 1998–2004); President, ACS Michigan Chapter, (1981–1983); and member, Committee on Trauma (1993–2003). He has also been active in a number of surgical organizations, including the American Association for the Surgery of Trauma, American Surgical Association, Central Surgical Association, Midwest Surgical Association, Society of University Surgeons, and Western Surgical Association.

Dr. Bush

Dr. Bush received her doctor of medicine degree from the University of North Carolina School of Medicine, Chapel Hill, in 1992. She completed her general surgery residency at the University of California, Davis, Medical Center, where she also spent two additional years as a vascular research fellow. She then finished her vascular surgery fellowship at Emory University Hospital, Atlanta, GA. Serving in several academic positions over her career, Dr. Bush was most recently vice-dean and professor of surgery at Texas A&M College of Medicine, Bryan, TX.

Dr. Bush has received several research support funding awards to conduct studies on vascular disease and improved treatment and has published broadly on an array of topics. In addition to service on the ACS Foundation Board, Dr. Bush has been a member of the ACS B/G (2007–2010). She is active in several surgical associations including American Venous Forum, Association of Women Surgeons, and the Society for Vascular Surgery. She has been honored with a number of awards, including Distinguished Fellow (2007) and Presidential Citation (2014), Society of Vascular Surgery; Distinguished Fellow (2015), American Venous Forum; and Outstanding Faculty Teaching Awards, Texas A&M College of Medicine in 2014 and 2015. She continues to practice vascular surgery at the Michael E. DeBakey VA Medical Center.

For more information on the ACS Foundation, contact Shane Hollett, ACS Foundation Executive Director, at 312-202-5506 or shollett@facs.org, and visit facs.org/acsfoundation. ♦
Dr. Henri Ford accorded honorary fellowship in RCSEng

Henri R. Ford, MD, MHA, FACS, FAAP, vice-president and surgeon-in-chief, Children’s Hospital Los Angeles; professor of surgery and vice-dean for medical education, Keck School of Medicine, University of Southern California; and member of the American College of Surgeons Board of Regents, was accorded Honorary Fellowship in the Royal College of Surgeons of England (RCSEng) on March 7 in London, U.K.

A world-renowned Haitian-American surgeon, Dr. Ford played a prominent role in organizing and leading medical teams in response to the catastrophic 2010 earthquake in Haiti. Born in Haiti, Dr. Ford regularly returns to his native country to teach, lead operating teams, and assist in developing surgical systems, which the island nation historically has lacked. His accomplishments there are myriad. For example, in May 2015, Dr. Ford led a team of health care professionals that made history by completing the first separation of conjoined twins in Haiti. (Read more about the operation at www.cbsnews.com/news/more-than-just-a-surgery-conjoined-twins-separated-in-haiti/ or at bulletin.facs.org/2015/08/dr-henri-ford-performs-first-separation-of-conjoined-twins-in-haiti/.)

Dr. Ford and his family fled Haiti’s oppressive regime and came to the U.S. when he was 13 years old. He received his medical degree from Harvard Medical School, Boston, MA, and trained in general surgery at Weill Cornell Medical College, New York, NY. He completed his pediatric surgical training at Children’s Hospital of Pittsburgh, PA. Prior to joining Children’s Hospital Los Angeles in 2005, Dr. Ford was professor and chief, division of pediatric surgery, and surgeon-in-chief, Children’s Hospital of Pittsburgh and the University of Pittsburgh School of Medicine.

Su-Anna Boddy, MS, FRCS, council member for the RCSEng, introduced Dr. Ford at the ceremony and spoke of his accomplishments, and Clare Marx, CBE, DL, PRCS, RCSEng president, formally awarded him the honor.

Coming next month in JACS and online now

Personal and professional well-being of surgical residents in New England

Peter S. Yooa, MD, FACS; John J. Tacketta, MD, MHS; Mark W. Maxfielda, MD, MHS; and colleagues found that surgical residents attend to their own preventive health maintenance, finances, sleep, and stress reduction with variable success. Residency programs should make modest programmatic accommodations to allow trainees to tend to various aspects of their personal well-being.

This article and all other JACS content is available at www.journalacs.org.
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 February 11–12 at the College’s headquarters in Chicago, IL. The following is a summary of their discussions and actions.

**ACSPA**
As of February 9, the ACSPA political action committee (ACSPA-Surgeons PAC), raised a total of $1,081,165 from more than 2,100 College members and staff. In addition, the Surgeons PAC has disbursed more than $1,044,000 to more than 200 congressional candidates, leadership PACs, and party committees. In line with congressional party ratios, 59 percent was given to Republicans and 41 percent to Democrats.

**ACS**
In addition to reviewing reports from the ACS division directors, the B/R reviewed and approved new policy statements on the following:

- 2017 ACS Statement on Principles on Health Care Reform (see page 36 of this issue)
- Statement on the Use of General Anesthetics and Sedation Drugs in Young Children

and Pregnant Women (see page 39, April Bulletin).

**Division of Education**
The Board of Regents approved the continuation of the Surgical Education and Self-Assessment Program (SESAP®) for another three-year cycle. The Board also approved the ACS Division of Education’s collaboration with the American Society of Colon and Rectal Surgeons to further develop, implement, and evaluate the impact of the Colorectal Objective Structured Assessment of Technical Skill program.

A total of 11,745 surgical professionals attended the Clinical Congress held in Washington, DC, on October 16–20, 2016.

**Division of Integrated Communications**
To further build enthusiasm for the digital version of the Bulletin, the Division of Integrated Communications is launching a marketing campaign to encourage readers to read the monthly publication in one of its online formats. Future plans for the Bulletin website call for revitalizing and reconstructing it to make it more responsive and reader friendly. New features that are under consideration include videos, a running news feed, and an open forum. The goal is to make the Bulletin the go-to source of news, information, and commentary for members of the College. To further assist the division in determining what today’s Bulletin readers want and need, a survey will be conducted in the spring.

**Media coverage highlights for 2016**
Media coverage of the landmark findings from the Flexibility in Duty Hour Requirements for Surgical Trainees (FIRST) Trial began February 2, 2016, when results were published in the New England Journal of Medicine and presented concurrently at the 2016 Academic Surgical Congress. The key takeaway message from this first national randomized trial of resident duty hours was that flexible, less restrictive duty hour policies are safe for patients, reduce handoffs, and lead to greater resident satisfaction. The Resident and Associate Society of the ACS also released a statement endorsing the study’s findings. The FIRST Trial news story received 2,088 total media mentions in the period from its publication in February to December 2016, and 167 articles mentioned the ACS.

In addition, the ACS media relations team prepared a press release on a study published in the Journal of the American College of Surgeons (JACS) describing the increasing number of patients who would benefit from liver transplant being removed from...
the wait list because they are “too sick to transplant.” Study authors from UMass Memorial Medical Center, Worcester, MA, reported that the CMS quality improvement initiative, called Conditions of Participation, had inadvertently increased removal of the sickest patients from the transplant list. This JACS study showed staying power throughout the year, and continued to get mentioned as media reported on the current CMS transplant policy.

Social media
A total of 2,172 unique discussion contributors posted 15,892 messages across all ACS Communities in 2016, a year in which nearly 908,000 web pages were viewed by the 25,000-plus members who have agreed to the site’s terms of use. More than 11,000 members have now uploaded their profile photos. Hot topics of discussion in 2016 included surgical attire, reapplications and privileges, robotic surgery, the Medicare Access and CHIP (Children’s Health Insurance Program) Reauthorization Act, and Maintenance of Certification reporting.

facs.org
The College’s public-facing website, facs.org, remains the go-to place for members seeking to stay up to date on College programs and initiatives and to conduct business tasks such as paying their dues. Website traffic increased in 2016 from the previous year. The annual comparison is as follows:

- Total page views—
  + 10.62 percent (8,926,044 versus 8,069,243 in 2015)

- Unique page views—
  + 9.01 percent (6,257,698 versus 5,722,188 in 2015)

- Average time on a page—
  + 4.24 percent (00:01:31 versus 00:01:28 in 2015)

  An online guide for first-time Clinical Congress attendees was developed to help them get the most out of their initial experience. In fall 2016, a series of new informational videos were added online in the Advocacy section to help surgeons prepare for proposed changes to the physician payment system.

  In January, the website was enhanced to include a store. The store carries a choice of Bleeding Control (BCon) Kits for purchase that carry the branding of the College, the ACS Committee on Trauma (COT), and the Hartford Consensus. Also in January, the website opened an Instructor Portal, built collaboratively by the COT and Informational Technology, to allow certified instructors to post their BCon classes on the site for public viewing and registration. Since the website’s launch, it has had more than 80,000 visitors.

Division of Member Services
The B/R accepted resignations from seven Fellows: one cardiothoracic, two general, one neurological, one ophthalmic, one pediatric, and one plastic and reconstructive surgeon. The B/R also approved a change in status from Active (dues paying) to Retired for 112 Fellows, and from Senior (non-dues paying) to Retired for 15 Fellows, for a total of 127 Fellows.

The Board of Regents approved an addition to the International Fellowship requirements, which mandates an interview with all international applicants for Fellowship beginning in 2018.

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 777 hospitals participate in the ACS National Surgical Quality Improvement Program (ACS NSQIP®), 677
of which participate in the adult option. Following is the breakdown of participating sites by ACS NSQIP category:

- **Essentials**: 312
- **Pediatric**: 100
- **Procedure Targeted**: 294
- **Small and Rural**: 71

Over the past 12 months, ACS NSQIP enrollment has grown 12 percent.

**MBSAQIP**
A total of 826 surgery centers participate in the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP)—744 which are fully accredited, and 48 of which are initial applicants. The remaining 34 are data collection centers that were originally American Society for Metabolic and Bariatric Surgery provisional centers that chose to continue with data entry, but did not complete the process to meet full accreditation status.

**Cancer Programs**
A total of 1,508 cancer centers are accredited by the Commission on Cancer.

**COT**
As of January 18, 670 hospitals were participating in the Trauma Quality Improvement Program (TQIP®), broken down as follows:

- **Adult TQIP**: 547 program participants
- **Pediatric TQIP**: 123 program participants

As of September 20, 2016, a total of 432 hospitals have ACS COT verification, broken down as follows:

- **Adult COT verified enters**: 344
- **Pediatric COT verified centers**: 30
- **Combined Adult & Pediatrics centers**: 58 combined facilities

**NAPBC**
Interest in National Accreditation Program for Breast Centers (NAPBC) accreditation remains strong both within the U.S. and internationally. More than 600 U.S. centers have NAPBC accreditation, and the NAPBC has received approximately 50 new applications for 2017 to date. Reaccreditation rates for 2017 remain at more than 95 percent. NAPBC accredits three international centers in Abu Dhabi, UAE; Johannesburg, South Africa, and Toronto, ON.

**ACS Foundation**
The ACS Foundation had a strong year in its mission to obtain financial support for the philanthropic and educational work of the College. Thanks to the generous support of Fellows and friends of the College, contributions in 2016 increased 11 percent from the previous years. Examples of the Foundation’s support in 2016 include the following:

- **Modest Annual Giving Campaign**
- **$165,000 surgical skills courses**
- **$821,616 for Opioids—Physician/patient Education Program**
- **$12,150,000 for John H. Hartford Foundation, Agency for Healthcare Research and Quality Comprehensive Unit-Based Safety Program, and hospital-acquired infections data collection**
- **A shift to a major gifts focus ♦**
The Surgical History Group (SHG) of the American College of Surgeons (ACS) is calling for abstract submissions for Clinical Congress 2017, which will take place in San Diego, CA, October 22–26, 2017.

Now in its third year, the SHG invites surgeons, residents, Fellows, and medical students to submit abstracts for consideration in this year’s dedicated poster session. **Topics should be of historical significance** to the field of surgery or surgical subspecialty, including medical discoveries, technology, techniques and treatment methods, events, and the personalities that shaped the field of surgery as we know it.

SUBMIT YOUR ABSTRACT BY JUNE 1, 2017

For more information, visit [facs.org/about-acs/archives/shg](http://facs.org/about-acs/archives/shg).
I was fortunate to be chosen as the American College of Surgeons (ACS) Traveling Fellow to Germany in 2016, and I thank both the ACS and the German Society of Surgery for this wonderful educational and cultural opportunity. I would especially like to thank Tobias Keck, MD, FACS, director and surgeon-in-chief, Universität zu Lübeck; Norbert Senninger, MD, FACS, director, clinical for general and visceral surgery, Universitätsklinikum Münster; Frau R. Nowoiski, MD; and Gabriele Schackert, MD, for their assistance in organizing and planning my two-week trip to Germany.

The primary goal of my fellowship was to learn about the German surgical training system and the approach used there to surgically treat hepatopancreatobiliary malignancies. I also wanted to attain a better understanding of a nation that is a leading economic power with a rich cultural history, and the seventh-most visited country in the world.*

I brought my wife, Jane, and my three daughters on this once-in-a-lifetime trip. I wanted my family to share in the experience and broaden their own view of the world through international travel.

**Berlin**

My first stop was the 133rd Congress of the German Society of Surgery, April 26–29, 2016, in Berlin. On the first day of the meeting, I attended a joint session between the German and New Jersey Chapters of the ACS moderated by Drs. Senninger and Lewis Wetstein, MD, FACS, a thoracic and cardiovascular surgeon, Freehold, NJ. Dr. Keck started the session with a presentation on the benefits of ACS Fellowship for European surgeons and recounted his experiences as the German Traveling Fellow to the U.S. in 2008. He visited several medical centers that specialize in pancreatic surgery and became interested in learning how to perform a laparoscopic Whipple. Albert Tuchmann, MD, FACS, a vascular surgeon, Vienna, Austria, and Adam Dziki, MD, FACS(Hon), from Poland, also shared their experiences regarding involvement in ACS chapters. The session ended with members of the New Jersey Chapter of the ACS giving talks on adrenal incidentalomas and the changing paradigm of surgical management for perforated diverticulitis. It made for an interesting exchange of ideas and perspectives from European and U.S. surgeons about the challenges and rewards of international collaboration in surgery.

The next day I gave a presentation titled Bile Duct Surgery in the Treatment of Hepatobiliary and Gallbladder Malignancies: Effect of Hepatic and Vascular Resection on Outcomes. This was a

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outcomes-based analysis of the 2012 ACS National Surgical Quality Improvement Program Participant Use File showing increased morbidity and mortality when hepatic and vascular resection were performed for hilar cholangiocarcinoma and gallbladder cancer. Later that day my family and I ran in a 10 kilometer race sponsored by the German Surgical Society to promote organ donation.

On the third day of the Congress, I attended the Member Assembly meeting of the German Society of Surgery to receive a certificate of scholarship. I met with Gabriele Schackert, MD, President of the German Society of Surgery, and was truly honored to be recognized.

Afterward, I visited the Charité Campus Virchow-Klinikum, and met with Johann Pratschke, MD, FACS, chairman, department of general, visceral, and transplantation surgery. We discussed the economics of running a clinical department of surgery and the need to maintain a positive balance sheet. He introduced me to Moritz Schmelzle, MD, chief of hepatic surgery, who took me to the operating room (OR) to observe a donor organ harvest of pancreas and liver. Dr. Schmelzle then invited me to scrub with him on an extended left heptectomy for a patient with a large symptomatic hemangioma. Dr. Schmelzle performed the operation expertly using the cavitron ultrasonic surgical aspirator device. When I asked him why he did not use any vascular staplers during the case, he said that for open hepatic resections their department does not use staplers in order to keep costs down, but they do use them for laparoscopic resections.

We discussed his research interests in the role of stem cells in liver regeneration, as well as his work in treating patients with advanced colorectal liver metastases with two-stage heptectomy. At his institution, surgeons perform portal vein embolization between cycles of chemotherapy so that no time is lost waiting for liver hypertrophy. He also explained the German model of medical training, which includes medical school and residency training, and individual training that may vary in length and content depending on a surgeon’s interests and the availability of training opportunities.

On the last day of the Congress, I attended a video session on Oncologic Visceral Surgery. I heard Jurgen Weitz, MD, chair, department for visceral, thoracic, and vascular surgery, University Hospital in Dresden, speak on Stapler Hepatectomy: Tips and Tricks. He discussed the anatomic variations in portal vein, bile duct, and hepatic artery anatomy and the challenges these differences present for hepatic resection. Dr. Weitz then showed a video of a right heptectomy using the stapler technique.

Dr. Pratschke presented a video on Laparoscopic Hemihpatectomy: Tips and Tricks, showing his method of extra-hepatic vascular control and then subsequent parenchymal transection using the stapler technique. Both videos were informative and well-produced.

During my time in Berlin, I was able to spend some time touring the city and found the architecture and cosmopolitan atmosphere impressive, especially in light of the fact that 75 percent of the city had been destroyed during World War II. The Holocaust Memorial was a powerful reminder of that dark chapter in German history, but the honesty and transparency of the exhibit were impressive. It is a fitting tribute to those who were killed during this period.
We visited the Berlin Wall and met a taxi driver who was 13 years old when the wall came down. His emotional retelling of the event was truly memorable.

Lübeck
Next, we traveled to Lübeck, a quaint city known for its coastal atmosphere and world-famous marzipan.

My wife and I had dinner with Dr. Keck and his wife, a gynecologist. Over dinner, we discussed Dr. Keck’s experience as an ACS Traveling Fellow to the U.S in 2008. He spoke about his experiences as a new chairman and how he expanded the pancreatic surgery program at his medical center from 17 pancreatic resections per year to more than 100. I also learned about his family and the challenges of maintaining work-life balance for someone in his position.

Dr. Keck took me to the surgical morning report at the medical center, during which the operations performed over the weekend were discussed. I then gave grand rounds on the Wake Forest experience with hyperthermic intraperitoneal chemotherapy (HIPEC) and cytoreductive surgery (CRS) for peritoneal disease from colorectal cancer in comparison with liver resection for colorectal hepatic metastases. Our data demonstrated similar outcomes for these two procedures, suggesting similar tumor biology for these patients. The talk was well received and I was asked numerous questions about the role of HIPEC and CRS for metastatic colorectal cancer and indications/contraindications for surgery.

Afterward, I spent some time with Dr. Keck discussing the biobanking system he has developed in his department and the integration of research data with the electronic health record. This approach allows patients to be identified through an automated screening process for potential clinical trials.

Jens Habermann, MD, head of the section on translational surgical oncology, gave me a tour of the proteomics lab, and in the afternoon I scrubbed in with Dr. Keck on a total gastrectomy with D2 lymph node dissection for gastric cancer.

The following day, I obtained firsthand experience with the medical center’s three state-of-the-art biospecimen storage and retrieval systems. The complexity and automation of these machines were impressive. I then went to the OR and scrubbed in on a distal pancreatectomy and splenectomy with chief consultant privatdozent (PD) Dirk Bausch, MD.

Heidelberg
I visited the Heidelberg University Hospital, where I met Prof. Dr. med. Alexis Ulrich, MBA, vice-chairman, department of surgery. We discussed the German model of surgical training and the team approach that the surgical department uses. Essentially, the chair and vice-chair see patients and assign operative cases to the

We discussed Dr. Schmelzle’s research interests in the role of stem cells in liver regeneration, as well as his work in treating patients with advanced colorectal liver metastases with two-stage hepatectomy.
oberärzte (consultant surgeons with special expertise) in the department. The oberärzte operate five days a week. Though the consultant surgeons visit their patients on the wards a couple times a week, a separate team of residents that is supervised by another attending surgeon has primary responsibility for the day-to-day management and discharge of postoperative patients. Dr. Ulrich stressed that the team approach in German surgery departments makes for close working relationships among surgeons, improved efficiency, and better use of resources, time, and the workforce.

The weekly morbidity and mortality conference focused on adverse events from the previous week of operations. After the discussion, I visited the operating suites, where I met PD Dr. med. Oliver Strobel and scrubbed in on a Whipple resection for pancreatic cancer with intraductal papillary mucinous neoplasm, which turned into a total pancreatectomy due to a positive neck margin.

Professor and chairman Markus Büchler, MD, FACS, joined us for this case. Dr. Büchler told me about the University of Heidelberg department of surgery and the vast clinical and research enterprise he leads there. We briefly discussed the controversial role of radiation therapy for pancreatic cancer and the different approaches used in the U.S. and Europe. Dr. Büchler showed me around the operating suites and the multiple pancreatic and hepatobiliary operative cases going on at the same time, highlighting the high surgical volume of his department. I also observed a segment six partial hepatectomy for hydatid disease performed by PD Dr. med. Arianeb Mehrabi. Though rare in the U.S., echinococcal disease is endemic in parts of Germany.

Heidelberg is a beautiful city, and my family and I were able to visit the Castle (Schloss) Heidelberg, a famous landmark, and the University of Heidelberg Student Prison (Studentenkarzer), which housed academic miscreants in the 16th century.

An exceptional experience
After two wonderful weeks in Germany, I can say the ACS Traveling Fellowship exceeded my expectations on all accounts. All the surgeons I met openly welcomed me to their respective institutions, and I learned something from all of them. Hopefully, I returned the favor through my research presentation and grand rounds talk. Although I saw differences in technique and methods of training, I felt a common bond with my hosts as physicians committed to patient care through surgery and research.

I again want to thank the ACS and the German Society of Surgery for this opportunity and experience. It has affirmed my commitment to medicine and expanded my view of surgery on a global stage. I will always remember my time as a Traveling Fellow to Germany with honor and gratitude.

♦

SCHOLARSHIPS
SCHOLARSHIPS

Community Surgeons Travel Awards available for 2018

The International Relations Committee of the American College of Surgeons (ACS) has announced the availability of 2018 travel awards for surgeons 30–50 years old. All applications and supporting documentation must be received by the International Liaison by July 5, 2017, in order for an applicant to receive consideration by the selection committee.

These awards, in the amount of $4,000 each, provide international surgeons with the opportunity to attend and participate fully in the educational activities of the annual ACS Clinical Congress. They are proposed to specifically assist surgeons who work in community or regional hospitals or clinics in countries other than the U.S. and Canada, or who are from poorly resourced academic departments of surgery in low-income countries.

Each awardee will receive gratis registration to the Clinical Congress and to one Postgraduate Course offered at the meeting. Assistance will be provided to obtain preferential housing in an economical hotel in the Clinical Congress city. In 2018, the Clinical Congress will take place October 21–25 in Boston, MA.

• Are graduates of schools of medicine who have completed their surgical training.
• Ages 30–50 years old on the date that the application is filed.
• Submit their applications from their intended permanent location.
• Are in surgical practice, teaching, or research for at least one year at their intended permanent location, following completion of all formal training (including fellowships and scholarships).
• Show evidence of commitment to high-quality surgery, to surgical teaching, and to improving access to surgical care in their community.
• Submit a fully completed application form via the ACS website. The application and accompanying materials must be submitted in English; submission of a curriculum vitae only is unacceptable.
• Preference will be given to applicants who have not already experienced training or surgical fellowships in the U.S. or Canada.
• Submit independently prepared letters of recommendation from three colleagues. One letter must be from the chair of the department in which they hold a clinical or academic appointment or from a Fellow of the ACS in their country. The letter should directly address the applicant's commitment to high-quality surgery, surgical teaching, and improving access to surgical care locally. Letters of recommendation should be submitted by the authors.

The Community Surgeons Travel Awards must be used in the designated year. They cannot be postponed. Awardees are expected to provide a written report upon their return home, specifically focusing on the value of the visit to the awardee and the potential beneficial effect for patients in the country of origin.

Unsuccessful applicants may reapply only twice and only by completing and submitting a new application together with new supporting documentation. The application is available online at facs.org/member-services/scholarships/international/communitytravel. Supporting materials and questions should be directed to the International Liaison at kearly@facs.org or via fax at 312-202-5021.

All applicants will be notified of the selection committee’s decision in November 2017. Applicants are urged to submit their completed applications and supporting documents as early as possible to provide sufficient time for processing.
The American College of Surgeons (ACS) offers International Guest Scholarships to young surgeons from countries other than the U.S. or Canada who have a demonstrated interest in teaching and research. Completed applications and all supporting documentation for the International Guest Scholarships for the year 2018 must be received at the office of the International Liaison Section by July 5, 2017.

The scholarships, in the amount of $10,000 each, provide scholars with an opportunity to visit clinical, teaching, and research activities in the U.S. and Canada and to attend and participate fully in the educational opportunities and activities of the ACS Clinical Congress.

This scholarship endowment was originally provided through the legacy that Paul R. Hawley, MD, FACS(Hon), former ACS Director, left to the College. More recently, gifts from the family of Abdol Islami, MD, FACS, the Stavros Niarchos Foundation, and other donors to the International Guest Scholarship endowment have enabled the College to expand the number of awards.

Requirements for applicants and awardees
Applicants must meet the following criteria:

- Are graduates of schools of medicine who have completed their surgical training.
- Ages 35–50 years old on the date that the application is filed.
- Submit their applications from their intended permanent location.
- Have been in surgical practice, teaching, or research for at least one year at their intended permanent location, following completion of all formal training (including fellowships and scholarships).
- Demonstrate a commitment to teaching and/or research in accordance with the standards of the applicant’s country.
- Early careerists are deemed more suitable than those who are serving in senior academic appointments.
- Preference may be given to applicants who have not already experienced training or surgical fellowships in the U.S. or Canada.
- Submit independently prepared letters of recommendation from three of their colleagues. One letter must be from the chair of the department in which they hold an academic appointment or a Fellow of the ACS in their country. The chair’s or the Fellow’s letter should include a statement detailing the nature and extent of the teaching and other academic involvement of the applicant. Letters of recommendation should be submitted by the person making the recommendation.

The online application form, available at web2.facs.org/scholarshipsinternational/, is structured to assist the Scholarship Selection Subcommittee and to assist the applicant in submitting structured curriculum vitae.

The International Guest Scholarships must be used in the designated year for which they are designated. They cannot be postponed. Applicants who are awarded scholarships will provide a full written report of the experiences provided through the scholarships upon completion of their tours.
The scholarships, in the amount of $10,000 each, provide scholars with an opportunity to visit clinical, teaching, and research activities in the U.S. and Canada and to attend and participate fully in the educational opportunities and activities of the ACS Clinical Congress.

Unsuccessful applicants may reapply only twice and only by completing and submitting a new application together with new supporting documentation. The scholarships provide successful applicants with the privilege of participating in Clinical Congress 2018, October 21–25, in Boston, MA, with public recognition of their presence. They will receive gratis admission to selected postgraduate courses plus admission to all lectures, demonstrations, and exhibits. Assistance will be provided in arranging visits following the Clinical Congress to various clinics and universities of their choice.

Supporting materials and questions should be directed to International Liaison Section, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211; or to the International Liaison at kearly@facs.org or via fax at 312-202-5021.

All applicants will be notified of the selection committee’s decision in November 2017. Applicants are urged to submit their completed applications and supporting documents as early as possible to provide sufficient time for processing.

Applications for 2018 Alliance Scholar Awards accepted through June 30

The Alliance for Clinical Trials in Oncology Foundation is accepting applications for the 2018 Alliance Scholar Awards. Applications must be submitted by 12:00 midnight (CST) on June 30. Alliance Scholar Award applicants must be oncology junior faculty at Alliance institutions within five years of training (rank below associate professor) and have completed training in an oncology clinical specialty (medical, surgical, radiation, gynecologic, and so on). Additionally, proposals must include a letter of support from the appropriate Alliance Scientific Committee Chair to ensure the proposal is closely tied to the Alliance’s research agenda.

Alliance Scholar Award recipients will receive a two-year, non-renewable cancer research grant of $40,000 in direct costs per year, plus 10 percent in indirect costs for each of the two years. Successful applicants will be announced at the plenary session at the 2017 Alliance Fall Group Meeting held in Chicago, IL, November 2–4. Funding will begin approximately January 1, 2018. For application requirements and the link to the online submission portal, visit the Alliance Scholar Awards page on the Alliance website at bit.ly/1QkJipN.

The Alliance/American College of Surgeons Clinical Research Program offers opportunities for surgeons to become involved in the research and development of evidence-based practices in surgical oncology. If you would like to participate in oncology clinical research or oncology-related projects, contact clinicalresearchprogram@facs.org.
The new QI conference that brings together staff from all surgical areas to share experiences and learn.

Register today!

facs.org/QualitySafetyConference
**MEETINGS CALENDAR**

## Calendar of events

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

### MAY

**Biennial Meeting of the Israeli Surgical Society**  
May 9–11  
Kfar Blum, Israel  
Contact: Dr. Joseph Klausner,  
Klausner.joseph@tlvmc.gov.il

**Australia and New Zealand Chapter**  
May 10  
Adelaide, South Australia  
Contact: Rowena Bentley,  
Rowena.Bentley@surgeons.org

**2017 ACS Surgical Coding Workshop**  
May 11–12  
Oakbrook, IL  
Contact: Jan Nagle, jimgdata@aol.com

**Turkey Chapter**  
May 11–12  
Ankara, Turkey  
Contact: Dr. Mehmet Haberal,  
rectorate@baskent.edu.tr

**West Virginia Chapter**  
May 11–13  
White Sulphur Springs, WV  
Contact: Sharon Bartholomew,  
wvacs1@gmail.com

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

**Colombia Chapter**  
May 14–17  
Bogota, Colombia  
Contact: Dr. William Sanchez  
Maldonado,  
sanchez.william@cable.net.co

**Michigan Chapter**  
May 17–19  
Boyn Falls, MI  
Contact: Carrie Steffen,  
carrie@michiganacs.org,  
www.michiganacs.org

**Illinois Chapter**  
May 18–20  
Champaign, IL  
Contact: Luann White,  
lwhite26@gmail.com,  
www.ilchapteracs.org

**Maine Chapter**  
May 19–21  
Bar Harbor, ME  
Contact: Gordon Smith,  
gsmith@mainemed.com,  
www.mainefacs.org

**Missouri Chapter**  
May 19–21  
Lake Ozark, MO  
Contact: Denise Boland,  
MissouriChapterACS@gmail.com,  
www.moacs.org

**Jamaica Chapter**  
May 20  
Kingston, Jamaica  
Contact: Dr. David Hunter,  
davhunter@hotmail.com

**Metro Philadelphia Chapter**  
May 22  
Philadelphia, PA  
Contact: Lauren Newmaster,  
lnewmaster@pamedsoc.org

**Rhode Island Chapter**  
May 22  
Providence, RI  
Marc Bialek,  
mbialek@rimed.org,  
www.riacs.org

**Eastern Long Island Chapter**  
May 23  
Smithtown, NY  
Contact: Laura Dinardo,  
lauradinardo@stonybrookmedicine.edu

**Greece Chapter**  
May 26–27  
Athens, Greece  
Dr. Pantelis Vassilu,  
pant_greek@hotmail.com

### FUTURE CLINICAL CONGRESSES

2017  
October 22–26  
San Diego, CA

2018  
October 21–25  
Boston, MA

2019  
October 27–31  
San Francisco, CA