# Contents

## FEATURES

**COVER STORIES:** Federal legislative priorities

ACS pushes forward on federal legislative priorities

Justin Rosen

Using advocacy to advance ACS policy priorities for surgeons and their patients

Justin Rosen, Katie Oehmen, and Michael Carmody

ACS Chapter Lobby Days Program: Surgeons work the halls of state capitols to advocate for the profession

Christopher L. Johnson

Acute care surgery’s role in expanding the surgical workforce in Latin America

Gregory Peck, DO, FACS; David Blitzer, MD; Marissa A. Boeck, MD, MPH; Marc de Moya, MD, FACS; Paula Ferrada, MD, FACS; Rodrigo Vaz Ferreira, MD; Vicente Gracias, MD, FACS; John G. Meara, MD, DMD, MBA, FACS; Marcelo Ribeiro, Jr., MD, MSc, PhD, FACS; Edgar Rodas, MD, FACS; Joseph V. Sakran, MD, MPH, MPA, FACS; Mary E. Schroeder, MD, FACS; Ana Milena Del Valle, MD; Tanya Liv Zakrison, MD, MPH, FACS

International volunteerism:

Dr. Zalamea leads collaborative mission in the Philippines

Brittanie Wilczak, MPH

The Global Tracheostomy Collaborative:

Multidisciplinary quality improvement in tracheostomy care

David Roberson, MD, FACS, FRCS, and Gerald B. Healy, MD, FACS, FRCS(Hon), FRCSI(Hon)
Contents continued

COLUMNS

Looking forward 9
David B. Hoyt, MD, FACS

What surgeons should know about...
Alternative Payment Models 47
Matthew Coffron, MA

ACS NSQIP best practices case studies: Preoperative smoking cessation: Every patient, every operation 50
Paul Preston, MD; Efren Rosas, MD, FACS; and Tammy Peacock, RN

From residency to retirement: Surgical training, global surgery, and a generally applicable training model 54
Margareta Berg, MD, PhD

ACS Clinical Research Program: ACS CRP sponsors educational sessions at Clinical Congress 2017 58
Amanda Francescatti, MS; Judy C. Boughey, MD, FACS; Y. Nancy You, MD, FACS; and Kelly K. Hunt, MD, FACS

From the Archives: The covert operations performed on President Grover Cleveland 60
John D. Ehrhardt, Jr., and J. Patrick O’Leary, MD, FACS

A look at The Joint Commission:
The Joint Commission releases new measures for hip and knee replacement operations 62
Carlos A. Pellegrini, MD, FACS, FRCSI(Hon), FRCS(Hon), FRCSEd(Hon)

NTDB data points: Gone retroviral:
Trauma and HIV 64
Richard J. Fantus, MD, FACS

NEWS

Richard J. Finley, MD, FACS, FRCSC, to receive Distinguished Service Award 66
Surgeons honored for volunteerism and humanitarianism 68
Matthew Fox

ACS releases quality and safety manual 75

Official notice: Annual Business Meeting of Members, American College of Surgeons 75
Dr. Jo Buyske to serve as next ABS executive director 76

OGB convenes informational meetings at Clinical Congress 2017 76

Dr. Britt awarded NIH grant to develop strategies to address health care disparities 77

Coming next month in JACS and online now 77

Members in the news 79

Report on ACSPA/ACS activities, June 2017 83
Diana L. Farmer, MD, FACS, FRCS

Register for ACS TQIP Conference November 11–13 in Chicago 87

SCHOLARSHIPS

ACS ANZ Traveling Fellow reports on experience at Australian trauma centers 88
Clay Cothren Burlew, MD, FACS

Applications for international 2019 ACS Traveling Fellowships due November 15 93

2018–2020 Faculty Research Fellowships available 95

Apply for 2018 ACS/ASBrS International Scholarship 97

MEETINGS CALENDAR

Calendar of events 100
Letters to the Editor should be sent with the writer’s name, address, e-mail address, and daytime telephone number via e-mail to dschneidman@facs.org, or via mail to Diane S. Schneidman, Editor-in-Chief, Bulletin, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611. Letters may be edited for length or clarity. Permission to publish letters is assumed unless the author indicates otherwise.
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Medical Director, Trauma
Author bios*

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

**DR. BERG** (a) is consultant orthopaedic surgeon, adjunct university lecturer, Luleå University of Technology, Institution of Health Sciences, Sweden, and founder of the Surgicon Project.

**DR. BLITZER** (b) is a general surgery resident, MedStar Union Memorial Hospital, Baltimore, MD.

**DR. BOECK** (c) is a chief general surgery resident, New York Presbyterian Hospital, Columbia University, New York, NY.

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

**DR. BURLEW** (e) is professor of surgery; director, surgical intensive care unit; and program director, surgical critical care and trauma and acute care surgery fellowships, department of surgery, Denver Health Medical Center, University of Colorado.

**MR. CARMODY** (f) is a Government Affairs Coordinator, ACS Division of Advocacy and Health Policy, Washington, DC.

**MR. COFFRON** (g) is Manager, Policy Development, ACS Division of Advocacy and Health Policy.

**DR. DEL VALLE** (h) is a general surgeon, fellow of trauma surgery and acute critical care, Hospital de Rancagua, Santiago, Chile.

**DR. de MOYA** (i) is chief, division of trauma, acute care surgery, Medical College of Wisconsin/Froedtert Trauma Center, Milwaukee.

**MR. EHRHARDT** (j) is a medical student, Florida International University Herbert Wertheim College of Medicine, Miami.

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

DR. FARMER (l) is a pediatric surgeon, Pearl Stamps Stewart Professor and chair, department of surgery, University of California, Davis, Health System, Sacramento. She is Chair, ACS Board of Governors.

DR. FERRADA (m) is associate professor of surgery and director, surgical critical care fellowship program, Virginia Commonwealth University (VCU) School of Medicine; and medical director, surgical and trauma intensive care unit, VCU Health System, Richmond, VA. She is a Councilor of the Young Fellows Association (YFA) of the ACS, and President, Virginia Chapter of the ACS.

DR. VAZ FERREIRA (n) is assistant professor, Faculdade de Medicina, Universidade do Estado do Amazonas, Manaus, Brazil.

MR. FOX (o) is News Editor, ACS Division of Integrated Communications, Chicago, IL.

MS. FRANCESCATTI (p) is Senior Manager, ACS CRP, Cancer Programs, Division of Research and Optimal Patient Care, Chicago, IL.

DR. GRACIAS (q) is senior vice-chancellor, clinical affairs, Rutgers Biomedical Health Sciences, president and chair of Rutgers Health Group, and professor of surgery, Rutgers University Robert Wood Johnson Medical School, New Brunswick, NJ.

DR. HEALY (r) is Emeritus Gerald B. Healy Chair in Otolaryngology, Boston Children’s Hospital, MA, and professor of otology and laryngology, Harvard Medical School, Boston. He is a Past-President of the ACS.

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Author bios continued

DR. HUNT (s) is Hamill Foundation Distinguished Professor of Surgery in honor of Dr. Richard G. Martin, Sr., and chair, department of breast surgical oncology, University of Texas MD Anderson Cancer Center. She is Program Director, ACS CRP.

MR. JOHNSON (t) is State Affairs Associate, ACS Division of Advocacy and Health Policy.

DR. MEARA (u) is director, Program in Global Surgery and Social Change, Harvard Medical School; chair, department of plastic and oral surgery, Boston Children’s Hospital; and co-chair, The Lancet Commission on Global Surgery.

DR. MEJIA TORO (v) is assistant professor of surgery, trauma, and acute care surgery, Universidad de Antioquia, Pablo Tobon Uribe Hospital, and Hospital Universitario San Vicente Fundación, Medellin, Colombia.

MS. OEHMEN (w) is an ACS Professional Association-SurgeonsPAC and Grassroots Manager, ACS Division of Advocacy and Health Policy.

DR. O’LEARY (x) is executive associate dean of clinical affairs and assistant vice-president for strategic planning, Florida International University Herbert Wertheim College of Medicine, Miami.

DR. PECK (z) is assistant professor of surgery, associate director of trauma program, performance improvement, and acute care surgery fellowship, Rutgers Robert Wood Johnson Medical School. He is a member of the ACS YFA and Education Workgroup.

MS. PEACOCK (y) is surgical outcomes improvement manager, Kaiser Permanente Northern California Regional Offices, Oakland.

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

continued on next page
Author bios continued

DR. PRESTON (bb) is senior physician, Permanente Medical Group, and safety lead, Kaiser Foundation Hospital, San Francisco, CA.

DR. RIBEIRO (cc) is professor of surgery, division of general and trauma surgery, Universidade Santo Amaro–UNISA, São Paulo, Brazil. He is general secretary, Sociedade Brasileira de Atendimento Integrado ao Traumatizado.

DR. ROBERSON (dd) is associate in otolaryngology, department of otolaryngology and communication enhancement, Boston Children’s Hospital, and associate professor, department of otology and laryngology, Harvard Medical School.

DR. RODAS (ee) is associate professor of surgery, division of acute care surgery, Virginia Commonwealth University School of Medicine, Richmond.

DR. ROSAS (ff) is a surgeon, Kaiser Permanente Northern California, San Jose.

MR. ROSEN (gg) is Congressional Lobbyist, ACS Division of Advocacy and Health Policy.

DR. SAKRAN (hh) is assistant professor of surgery, Johns Hopkins University, Baltimore, MD, and a member of the YFA ACS Governing Council.

DR. SCHROEDER (ii) is assistant professor of surgery, George Washington University, Washington, DC.

MS. WILCZAK (jj) is Program Administrator, Operation Giving Back, ACS Division of Member Services, Chicago.

DR. YOU (kk) is associate professor, section of colorectal surgery, department of surgical oncology, and medical director, Familial High-Risk Gastrointestinal Cancer Clinic, University of Texas MD Anderson Cancer Center, Houston. She is Vice-Chair, ACS CRP Education Committee.

DR. ZAKRISON (ll) is associate professor of surgery, University of Miami. She is a trauma surgeon and surgical critical care intensivist, Ryder Trauma Center, Jackson Memorial Hospital, Miami, FL.
The Program Committee and the staff of the American College of Surgeons (ACS) have done a superb job of creating a Clinical Congress program that Fellows and other members will find beneficial in their efforts to Do What’s Right for the Patient—the theme Courtney M. Townsend, Jr., MD, FACS, ACS President, selected for the conference. Clinical Congress 2017, October 22–26, will feature several new elements and activities in addition to the outstanding hands-on and didactic learning opportunities and timely discourse on relevant surgical issues that you’ve come to expect from the annual meeting. Perhaps one of the most exciting new developments this year is that it will be our first time in San Diego, CA.

Educational programming

The Clinical Congress 2017 program covers a range of critical topics across the scope of surgery. A total of 11 Named Lectures, 118 Panel Sessions on leading-edge advances in surgical patient care, 19 Meet-the-Expert Sessions, and 21 Town Hall Meetings were scheduled for presentation at press time. The Martin Memorial Lecture delivered by David R. Williams, MD, a physician astronaut, on leadership and teamwork is sure to be a crowd pleaser. The Martin Memorial Lecture is sponsored by the American Urological Association and will take place immediately after the Opening Ceremony Monday, October 23.

A highlight of this year’s educational program will be the presentation of three Special Sessions. On Monday, ACS Past-President L.D. Britt, MD, MPH, DSc(Hon), FACS, FCCM, FRCS(Eng)(Hon), FRCS(Ed)(Hon), FWACS(Hon), FRCSI(Hon), FCS(SA)(Hon), FRCS(Glasg)(Hon), and Ajit K. Sachdeva, MD, FACS, FRCSC, Director, ACS Division of Education, will provide an overview of the new ACS Academy of Master Surgeon Educators. On Tuesday, we will recognize the 50th anniversary of publication of the first edition of Schwartz’s Principles of Surgery. The author of that landmark text, ACS Past-President Seymour I. Schwartz, MD, FACS, will moderate, and David C. Linehan, MD, FACS, a cancer surgeon at the University of Rochester Medical Center, NY, will co-moderate.

And on Wednesday, we will get an update on the Comparison of Outcomes of Antibiotic Drugs and Appendectomy (CODA) Trial from moderator David R. Flum, MD, MPH, FACS, chief medical officer, UW Medicine, Seattle, WA, and co-moderator Giana Davidzon, MD, MPH, assistant professor, division of general surgery, and associate member, University of Washington Harborview Injury Prevention and Research Center, Seattle.

We continue to make the Scientific Forum more accessible to all attendees. This year, the Scientific Forum will feature the usual oral presentations of outstanding scholarly work by surgical investigators. A new feature of this year’s program, however, is that all scientific posters will be submitted and available for viewing electronically on any mobile device or computer throughout the entire Clinical Congress, and Continuing Medical Education credit will be provided for e-Poster Rounds.

Valerie W. Rusch, MD, FACS, Chair of the Program Committee, Dr. Sachdeva, and I anticipate that you will find Clinical Congress invaluable in your effort to meet the Maintenance of Certification requirements described in last month’s “Looking forward” column, as well as various regulatory and institutional mandates. The ACS designates this live activity for a maximum of 47.5 AMA PRA Category 1™ Credits. Self-Assessment Credits will be available for most Panel Sessions, Postgraduate Courses, and Video-Based Education Sessions, and certificates will be issued to attendees who achieve specific levels of verification through participation in Didactic and Skills Courses.

Member engagement activities

The planners of the Clinical Congress have always sought to engage your mind through educational programming, but over the last few years, they also have sought to engage your body and spirit. This year’s Clinical Congress will feature several wellness events, including 5K running and walking tours of San Diego, a spinning class, and yoga sessions. The cost per program is $10.
Clinical Congress 2017 will feature several new elements and activities in addition to the outstanding hands-on and didactic learning opportunities and timely discourse on relevant surgical issues that you’ve come to expect from the annual meeting. Perhaps one of the most exciting new developments this year is that it will be our first time in San Diego, CA.

ACS Taste of the City is back this year. Participants in this event, which takes place Wednesday night, will experience San Diego’s beautiful waterfront and sunset while networking with colleagues and sampling local cuisine. Bring your family for an evening of live mariachi music, tacos and beverages, fun activities, and camaraderie. The ACS presents this event free of charge to you and your guests, but we ask that you indicate on your registration form whether you plan to attend and how many guests you plan to bring, so we can accommodate everyone.

In addition, Clinical Congress attendees and guests will have an opportunity to engage their sense of altruism through participation in the Feeding San Diego BackPack program. ACS volunteers will decorate 2,500 backpacks and fill them with essential food items for families and children in need. The $25 registration fee for this program will be used to offset the costs of supplies, transportation/distribution, and other overhead costs.

More than a fresh coat of paint
For several decades, the Clinical Congress has featured a Resource Center, where attendees could talk with staff about the products and services that the ACS offers its members. This year, we have re-envisioned and redesigned this area as ACS Central. It still will be where you can meet staff, learn about ACS programs, and purchase ACS products, but it also will be where you will want to go to meet with friends and colleagues, charge your mobile devices, update your Member Profile, and receive a flash drive with your own professional photo.

ACS Central will house the ACS Theatre, where Monday through Wednesday short sessions describing new College programs and products will be presented. ACS leaders also will be on hand in the theater to engage in informal “meet and greet” discussions with attendees.

Sunny San Diego
While in San Diego, I encourage you to learn about the storied history of the “Gibraltar of the Pacific” and its ties to the U.S. Navy and Marine Corps. With its temperate climate, you and your family will want to get out and explore the cageless San Diego Zoo, Balboa Park, and Orange County’s Knott’s Berry Farm and Disneyland. You might also consider taking a ferry to Coronado Island and visit the Hotel Del Coronado—the second-largest wooden structure in the U.S.—or head south of the border to Tijuana, Mexico.

Of course, San Diego County and the surrounding area are home to some of the finest beaches for surfing, sunbathing, and watching the sunset. And San Diego offers countless casual and fine dining options.

See you next month for Clinical Congress 2017, where you will have many opportunities to learn about advances in surgical care and the issues that affect your practice, as well as connect with friends, and take in the Southern California vibe. I am really excited to see all of you in the part of the world I have called home for nearly four decades.

If you have comments or suggestions about this or other issues, please send them to Dr. Hoyt at lookingforward@facs.org.
ACS pushes forward on federal legislative priorities

by Justin Rosen
Since the start of the 115th Congress in January, the American College of Surgeons (ACS) Division of Advocacy and Health Policy (DAHP) has been actively engaged with legislators on Capitol Hill, ensuring that the interests of surgeons and surgical patients are represented during policy debates.

In the first half of 2017, the ACS hosted a Commission on Cancer (CoC) advocacy day; a Committee on Trauma (COT) congressional Stop the Bleed® briefing; and the 2017 Leadership & Advocacy Summit. These events brought hundreds of surgeon-advocates to Washington, DC, to inform members of Congress about the College’s legislative priorities. The ACS is monitoring and advocating for passage of numerous pieces of legislation, including the Ensuring Access to General Surgery Act (H.R. 2906/S. 1351), the Mission Zero Act (H.R. 880/S. 1022), and the Protecting Access to Care Act.

Informing Congress about your priorities

CoC advocacy

The CoC Advocacy Committee held its annual planning meeting followed by a day on Capitol Hill February 16–17. Attendees met with their representatives, senators, and congressional staff to discuss issues that affect cancer patients, survivors, and surgeons. Throughout this event and at the legislative meetings, CoC Advocacy Committee members assisted in boosting the co-sponsorship of bills before Congress and raising the profile of oncological issues on Capitol Hill.

The CoC also participated in two lobby days in March and June through One Voice Against Cancer (OVAC). At these OVAC Lobby Days, participants met with House and Senate appropriators to express support for increases in cancer research funding, including continued support for the Cancer Moonshot initiative.

Specifically, the CoC advocated for $36 billion in funding for the National Institutes of Health for fiscal year (FY) 2018, a $2 billion increase from FY 2017 levels, including $6 billion for the National Cancer Institute. The CoC also requested that Congress fund the Centers for Disease Control and Prevention cancer programs at $514 million in FY 2018.*

COT Stop the Bleed congressional briefing

Leaders of the ACS and the COT hosted a congressional briefing February 28 to highlight the Hartford Consensus and the ACS Stop the Bleed training program. Congressional participants included Rep. Gene Green (D-TX), ranking member of the U.S. House Committee on Energy and Commerce Health Subcommittee, and Rep. Richard Hudson (R-NC), who serves on the same subcommittee. Throughout the briefing, lawmakers and congressional staff had the opportunity to participate in immediate responder simulation in using traditional and nontraditional bleeding control methods until emergency medical services personnel arrive to start the provision of definitive care.

This congressional briefing is a component of the Stop the Bleed advocacy strategy, which aims to train civilians to recognize life-threatening bleeding situations and to intervene effectively to save lives. It is a priority for the ACS to ensure that Stop the Bleed awareness and training become as commonplace as cardiopulmonary resuscitation and the Heimlich maneuver.

As the College continues to advocate and promulgate the program, the DAHP continues to meet with congressional leaders to get their assistance in increasing the number of certified Stop the Bleed instructors on Capitol Hill, as well as their support for continued training of members of Congress, congressional staff, and Capitol Police.

Leadership & Advocacy Summit 2017

More than 300 surgeons and residents participated in the ACS advocacy day on Capitol Hill at the Leadership & Advocacy Summit 2017, May 6–9. Participants
came to Washington primarily to meet with lawmakers and congressional staff to educate them about key ACS legislative priorities.14

While the Advocacy Summit takes place once a year, Fellows can engage with their members of Congress and local legislators at any time. DAHP staff is available to assist Fellows in arranging congressional meetings, either in-district or in Washington, to discuss ACS legislative priorities. An updated list of the College’s legislative priorities and their corresponding legislative one-page issue briefs are available at SurgeonsVoice.org.

Health care reform
The College remains actively involved in efforts to address the Affordable Care Act (ACA) and other health care reform legislation. The House passed the American Health Care Act in May, and in July the Senate tried and failed to pass any legislation to repeal and/or replace the ACA. The College has outlined concerns regarding key bills in letters to the following legislators: Speaker of the House Paul Ryan (R-WI), House Minority Leader Nancy Pelosi (D-CA), Senate Finance Chairman Orrin Hatch (R-UT), Senate Majority Leader Mitch McConnell (R-KY), and Senate Minority Leader Chuck Schumer (D-NY).

The College continues to work to ensure that its health care reform principles—patient safety and quality, patient access to surgical care, reduced health care costs, and medical liability reform—are included in any congressional compromise legislation. Details regarding these health care reform principles are as follows:5

- **Safety and quality**: The ACS supports well-designed clinical comparative effectiveness research, physician quality data, appropriate public reporting, and encourages realistic health information technology use and adoption.

- **Patient access to surgical care**: To ensure that surgical patients have access to appropriate care, a well-trained surgical workforce must be available and able to meet the full spectrum of patient needs for both general surgery and specialty care, including children’s surgical specialists. The ACS maintains that ongoing, broad health care reform initiatives should be directed at reform of the health insurance industry, including efforts to address issues of cost containment, ensure coverage for medically indigent patients and patients with preexisting health care conditions, and reduce administrative overhead.

- **Reduced health care costs**: ACS Quality Programs improve surgical care and cut costs by helping to prevent inefficiencies and preventable complications through the continuous quality improvement process. The College also has supported payment reforms that would incentivize participation in outcomes improvement and patient safety activities.

  The ACS further maintains that the development of Medicare payment policies and other efforts to reduce health care spending should remain under the purview of Congress with input from stakeholders and patients. The College, therefore, supports the repeal of the Independent Payment Advisory Board, an unelected governmental body.

- **Medical liability reform**: 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 present U.S. medical liability system is broken and fails to encourage an environment in which it is possible to achieve these objectives. The ACS actively supports reforms aimed at improving safety, quality, and accountability; creating a more just tort system, including caps on noneconomic damages; and encouraging

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The College continues to work to ensure that its health care reform principles—patient safety and quality, patient access to surgical care, reduced health care costs, and medical liability reform—are included in any congressional compromise legislation.

culture change at hospitals and in health care systems that will allow for the swift adoption of alternative patient-centered reforms, such as communication and resolution programs.

ACS-supported legislation
In keeping with these health care reform principles, the College is supporting several pieces of legislation that were under congressional consideration at press time. Details about these bills follow.

Mission Zero Act
It is a longstanding priority of the ACS to establish and maintain high-quality, adequately funded trauma systems throughout the U.S. and the nation’s armed forces. To this end, the ACS was a sponsor of the National Academy of Sciences, Engineering, and Medicine (NASEM) report from June 2016, titled *A National Trauma Care System: Integrating Military and Civilian Trauma Systems to Achieve Zero Preventable Deaths After Injury*. The NASEM report outlines the steps necessary to secure a national trauma system and sets the goal of achieving zero preventable deaths from traumatic injury.

The House and Senate have reintroduced bipartisan legislation, the Mission Zero Act (H.R. 880/S. 1022), which calls for implementing recommendations in the NASEM report. More specifically, the legislation would create a grant program to assist civilian trauma centers in partnering with military trauma professionals to establish a pathway to provide patients with quality trauma care in times of peace and war. This goal would be accomplished through grant funding used to embed military trauma teams/providers into civilian trauma facilities, including a $1 million grant to host military trauma teams at eligible high-acuity Level I trauma centers and grants for trauma centers to host individual health care professionals ($100,000 for physician or $50,000 for nonphysician providers) at eligible Level I, II, or III trauma centers.

The Mission Zero Act was reintroduced in the House by Reps. Michael Burgess, MD (R-TX), Chairman of the House Energy and Commerce Health Subcommittee; Cathy Castor (D-FL); Representative Green; and Richard Hudson (R-NC) in February 2017; and it was reintroduced in the Senate by Sens. Johnny Isakson (R-GA), John Cornyn (R-TX), and Tammy Duckworth (D-IL). The Mission Zero Act was marked up unanimously by the House Energy and Commerce Committee in July 2017 and the next step is consideration from the full House of Representatives. The Senate companion (S. 1022) is awaiting
action by the Senate Health Education Labor and Pension Committee (HELP).

The College continues to make strengthening the nation’s trauma system a priority for the 115th Congress, while elevating the goal of zero preventable deaths and ensuring all trauma patients receive appropriate care within the golden hour.

Ensuring Access to General Surgery Act
The ACS is actively engaged in promoting the Ensuring Access to General Surgery Act (H.R. 2906/S. 1351), introduced in the House by Reps. Larry Bucshon, MD, FACS (R-IN), and Ami Bera, MD (D-CA), and in the Senate by Sens. Chuck Grassley (R-IA) and Brian Schatz (D-HI). This legislation would direct the U.S. Department of Health and Human Services (HHS) to conduct a study of general surgery shortage areas throughout the U.S. and give the Secretary of HHS the authority to issue a formal general surgery shortage area designation based on the study results.

The ACS asserts that research is necessary to define what constitutes a general surgery shortage area and to determine where these areas exist. The legislation would provide HHS with a new mechanism for potentially increasing patient access to quality health care services. Providing incentives for general surgeons to locate or remain in communities with workforce shortages could become critical in guaranteeing that all Medicare beneficiaries, regardless of geographic location, have access to surgical care.

ACS members who participated in the Advocacy Summit played a key role in advancing the Mission Zero Act and the Ensuring Access to General Surgery Act. As a result of these surgeon-advocate efforts, the Mission Zero Act gained eight new co-sponsors and there was increased awareness of the Ensuring Access to General Surgery Act prior to its introduction in June.

Medical liability reform
The House of Representatives passed the Protecting Access to Care Act (H.R. 1215) on June 28 to reform our nation’s medical liability system. This ACS-supported legislation would establish a cap of $250,000 on non-economic damages, implement a three-year statute of limitations after injury or one year after the date of discovery, and limit attorney fees. If enacted, the legislation is expected to reduce the federal deficit by about $50 billion over 10 years. At press time, the Protecting Access to Care Act had moved to the Senate for further action.

Surgeon-advocates play a key role
The involvement of surgeon-advocates is vital to establishing an active relationship with federal and state legislators. The key to successful advocacy is an engaged membership, and the ACS suggests that Fellows participate in the following activities:

- Attend the next ACS Leadership & Advocacy Summit 2018, May 19–22, in Washington, DC
- Offer your federal/state legislators a facility/office tour, so they can see how their policies affect the care you provide to patients
- Meet with your member of Congress in your home district or in Washington, DC
- Participate in grassroots efforts through SurgeonsVoice.org

The DAHP is available to help with these efforts and can assist with preparations for a congressional meeting or facility tour. For more information, contact ahp@facs.org.

Acknowledgments
Carrie Zlatos, Senior Congressional Lobbyist, and Kevin Walter, DC, Communications Manager, contributed to this article.
It is essential that surgeons be politically active and serve as advocates for their patients and their profession. This article provides an overview of the legislative and political process and describes the role of the American College of Surgeons (ACS) Division of Advocacy and Health Policy (DAHP) and the actions it takes to represent surgeons and surgical patients in Washington, DC.

How a bill becomes a law
Any senator or representative may introduce a bill by filing it with the Clerk of the Senate or the House of Representatives. Once a bill is submitted, the Clerk assigns it a bill number and sends it to the committee(s) of jurisdiction. Most health care authorization legislation falls within the purview of four committees: House Energy and Commerce; House Ways and Means; Senate Finance; and Senate Health, Education, Labor, and Pensions (HELP). After a bill is referred to a committee, it is subject to hearings and
markups. A hearing involves invited guests and industry experts who testify on the potential effects of the legislation. The markup process allows for legislators to amend the legislation before voting on it. The vote after markup will determine whether a bill is voted out of committee, fails, or is returned to the committee for further development.

If a bill is successfully voted out of committee, it will either be referred to another committee of jurisdiction or advance to the full chamber for a vote if the House or Senate leadership decides to move the bill forward. Once a bill passes in the full chamber, it will advance to the other chamber, where the entire process is repeated. Assuming the same version passes the second chamber (versions can vary due to markups and amendments), the bill will continue to the president, who may either sign or veto the legislation. If the president vetoes the bill, Congress can override the veto with a two-thirds majority in both chambers.

If the House and Senate pass different versions of a bill, a conference committee is formed with members of the House and Senate to iron out the differences and create compromise language. This compromise language will then be subject to a vote by the full House and Senate.

**Branches of government**

The three branches of government are the executive branch (the president and his or her administration), the judicial branch (the U.S. Supreme Court and lower-level federal district courts), and the legislative branch (Congress). The responsibilities and authority of each are described as follows.

**Executive branch**

The president plays a significant role in setting the tone for a national legislative agenda but is limited as to what he or she can do without congressional approval. The president may issue executive orders, which are policy directives deemed to carry the full force of the law, and may sign or veto legislation.

The president also appoints individuals to key federal agencies, which are part of the U.S. Department of Health and Human Services (HHS). These agencies include the following:

- Centers for Medicare & Medicaid Services (CMS)
- U.S. Food and Drug Administration (FDA)
- Health Resources and Services Administration (HRSA)
- National Institutes of Health (NIH)
- Centers for Disease Control and Prevention (CDC)

**Judicial branch**

The judicial branch plays a critical role in sustaining or overturning legislation that can significantly affect day-to-day clinical practice. For example, the judiciary has ruled against physician data protections pertaining to Medicare claims data, and in February struck down a Florida law that restricted what physicians can say to patients regarding firearm ownership. In addition, the Supreme Court played a role in shaping and reaffirming the legality of parts of the Affordable Care Act.

**Legislative branch**

As the nation’s legislative body, Congress has the most direct effect on health policy. As mentioned earlier, several congressional committees have jurisdiction over health policy. These committees and their purview are as follows:

- **House Energy and Commerce**: The Energy and Commerce Health Subcommittee considers bills and resolutions pertaining to public health and quarantine; hospital construction; mental health; biomedical research and development; health information technology, privacy, and cybersecurity; public (Medicare, Medicaid) and private health insurance; medical professional liability; the
GLOSSARY OF LEGISLATIVE TERMS
At times, it may seem as though the political sector uses a language all its own. Following are a few key terms that surgeon-advocates are likely to encounter:

- **Appropriations bill**: Legislation that provides funds for authorized programs.
- **Authorization bill**: Legislation that establishes a program and sets funding limits.
- **Companion bills**: Identical bills introduced separately in the House and Senate.
- **Congressional Budget Office (CBO)**: A federal agency that provides nonpartisan information about how legislation will affect the U.S. economy and budget. Most commonly, the CBO will issue a "score" on a bill, which describes the economic impact of specific legislation.
- **Continuing resolution**: A resolution enacted to allow specific executive branch agencies to continue operating even though funds have not been appropriated for them for the following fiscal year.
- **Grassroots advocacy**: When constituents reach out directly to their legislators to advocate on a topic. For example, when members take action on a SurgeonsVoice action alert.
- **Grasstops advocacy**: Using key contacts within an organization to target specific legislators. For example, if a surgeon has ties to the Speaker of the House, then the ACS advocacy team might call upon that Fellow to contact the Speaker on a specific topic.
- **Hotline**: Used to advance legislation in the Senate when there is unanimous consent among all senators.
- **Joint resolution**: Legislation similar to a bill that has the force of law if passed by both chambers of Congress and signed by the president; generally reserved for special circumstances.
- **Resolution**: A measure passed only in one chamber to express the sentiment of that body. A simple resolution does not have the force of law.
- **Under suspension**: Allows for an expedited voting process for noncontroversial items in the House. A two-thirds majority vote is required to suspend the rules.
- **Voice vote**: A vote conducted by voice with no official roll call. These are typically used for noncontroversial bills or for House/Senate procedural votes.*

the U.S. budget. Both have Labor and Health and Human Services subcommittees that focus more directly on health care appropriations, choosing the funding amounts for programs authorized by the aforementioned health authorization committees.

The role of congressional staff
Capitol Hill staff also play a crucial role in the legislative process. These legislative aides and advisors keep the congressional offices and committees running. Because members of Congress and congressional committee leaders cannot be subject matter experts in all areas, they rely on staff to keep track of the details about individual topics. As a result, the congressional staffer frequently makes policy decisions for the office. As the gatekeepers to the members, who often have less time for meetings, it is common to find a meeting with staff to be more productive and substantive.

ACS government relations
The ACS DAHP is dedicated to ensuring surgeons’ voices are heard in Washington, DC, and throughout federal agencies, as well as statehouses. To this end, the DAHP comprises a pool of federal lobbyists, each responsible for tracking activity in a key legislative committee, building relationships with congressional offices, and serving as a trusted resource on surgeon-specific health care topics.

Coalitions
To enhance the College’s presence on Capitol Hill, the ACS also participates in several coalitions that bring together similar-minded health care organizations to pool their resources and to speak with a unified voice. For example, the Health Coalition on Liability and Access is a national advocacy coalition working to enact medical liability reform at the federal level. In addition, the Surgical Coalition comprises 30 surgical organizations that meet several times a year to map out a pro-surgery strategy and legislative action plan. This Surgical Coalition has successfully sought repeal of the sustainable growth rate (SGR) formerly used to calculate Medicare physician payments and to limit the impact of a flawed CMS policy on global surgery codes.

The ACS works with specialty coalitions to advocate on issues related to cancer, trauma, pediatrics, and rural surgery.

Participation in coalitions has many benefits inside the beltway, but it’s the College’s grassroots action from surgeon-advocates that makes the biggest difference. When the ACS advocacy team can point to the number of surgeons in a legislator’s district who have taken action on an issue, it can be a legislative game changer.

SurgeonsVoice
SurgeonsVoice is the nationwide, interactive advocacy program of the American College of Surgeons Professional Association (ACSPA). This program provides surgeons with tools to become effective advocates in every U.S. congressional district and to establish professional and personal relationships with decision makers, both on and off Capitol Hill, as well as at the state and regional level. Fellows may seek assistance and coordinate advocacy efforts through the DAHP, but SurgeonsVoice is a self-service tool kit that allows ACS members to carry out advocacy activities anytime, anywhere in the nation without having to set foot in Washington, DC.

SurgeonsPAC
The ACSPA’s political action committee, ACSPA-SurgeonsPAC, was established in 2002 to enable members of the ACS to help elect, and reelect, U.S. House and Senate candidates for Congress who are willing to promote issues of importance to surgery and the surgical patient at the federal level. SurgeonsPAC plays a critical role in ensuring that the College, particularly surgeon-advocates and the federal legislative team, are able to establish and maintain relationships with legislators and advance the College’s health policy priorities.

When the SurgeonsPAC Board and staff make the determination to support a candidate,
surgeon-advocates have the opportunity to participate in an in-district check delivery or attend a local event in Washington, DC. To learn more about delivering a SurgeonsPAC check at home or in Washington, DC, contact ACSPA-SurgeonsPAC and Grassroots Manager, Katie Oehmen, at koehmen@facs.org.

Get involved and stay involved

The involvement of surgeon-advocates is paramount to establishing an active relationship with federal and state legislators. The key to successful advocacy is an engaged membership, and you can help support this work by engaging in the following activities:

• Attend the Leadership & Advocacy Summit 2018, May 19–22 in Washington, DC

• Host a tour of your institution or practice for your federal/state legislators

• Meet with your member of Congress in your home district or in Washington, DC

With respect to meeting with your legislators, it is important to bear in mind that Congress follows a set calendar of legislative days in Washington, DC, interspersed with in-district work periods (recess). A common misconception about a congressional recess is that it is a vacation for the members of Congress. Lawmakers typically will have numerous in-district events and meetings to make the most of their limited time at home. These periods away from Capitol Hill present a great opportunity for surgeon-advocates to meet in-district with their legislators and engage them on health care issues. Two ways to conduct these meetings are to schedule a meeting in the district office or to invite them to join you on a tour of your institution or practice.

The ACS DAHP staff is available to help with these efforts and can assist with preparations for a congressional meeting or facility tour. For more information on advocacy or ACS policy priorities, contact DAHP staff at ahp@facs.org or 202-337-2701.

REFERENCES

The American College of Surgeons (ACS) Chapter Lobby Day Grant Program, now in its seventh year, provides financial support for chapters to conduct state capital lobby days. Fellows, residents, and members of the ACS participate in state lobby days to advocate for legislation that will improve patient safety and quality, and to educate lawmakers about their chapter’s legislative priorities.

ACS chapters in 12 states—Alabama, California, Connecticut, Florida, Georgia, Illinois, Indiana, Kansas, Massachusetts, Oregon, Texas, and Wisconsin—received matching grants through the grant program to help fund lobby days at the state capitol in 2017. The financial grants can be as much as $5,000 with a $2,500 match, along with ACS State Affairs staff support for planning and on-site implementation of the lobby day event. This year, the ACS launched a Chapter Advocacy Initiative Pilot Program, which carries a larger grant of $15,000. It was made available to one chapter that provided a plan to engage the state legislature on a high-priority issue.

GSACS uses new initiative for Stop the Bleed® training

The Georgia Society of the American College of Surgeons (GSACS) received the first Chapter Advocacy Initiative Pilot Program grant to conduct Stop the Bleed training in the state capitol building and develop a legislative campaign to advocate for an additional $1 million for the state’s Georgia Trauma Commission (GTC) to purchase bleeding control kits for public schools. The training took place in four locations on Georgia’s Capitol Hill during the February 7 lobby day. Additionally, the GSACS purchased and donated three large bleeding control kits, which were installed in the capitol building and the adjacent legislative office building.

In anticipation of the training event at the state capitol, both the Georgia House of Representatives and the Georgia Senate passed special resolutions declaring February 7, 2017, as Trauma Awareness Day. The GSACS President-Elect and GTC...
John Harvey, MD, FACS, demonstrates to the media how to apply a tourniquet, at the Georgia state capitol, February 7, 2017

Chairman, Dennis W. Ashley, MD, FACS, accompanied by R. Frederick Mullins, Robert S. Cowles III, John C. Bleacher, and Colville H.B. Ferdinand (all MD, FACS), and trauma survivor Ashley Power, addressed the senators and accepted the Trauma Day resolution on the floor of the Senate.

The GSACS also held a rally and news conference outside the capitol building featuring Drs. Ashley and Cowles and Ms. Power. Ms. Power was reunited with GSACS members James R. Dunne, MD, FACS, and Heather G. MacNew, MD, FACS, two of the trauma surgeons who cared for her. During the press conference, Peter M. Rhee, MD, FACS, a GSACS member, introduced Gwinnett Police Officer L. L. Hurst, who described how within days after training, he applied what he learned through the Stop the Bleed training to save the life of a bystander wounded in a drive-by shooting. The media reports about Georgia’s Trauma Awareness Day and Stop the Bleed program reached more than 4 million members of the public (see photo, this page).

“The ACS Chapter Lobby Day Grant Program is a direct investment in ACS chapters and members. Georgia’s Trauma Awareness Day would simply not have occurred without the ACS support,” said Dr. Ashley.

Trauma care and funding

The Alabama, San Diego, Northern and Southern California, and the North and South Texas Chapters also focused their lobby day efforts on trauma care and funding in 2017. The Alabama Chapter’s lobby day took place April 19 and centered on funding for the state’s trauma system. At present, no public funding has been allocated to the Alabama trauma system. Lobbyists for the Medical Association of the State of Alabama kicked off the event with a brief presentation on the challenges facing the state, including ongoing budget negotiations to fund Medicaid, as well as leadership issues arising from the sudden resignation of Gov. Robert Bentley (R) April 10 and the transition to Lt. Gov. Kay Ivey, who immediately took over as governor. State Sen. Larry Stutts, MD (R), an obstetrician-gynecologist, stopped by the morning session to discuss the importance of the trauma system for patient care and acknowledged the challenge Alabama has with hospital closures, including the closure of Level II trauma centers, resulting in additional pressure on the state’s Level I trauma centers. Lobby day participants met with Senate Majority Leader Greg Reed (R), who agreed that the state trauma system needed to be funded, but emphasized the challenges to funding Medicaid and the uncertainty about how congressional action on the Affordable Care Act (ACA) would affect the Medicaid program.

The San Diego and Northern and Southern California Chapters focused their advocacy efforts on passage of Assembly Bill (AB) 909, which would require the installation of bleeding control kits containing tourniquets, pressure dressings, and Stop the Bleed branded instructional materials in all public places in the state. Leaders of the San Diego and Northern and Southern California Chapters testified at a committee hearing on AB 909. Their joint lobby day April 18 included bleeding control training and demonstrations for legislators and staff, as well as the general public, in the capitol building.

The North and South Texas Chapters of the ACS incorporated the Stop the Bleed campaign into their
lobby day February 23, with a table in the capitol office building where chapter members demonstrated how to control bleeding through the use of tourniquets and gauze. Chapter members brought sample bleeding control kits to their meetings with state legislators to familiarize lawmakers and legislative staff with the value of making the kits widely available (see photo, this page). They also used the opportunity to raise the issue of increasing the state’s funding for graduate medical education. Rep. Trent Ashby (R) introduced a resolution recognizing the Stop the Bleed campaign and encouraging Texans to participate in the initiative.

The North and South Texas Chapters’ lobby day took place in conjunction with a joint chapter annual meeting in Austin. Including the lobby day as part of the annual meeting enabled the chapters to increase the number of members able to meet with state legislators.

Chapters make lobby days a collaborative effort

The Indiana Chapter of the ACS scheduled its lobby day to be part of the Chapter Winter Meeting February 7. The lobby day included a keynote address by Jennifer Walthall, MD, Secretary of the Indiana Family and Social Services Administration (FSSA). Dr. Walthall gave an overview of the responsibilities of the FSSA and spoke about the impact of the opioid epidemic in Indiana. Jerome Adams, MD, an anesthesiologist and Commissioner of the State Department of Health, stressed the importance of physician advocacy and involvement in the development of health care policy. Attendees met with more than a dozen legislators to discuss opioid prescribing restrictions and out-of-network surprise billing.

The Connecticut, Kansas, and Wisconsin Chapters joined with their state’s medical societies and other physician groups to demonstrate a unified voice for medicine with state legislators.

The Connecticut Chapter of the ACS jointly sponsored the Physicians’ Day at the Capitol with the Connecticut State Medical Society March 16. ACS surgeons and residents dug out from a late winter blizzard the day before to speak to legislators about the need for the state to adopt a definition of surgery and to identify ways to limit growing licensure, insurance, and living costs in the state in an effort to keep surgeons in the state after they complete their residency.

The program for the Connecticut lobby day included a morning meet-and-greet with members of the joint Public Health Committee, including Co-Chairs Sen. Heather Sommers (R) and Rep. Jonathan Steinberg (D), as well as Rep. William Petit, MD (R). After individual meetings with legislators, the participants attended a luncheon that featured presentations by Rep. Prasad Srinivasan, MD (R), a practicing physician and candidate for governor in 2018; Raul Pino, MD, Commissioner of the Department of Public Health; and Jonathan Harris, Commissioner of the Department Consumer Protection. Dr. Pino and Mr. Harris both addressed concerns about the state’s policies on mandatory use of the prescription drug monitoring program for opioids.

The Kansas Chapter of the ACS collaborated with the Kansas Academy of Family Physicians and the Kansas Chapter of the American College of Emergency
Physicians to sponsor a lobby day January 24. Discussion focused on efforts of moderate Republicans and Democrats to expand the state’s Medicaid program to receive additional federal dollars through the ACA.

The program featured speeches by House Minority Leader Jim Ward (D); Senate Assistant Majority Leader Vicki Schmidt (R), Chair of the Senate Public Health and Welfare Committee; Rep. Dan Hawkins (R), Chair of the House Health and Human Services Committee; and House Majority Leader Don Hineman (R). Each spoke about the opportunity to expand Medicaid, but also emphasized that Gov. Sam Brownback (R) staunchly opposes these efforts. Also discussed was the need to address the state’s financial crisis, which would likely require increasing taxes. In addition to voicing support for Medicaid expansion, Kansas Chapter members spoke with legislators about the need for insurance coverage of bariatric surgery and services.

The Wisconsin Surgical Society, a chapter of the ACS, sponsored Doctor Day 2017 on March 29, joining more than 400 physicians from around the state (see photo, this page). The main program included an update from Michael Heifetz, Director of Badger Care, the state’s Medicaid program. Mr. Heifetz made it clear that the state has no intention of expanding Medicaid, despite vocal objections from some physicians in the audience. The program also included a panel discussion featuring Reps. Debra Kolste (D) and Kathy Bernier (R) about the political environment in the state capitol and its impact on the development of health care policy.

“State lobby days are an important opportunity for surgeons to connect with their state legislators to reinforce their commitment to the total care of their patients (and the legislators constituents), at all levels including in the clinic, in the hospital, in follow up, and in the public health priorities and financial realms of legislation,” said Amy Liepert, MD, FACS, member of the Wisconsin Surgical Society and ACS Health Policy and Advocacy Group. “It is an opportunity to express the importance of this commitment, by making time in the recognized packed surgeon’s schedule to visit the legislator in the state house. The impression that this leaves with legislators demonstrates the commitment of surgeons to the total care of patients, is truly unparalleled, and is a great investment toward building future relationships.”

Lobby days at state capitols offer the opportunity for surgeons to meet with legislators in an environment where they are focused on the issues being debated in the legislature. It also is a great opportunity for surgeons, and especially residents, to see firsthand the legislative process at work, and to understand the value
of building relationships with their legislators. While there may not be a major policy or piece of legislation for chapters to advocate on every year, hosting a lobby day is still a great opportunity to cultivate those relationships. The Florida, Illinois, and Oregon Chapters used their lobby days to build relationships and share the surgical perspective on the health care issues before their legislatures.

The Florida Chapter of the ACS held its lobby day January 10. Rep. Julio Gonzales, MD (R), an orthopaedic surgeon, addressed participants about the benefits and challenges of being a physician member of the legislature. Several members had the opportunity to spend an hour with Carol Gormly, Health Policy Advisor to Florida Speaker of the House Richard Corcoran (R). Chapter members spoke with their legislators about important health care issues, including scope of practice, telemedicine, and recovery care centers.

Surgeons from the Metropolitan Chicago and Illinois Chapters of the ACS gathered in Springfield May 10. Lobby day participants met with targeted members of the House and Senate to advocate for H.B. 311, an insurance network adequacy bill, and to oppose S.B. 642, which would allow advanced practice nurses to practice independently, prescribe opioids, and to advertise as medical doctors.

The Oregon Chapter of the ACS hosted its state lobby day March 12–13. Rep. Knute Buehler, MD (R), spoke at a dinner the night before the day in the capitol. Dr. Buehler, an orthopaedic surgeon, focused his comments on tips for effective advocacy. During a briefing session the following morning, Courtni Dresser, director of government relations for the Oregon Medical Association, described the condition of the state, particularly with respect to Medicaid financing and the state budget. James Rickards, MD, MBA, the Chief Medical Officer of the Oregon Health Authority, further emphasized the difficult Medicaid budget situation.

Sen. Laurie Monnes-Anderson, RN (D), Chair of the Senate Healthcare Committee, also spoke about the difficult budget situation in the state, and indicated uncertainty regarding what would happen with the ACA. Changes to the health care law could necessitate that the state allocate considerably more funding to the Medicaid program in order to compensate for cuts in federal dollars. After the presentations, surgeons met with their elected officials to discuss chapter-supported legislation, such as a bill requiring children younger than two years old to be properly secured in a car seat in a rear-facing position.

While most state legislatures conduct their business during the first half of the year, a few states meet year round, which provides an opportunity for chapters to schedule their lobby days later in the year. The Massachusetts Chapter of the ACS is planning its 2017 lobby day for October 16.

Chapters that do not apply for or receive an ACS Chapter Lobby Day Grant are not precluded from engaging in lobby day activities. The Virginia Chapter of the ACS has partnered with the Medical Society of Virginia and other physician groups to host a lobby day January 30, 2018. The ACS encourages chapters and members to make use of opportunities to partner with other organizations hosting state lobby days. Alternatively, members can schedule time to meet with their legislators in their home district to build relationships and educate them about the issues of importance to surgeons and surgical patients. The ACS State Affairs staff is available to assist chapters and members with advocacy activities.

Applications for the 2018 ACS Chapter Lobby Day Grant Program have been sent to chapter leaders and administrators. The deadline to submit the application is September 15. For questions or more information about the program, contact Christopher Johnson at cjohnson@facs.org or at 202-672-1502, or visit facs.org/advocacy/state/chapter-grant.
Acute care surgery’s role in expanding the surgical workforce in Latin America

by Gregory Peck, DO, FACS; David Blitzer, MD; Marissa A. Boeck, MD, MPH; Marc de Moya, MD, FACS; Paula Ferrada, MD, FACS; Rodrigo Vaz Ferreira, MD; Vicente Gracias, MD, FACS; John G. Meara, MD, DMD, MBA, FACS; David Mejia Toro, MD; Marcelo Ribeiro, Jr., MD, MSc, PhD, FACS; Edgar Rodas, MD, FACS; Joseph V. Sakran, MD, MPH, MPA, FACS; Mary E. Schroeder, MD, FACS; Ana Milena Del Valle, MD; and Tanya Liv Zakrison, MD, MPH, FACS
In the April issue of the Bulletin, “Using global surgical indicators to improve trauma care in Latin America” introduced readers to the relationship between The Lancet Commission on Global Surgery’s (LCoGS) core surgical indicators and specific components of trauma program and systems development in Latin America. An article in the July issue of this publication centered on prehospital care using a trauma systems application of LCoGS indicator 1 (LCoGS I-1). This month, the authors explore the link between LCoGS indicator 2 (LCoGS I-2), workforce and acute care surgery education and training, as well as acute care surgery’s role in responding to World Health Assembly (WHA) Resolution 68.15.

Global preparedness for surgical care delivery
Access to surgical care is paramount to improving health care systems in resource-poor settings. Mounting evidence highlights the health, economic, and welfare inequities that result from inadequate access to surgical care. The LCoGS created indicators to track progress toward surgical care equity and universal access to surgery, and those indicators fall into three categories: preparedness, delivery, and impact (see Table 1, page 28).

At the 2015 68th WHA—the meeting during which the World Health Organization (WHO) established its top health policy priorities—strengthening emergency and essential surgical care was highlighted as a critically important component of universal health coverage through the passage of WHA Resolution 68.15. The resolution urged both member states and national-level leadership to prioritize emergency and essential surgery services by enacting significant improvements to the provision, access, monitoring, and policies regarding surgical care (see Table 2, page 29). With the increased role of global surgery in public health, the challenge will now be to accurately characterize the surgical capability—or capacity—of individual regions to provide universal coverage. One of the first steps toward addressing the capacity limitations in Latin America is to provide access to education and training opportunities that augment the surgical workforce. The LCoGS attempted to address the capacity issue first by suggesting a framework to strengthen national surgical systems. Its recommendations resulted in the six indicators in the aforementioned three categories.

The first two indicators are in the preparedness category: LCoGS I-1, timely access to care, and LCoGS I-2, the workforce density of surgery, anesthesia, and obstetrics (SAO) providers per 100,000 national population. The discussion that follows focuses on strengthening Latin America’s emergent and essential surgical workforce. To accomplish this, the proposed strategy is to expand the role of acute care surgery—an evolving specialty that includes three essential components: trauma, critical care, and emergency surgical care. We show that the workforce can be buttressed through an emphasis on education and training to scale up sustainable infrastructure with respect to preparedness LCoGS I-2 2030 targets.

Emergent and essential surgery workforce in Latin America
LCoGS I-2 is the most intuitive indicator—that is, national surgical capacity is reliant on the number of providers with operative and anesthetic capabilities. The LCoGS recommends that low- and middle-income countries (LMICs) set a target of 20 to 40 SAO providers per 100,000 people. The combined efforts of the LCoGS and the WHO have led to an assessment of SAO workforce density in 31 Latin American and Caribbean countries (176 countries total). The surgical workforce is commonly assessed via national data banks that document registered SAOs and/or extrapolation from survey studies. These methods include a mixture of subjective and objective sources, such as health care facility capacity surveys (for example, personnel, infrastructure, procedures, equipment, and supplies [PIPES]),
and records from licensing boards, health departments, professional societies, and ministries. These survey methods frequently fall short of capturing location-specific complexities that can significantly augment the surgical workforce. For example, regional dispersion tends to be heterogeneous within countries; in effect, the misdistribution of capable surgeons and educators only becomes apparent when assessing rural and urban areas separately. Scheffer and colleagues showed that although Brazil has an overall surgical workforce density of 46.55/100,000 population, a tremendous disparity exists between the northern (20.21/100,000), southern (60.31/100,000), and the Amazonian (< 1/100,000) regions. 6

Another consideration is how countries use mid-level and other allied health care professionals. Several LMICs have incorporated models in which mid-level providers deliver varying amounts of surgical care—task sharing—that may include basic operative services. Some nonclinical examples also include the acute care teams that address emergent and essential surgical disease in Colombia, and a newer consideration for the role trauma nursing managers may play in strengthening trauma program management. 7 Ultimately, for many LMICs, it will be impossible to meet the goals of WHA resolution 68.15 without considering comprehensive, interprofessional data on LCoGS I-2, and more specifically, how these data relate to a region’s ability and outcomes in addressing emergency surgical disease within its population.

Until now, we have considered a region’s surgical capacity as a raw number or density, which, of course, runs the risk of missing what provider capacity means. Use of provider density as a measure of capacity is both a quantitative and qualitative issue. Studies should begin characterizing the types of providers within a region to better determine the demand for specialized care and how implementation of prerequisite education, training, background, and experience can best occur within its own health system. The salient information regarding the surgical workforce then is not only the number of surgical care providers who are available, but also, and perhaps more importantly, details that potentiate the infrastructure and surgical system administrative leadership that generates the emergent and essential surgery preparedness. Indeed, a large proportion of surgical disease and death in many Latin American and other resource-limited countries is due to injury, which is promulgated by deficient trauma systems. Addressing this problem prompted a recent rise in acute care surgery development in Latin America, and stems from the historical vision and mission of the Panamerican Trauma Society (PTS).

<table>
<thead>
<tr>
<th>Category</th>
<th>LCoGS indicator</th>
<th>Description</th>
<th>Proposed trauma program/system element focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preparedness</td>
<td>1</td>
<td>The geographic accessibility of surgical facilities</td>
<td>Prehospital system and integration with hospital registry</td>
</tr>
<tr>
<td></td>
<td>2*</td>
<td>The density of specialist surgical providers</td>
<td>Acute care surgeon/fellowships; trauma program manager</td>
</tr>
<tr>
<td>Delivery</td>
<td>3*</td>
<td>The number of surgical procedures provided per 100,000 population</td>
<td>Trauma and emergent/essential hospital/societal registries</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>30-day perioperative mortality rates</td>
<td>Trauma and emergent/essential hospital/societal registries, formal trauma performance improvement and patient safety, and trauma morbidity/mortality review process</td>
</tr>
<tr>
<td>Impact</td>
<td>5*</td>
<td>The risk of impoverishing expenditure when surgery is required</td>
<td>Future work—ministries of health/education/finance and trauma/acute care surgery divisional business administration</td>
</tr>
<tr>
<td></td>
<td>6*</td>
<td>The risk of catastrophic expenditure when surgery is required</td>
<td>Future work—ministries of health/education/finance and trauma/acute care surgery divisional business administration</td>
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*World development indicators
Acute care surgery in North America

Implementing and expanding an acute care surgery specialty in North America was in response to an identified workforce crisis in on-call emergent and essential surgery coverage, and specifically to address “hospital-based emergency care at its breaking point,” a “worsening workforce in general surgery,” and “insufficient number of surgeons in emergency call panels.”8-12 Major North American trauma organizations, including the American College of Surgeons (ACS) Committee on Trauma (COT), the Western Trauma Association (WEST), the Eastern Association for the Surgery of Trauma (EAST), and the American Association for the Surgery of Trauma (AAST), joined forces and formed an ad hoc committee under AAST’s aegis in 2003, which ultimately led to the development of the reorganized curriculum of critical care, trauma, and emergency surgery, and formalized education and training for an acute care surgery specialty.13 Almost two decades later, the AAST Acute Care Surgery Committee recently guided education and training innovation in 2015 by approving the first global surgery electives in which North American acute care surgery fellows acquire concentrated short-term training under the direction of recognized Colombian and South African acute care surgeons in their care settings.

The first formal North American AAST/ACS-developed acute care fellowship was offered in 2008 at the University of Nevada School of Medicine, Las Vegas, and has since expanded to more than 20 fully
accredited programs with more in the certification pipeline. After completion of a two-year acute care surgery fellowship, candidates are double boarded by the American Board of Surgery (ABS) in general surgery and surgical critical care, possess both a trauma training certificate and an AAST acute care surgery fellowship certificate (if AAST-accredited program), and have an educational foundation in the extensive processes and maintenance required for continued trauma center verification by the ACS COT.

Training in acute care surgery covers a spectrum of surgical disciplines, including elective general surgery and emergency surgery in trauma, critical care, orthopaedic, neurosurgical, thoracic, vascular, and soft-tissue surgery. Importantly, training focuses not only on the technical aspects of multiple organ surgery, but also emphasizes the education and training to expand the workforce in emergent and essential care through a systems-based regional inclusive approach to surgical disease management. In other words, care is coordinated through close collaboration between multiple components, including tiered-level surgical care centers within a defined region. As a result, ACS COT-verified trauma programs demonstrate a capacity to collectively optimize care at the state and/or national level across the continuum of care from the prehospital setting to discharge and rehabilitation. Learning the ins and outs of this capacity is valuable to the young surgeon entering today’s local and global surgical workforce.

Education and training in Latin America

A lack of access and provider shortages in emergent and essential surgery (including trauma) have recently stimulated the development of a Latin American acute care surgery practice model, as well as the need for formal education and training programs. Acute care surgeons have helped to strengthen emergent and essential surgery education and training in Latin America since the PTS was established 30 years ago. Past-presidents and executives of the PTS have held simultaneous leadership roles in major North American academic surgical societies, like the ACS and AAST, and provided great synergy for an Americas acute care surgery professional roadmap. An acute care surgery curriculum that is standardized across North, Central, and South American academic institutions could engender interest among young surgeons in surgical specialties that bridge the existing surgical workforce gaps in resource-poor settings through reciprocal transnational rotations and shared curriculum structure.

The first two-year Latin American acute care surgery fellowship of which the authors are aware was initiated in 2013 in Cali, Colombia. A core group of leaders in several countries have focused on multidisciplinary efforts to strengthen the North, Central, and South American emergent and essential surgery workforce, education, and training through such examples of an acute care surgery academic implementation. Bidirectional and transnational efforts to better support growth and capacity as it relates to formalizing such programs has scaled up in recent years, perhaps partly as a result of the global surgery movement, but certainly through sustainable acute care surgery partnerships between the Americas.

Despite the establishment of newer fellowships, competency-based goals and objectives in emergent and essential surgery education and training programs at the graduate level still need development. In fact, formalization of education and training standards at all levels is necessary to strengthen the emergent and essential surgical systems of the future. At present, such formalization is underrepresented and/or underreported in Latin America, perhaps because of the overwhelming emergent and essential clinical demand or workforce shortage of local educators and incomplete integration of Latin America trauma/acute care surgical societies with other specialty surgical societies at the national level. For example, the Brazilian Medical Association recognizes neither trauma nor acute care surgery as a surgical specialty, even though the Brazilian Trauma Society has sought to improve awareness
of these practice areas. This lack of recognition is not due to a lack of regional interest, as the Brazilian College of Surgeons’ annual congress comprises several panel discussions on emergent and essential surgery, and attendance at these sessions is high among general surgeons and residents. A full spectrum of young persons’ interest exists, and in fact, the medical student involvement represented by the work of the Brazilian trauma leagues in emergent and essential surgery education is exemplary.

North, Central, and South American acute care surgeons and nurses in the ACS and the PTS have conducted various emergent and essential training courses and programs in Latin America. PTS members annually host Advanced Trauma Life Support (ATLS®), Advanced Trauma Operative Management (ATOM®), Advanced Surgical Skills for Exposure in Trauma (ASSET®), and Definitive Surgical Trauma Care courses, as well as additional programs listed in Table 3, this page. Lowering or eliminating financial barriers for trainees, physicians, and surgeons in LMICs to attend such courses has been a primary focus of PTS collaborations and is a response to insufficient government action to scale up local education and training. In Ecuador, an ATLS course may be cost-prohibitive at upward of 80 percent of the monthly salary for a trauma surgeon in Quito working within the public/government hospital, with no cost offset despite the surgeon and hospital owning the bulk of its societal trauma volume burden for the capital city. The PTS therefore has forgone fees associated with initiating nursing courses, for example, sharing with the ACS spirit of waived registration fees and donated teaching materials for medical student-level courses such as the Trauma Evaluation and Management (TEAM) course for Cuba. In fact, the Advanced Medical Response to Disasters course, as well as the Ultrasound in Emergency and Trauma and the Trauma Nursing courses, became a part of the Fourth International Symposium on Trauma hosted by the Cuban Society of Surgery-Trauma Section, in Havana.

**TABLE 3.**
**PTS MULTIDISCIPLINARY TRAINING COURSES**

<table>
<thead>
<tr>
<th>Course</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Advanced disaster medical response:</strong></td>
<td>Train multidisciplinary medical personnel in the basics of disaster medical management of specific disaster scenarios</td>
</tr>
<tr>
<td><strong>Essential trauma course:</strong></td>
<td>Deliver a systematic approach to the management of patients who sustain traumatic injuries in resource-limited areas</td>
</tr>
<tr>
<td><strong>Burn management:</strong></td>
<td>Review guidelines for burn management according to local facilities</td>
</tr>
<tr>
<td><strong>Transcutaneous echocardiography course:</strong></td>
<td>Teach technique of echocardiogram for the evaluation of the fluid status and cardiac function of critically ill patients</td>
</tr>
<tr>
<td><strong>Surgical skills:</strong></td>
<td>Discuss and practice the diverse surgical techniques used in trauma using live animal models</td>
</tr>
<tr>
<td><strong>Trauma nursing:</strong></td>
<td>Train hospital nurses to classify, monitor, care for, and supervise the management of injured patients</td>
</tr>
<tr>
<td><strong>Trauma quality improvement (QI):</strong></td>
<td>Promote a better understanding of QI, provide training in straightforward and practical techniques, such as preventable death reviews, and discuss ideas for future development of trauma QI</td>
</tr>
<tr>
<td><strong>Ultrasound in emergency and trauma basic:</strong></td>
<td>Train staff who manage patients needing trauma and other emergency care in management of emergency ultrasound</td>
</tr>
</tbody>
</table>

SEP 2017 BULLETIN American College of Surgeons
May 2017. The positive didactic impact of these experiences was presented at the 2017 ACS COT International Injury Care Committee meeting in Washington, DC. This was a particularly important statement for Cuba given its long tradition of training medical students and residents from many different LMICs throughout Latin America, Africa, and Asia, and because Cuba is home to the largest medical school in the world, ELAM (Escuela Latinoamericana de Medicina), the Latin American School of Medicine, specifically dedicated to a tuition-free mission of expansion of the global workforce.

In light of the fact that nearly 30 percent of the student body enrolled in the first TEAM course at the Faculty of Medical Sciences in Havana were from other countries (Angola, South Africa, Colombia, and Germany, among others), the ACS is ensuring the dissemination of high-quality emergency and essential surgery education and training propelled by such international students, as well as the Cuban graduates who participate in international medical missions. Recent education and training activities that are applicable to emergent and essential surgical care workforce at the citizen level include the ACS Stop the Bleed® course, which is delivered collaboratively by Latin American colleagues who serve on the ACS COT international committees.

**Call to action**

Measuring and meeting a projected workforce estimate will require better characterization of the specific local education and training paradigms that exist, as well as their matriculation and program output. The WHO global

<table>
<thead>
<tr>
<th>Workforce</th>
<th>Numbers (surgical and anesthesia density)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Distribution (for example, LMIC vs. HIC, rural vs. urban, public vs. private)</td>
</tr>
<tr>
<td></td>
<td>Access and barriers</td>
</tr>
<tr>
<td>Education and training</td>
<td>Tools (curriculum, structure, education materials, accreditation of training programs, ethical HIC-LMIC relationships)</td>
</tr>
<tr>
<td></td>
<td>Barriers and approaches to overcome</td>
</tr>
<tr>
<td></td>
<td>Measure the efficacy of these programs</td>
</tr>
<tr>
<td>Supply and demand</td>
<td>Establish workforce numbers independently by discipline</td>
</tr>
<tr>
<td></td>
<td>Dynamics that lead to shifts in supply and demand</td>
</tr>
<tr>
<td></td>
<td>Remuneration: public vs. private</td>
</tr>
<tr>
<td></td>
<td>Metrics to measure success and failure</td>
</tr>
<tr>
<td>Task shifting/sharing</td>
<td>Identify middle level providers</td>
</tr>
<tr>
<td></td>
<td>Task shifting vs. task sharing</td>
</tr>
<tr>
<td></td>
<td>Appropriate supervision/monitoring</td>
</tr>
<tr>
<td></td>
<td>Barriers to care</td>
</tr>
</tbody>
</table>
surgery workforce database is an example of an effort to understand present and projected needs to train emergent and essential care professionals.\textsuperscript{16} A 2017 PTS Education Committee survey aims to identify the specific and ongoing need from individual Latin American countries for formal emergent and essential education and training. For a meaningful way forward, the PTS is referring to the LCoGS Workforce, Education, and Training Working Group to provide an overview for emergent and essential surgery in Latin America (see Table 4, page 32). The 2015 LCoGS terms of reference document outlines the current state of the surgical workforce and sets out to describe how to ensure a continuous supply of health care professionals and to determine how to maintain high standards of care regardless of the location or time of day. To appropriately expand the surgical workforce in Latin America, the following key stakeholders must form partnerships with both private and public entities to champion a balance between the costs of education and training and the safeguarding of universal access to health care that is not profit-driven:

- Governments (Ministries of Health, Finance, Education, and Labor)
- WHO
- Multilateral/bilateral organizations (World Bank, U.S. Agency for International Development)
- Private foundations
- Education bodies (training colleges, societies, congresses, and so on)
- Academic and professional entities
- Industry

### TABLE 6.
**QUESTIONS GOING FORWARD FOR LATIN AMERICA**

- If an increase in number of trainees is needed, what is the national system’s capacity to manage them?
- How do we create these management systems?
- What models from the ACS, PTS, and other societies have worked particularly well?
- How do we measure success/failure of an approach?
- What are the metrics going forward? Supply and demand (immigration, attrition) must be defined in our current situation, and quickly.
- Among different workforce members (nurses, physicians, and so on) in different countries, are there opportunities for nurses to share in the formal systems education and training management (SAO nursing)?
- Which countries have improved the situation and how have they done it?
- Can we describe the dynamics that lead to shifts in supply and demand (disaster relief; war; terrorism; narcotics trafficking; educational, personal, and financial opportunities; and misconceptions about these factors)?
- What is the remuneration and retention in public vs. private hospitals?
- Can we describe the desired outcome? How do we get there?
- What are the barriers to how we measure success/failure? What are the metrics?
REFERENCES


continued on next page

It is anticipated that these efforts will result in the engagement of both public and private institutions that can take on the responsibility of funding acute care surgery education and training as a public health service, as well as cost-effectiveness. An investment in measuring the value of acute care surgery education and training to accomplish local, regional, and national acute care surgery recruitment and retention of quality emergent and essential providers at public and governmental entities is crucial. Advocacy efforts that promote not only universal access to care, but also universal access to education and training, are therefore critical. Stimulating an affordability of education/training (in Latin America, residents pay for residency training), salary improvement, professional satisfaction, data that reflect a profession’s clinical impact, and provision of tools to create work-life integration, also will help. The current landscape in education and training should be better defined so that the variability between countries can be elucidated and efforts consolidated (see Table 5, page 32). Then, the PTS and other national medical societies in the Americas will best identify collectively the desired workforce as it relates to emergent and essential surgery, what needs to be done, and how to do it (see Table 6, page 33).

Emergent and essential surgery is the focus of the 30th Annual Panamerican Congress of Trauma, Critical Care and Emergency Medicine in Mexico City, Mexico, November 27 to December 1. This annual congress has consistently demonstrated that leaders across numerous disciplines and organizations view this topic as a top health care priority. The emergence of surgical education and training is critical to the viability of reaching LCoGS I-2 targets and creation of national surgical plans that optimize emergency and essential care delivery. Current acute care surgery leaders in the Americas seek your help for support in working with individual Latin American surgical societies and national ministries to define the acute care surgery profession and its respective funding, policy, and legislation for the cross-disciplinary, interprofessional, population-based...
health care it provides as keys to meeting WHA Resolution 68.15. Consistent with the need for surgical system strengthening, especially regarding trauma national plans, acute care surgery can serve both as the approach to assess the surgical workforce and as a mechanism by which it can be improved. Herein we have highlighted scaling up the emergent and essential surgical workforce in Latin America. Importantly, we demonstrate the necessity of leveraging training and education—particularly focused on acute care surgery—as the cornerstone of our efforts.

Acknowledgements

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REFERENCES, CONTINUED


International volunteerism: Dr. Zalamea leads collaborative mission in the Philippines

The American College of Surgeons (ACS) Operation Giving Back (OGB) initiative was created with the mission “to leverage the passion, skills, and humanitarian ethos of the surgical community to effectively meet the needs of the medically underserved.”* Fellows of the ACS are committed to this vision and are providing care to underserved patients around the globe.

In an effort to acknowledge the service that these surgeon-volunteers provide, OGB is profiling some of these volunteers and partners to showcase their work and to describe how they met specific challenges providing care to the medically underserved around the world. This month’s profile is an interview with Nia Noelle Millan Zalamea, MD, FACS, a general surgeon in Memphis, TN. Dr. Zalamea is involved in two international volunteerism programs—the Memphis Mission of Mercy and the University of Tennessee Health Sciences Center Global Surgery Institute (UTHSCGSI).


Above: Dr. Zalamea (left) performing a right inguinal hernia repair on a young boy in Victoria, December 8, 2015
Describe the aims of the Memphis Mission of Mercy.

Memphis Mission of Mercy is a family-run, not-for-profit organization founded by my mother, Norma Zalamea, RN, and my father, Renato Zalamea, CRNA. This organization has delivered short-term medical and surgical care to various communities in the Philippines annually, and sometimes biannually, since 1999. Our model has been short-term medical and surgical care, in the form of open clinic and elective major operations. Our scope of care primarily includes otolaryngology and general surgery procedures, with an average of 40 major surgical cases per mission. Our team continues to evolve from relationships with health care professionals, family, and friends who either live, work, or have trained in Memphis. This network has generated a log of more than 150 volunteers.

Why did your parents start Memphis Mission of Mercy?

My parents are both from the Philippines and started Memphis Mission of Mercy because they saw an opportunity to serve our native country. In 1998, my father participated in a mission trip to Guyana organized by the American Association of Nurse Anesthetists (AANA). While there, he taught professionals about regional anesthesia, covering everything from blocks to spinals and epidurals. On the way back to the U.S., he was thinking about what he might be able to accomplish in the Philippines, an area of even greater need.

John Hodges, MD, FACS, an ear, nose, and throat (ENT) plastic surgeon, overheard my father discussing the idea with a colleague in the recovery room at Methodist Hospital in Memphis and offered to be our first volunteer physician. The rest is history.

How do patients find out about the Memphis Mission of Mercy?

We share and promote the Mission of Mercy work in targeted communities in various ways: through social media, via local community health care providers and social workers, friends and family of volunteers who spread the word in their communities, previous patients who have friends or family with health care needs, and area leaders and politicians with whom we have worked in the past and who follow our movement in the country. The local military, police, and clergy also help to promote the upcoming missions to people in remote and mountainous areas using open speakers on trucks, at health fairs, announcements at church services, and so on.

What criteria must patients meet to receive care through the Memphis Mission of Mercy?

Memphis Mission of Mercy partners with local social workers, community health workers, and hospital administrators to focus on patients with limited resources. We have no hard and fast financial line. The local community leaders and workers help us target...
people with economic and medical need. This level of screening and targeting is for our surgical patients. All patients are welcome, however, as we have an open and free clinic staffed by primary care professionals. We almost always identify candidates for surgery here as well.

The other international volunteer program you work with is the UTHSCGSI. What was the impetus for starting this program?

The UTHSCGSI is a developing division within the department of surgery with the purpose of better organizing, supporting, and developing opportunities for work and training in low- and middle-income countries (LMICs). The initiative sprang from a discussion between myself and Martin Fleming, MD, FACS, chief, division of surgical oncology, UT. During a physician leadership class, in the fall of 2015, I told Dr. Fleming that my family was looking to perform more long-term work in the Philippines, possibly by forming a mission hospital. For the past year, we have engaged with new and old partners alike, including academic partners, to establish a mission hospital for the purpose of developing a surgical system of care for low-income patients around the world. It was out of this conversation that we began to learn about the level of interest among faculty, residents, and students to provide care in LMICs.

To learn more about this interest in working in LMICs, we deployed a survey during a four-month period of time. Our survey was limited to UT Memphis medical students, surgical residents, and surgical faculty. Surgical departments that were a part of the survey included the following: ENT, general surgery, pediatric surgery, pediatric thoracic, and urology. These departments represent faculty members who expressed an interest in participating in developing the vision of this institute. A total of 64 medical students, 40 faculty members, and 23 surgical residents responded to the survey for a total of 127 respondents.

From this study, we learned that faculty respondents engage in a combined total of 58.5 weeks of surgical work in LMICs annually. Not only is the interest in international rotations and experience high among surgical residents and medical students, but more than half of the trainees and student respondents said they have already engaged in medical and/or surgical volunteer work in a LMIC. Armed with the knowledge of this on-the-ground activity, coupled with a strong interest in these opportunities as revealed in this survey, we decided that now would be the time to grow and sustain the work that we do in LMICs.

In addition, there is a distinct parallel between our work with the medically indigent patients in Memphis and the work that we perform in the communities we serve overseas. We know that a better understanding of the social history of our surgical patients in Memphis makes us not just better surgeons, but better physicians in general. This knowledge is applicable in the international setting as well. We also understand that lessons learned from our work in LMICs strengthen and inform our work here at home. We aim to dig deeper into this reciprocal relationship.
The UTHSCGSI will support and help coordinate work that is already being carried out by the UTHSCGSI faculty in South America, Africa, and parts of Southeast Asia.

What is the relationship between the UTHSCGSI and Memphis Mission of Mercy?

The two organizations are collaborating to establish a permanent mission site in Victorias, Negros Occidental, the Philippines. Victorias has a population of slightly more than 90,000 people, but that population is distributed among several islands where the poor have limited access to primary care, much less to surgical care. To find our mission home, we gathered public health data and accessed information from several towns and communities with which we had an existing relationship. We settled on the town of Victorias based on need.

What are the health care needs of the people served by this collaboration?

The community of Victorias is one of the largest in the region. The population is largely composed of plantation workers, laborers, and impoverished people. Approximately 40 percent of the population has nutritional deficiencies, and 20 percent of the population lives below the poverty line.

The community we are looking to serve has access to primary care for indigent patients, fueled with financial support from a local foundation that is supported through contributions from local philanthropists and businesspeople. The primary care center offers urgent care, emergency room, and infirmary services, as well as some cancer screenings, including fecal occult blood tests (FOBT) and pap smears with visual inspection and acetic acid. In 2016, 73 cancer patients were diagnosed in Victorias, and as of March 2017, a total of 47 had already died. Access to surgical care is a challenge, and poor patients on the island and in the region have limited access to surgical services.

Cancer remains a largely untreated disease in the region of Victorias. As was stated earlier, there is minimal screening, partially due to cost and access. There is no colon cancer screening, aside from FOBT, and mammography is costly. Unfortunately, the incidence of breast and colon cancer is on the rise in the Philippines, partially attributed to the emulation of the Western diet.

No formal or published data are available on untreated surgical issues in the community because medically indigent people often do not seek medical care for surgical problems until they need emergency care. Elective surgery is really reserved for those patients with financial means. The limited patient data that Victorias has shared with our team include the following:

- The top five chronic diseases in Victorias are pulmonary tuberculosis; chronic obstructive pulmonary disease; diabetes/hypertension/cerebrovascular disease; cancer (all types); and chronic kidney disease.
- The top five acute diseases in Victorias are acute respiratory infection (bronchitis, pneumonia); acute

In the “minor surgery” section of the health center in Victorias, this candle is used to heat instruments before cauterization.
gastroenteritis and intestinal parasites; acute myocardial infarction; acute urinary tract infection skin lesions; and infections, often related to trauma and resultant wounds.

Our collaborative efforts have served this community eight times on short-term missions, and each time we have been invited to include surrounding island communities of need.

What is the ratio of physicians to patients in the region that you will be serving through this collaborative effort?

From the city of Victorias, a total of 20 surgeons are within one-hour driving distance of a population totaling more than 600,000. This total does not include the communities that access care in Victorias by boat. These surgeons are of various disciplines (orthopaedics, general surgery, and so on), but patients with limited resources are unable to access such care on an elective or planned basis. As a result, many people obtain care only in the most catastrophic of circumstances—not unlike what happens with uninsured patients here in the U.S.

How did you become interested in the health care challenges facing patients in Victorias?

We were introduced to the community of Victorias by an orthopaedic surgeon from the neighboring town of Bacolod City. He was in Memphis doing some training at Campbell Clinic Orthopaedics, and when we were looking for a site, he introduced us to Victorias. What then followed was a series of eight Memphis Mission of Mercy short-term visits since 1999. We have come to deepen our knowledge and understanding of the community, and the community has done the same with our mission group.

How do you get funding?

Memphis Mission of Mercy’s funding begins with our original contributors: my family, our family friends, and then every volunteer who has come with us, as well as friends in the community who have supported our work. Each mission volunteer is responsible for his or her own plane ticket, but the host community provides board and lodging on our short-term missions. Our surgical instruments have been donated by area hospitals in Memphis, but we also have a relationship with Scanlan International, which has generously supplied us with high-quality ear, nose, and throat, plastic, and general surgery instruments.

With respect to the disposable or nonreusable supplies we use, we acquire much of that equipment through donations from hospitals in the Memphis area, including Methodist Le Bonheur; Regional One Health; Baptist Memorial; St. Francis; Johnston Memorial Hospital, Abingdon, VA; and Santa Barbara Cottage, CA. We also purchase supplies through Medical Assistance Program International, Americares, and Ethicon. We joke that we are equal opportunity beggars with regard to resources, supplies, and donations. All of these...
Ultimately, we believe that by working in this sort of international surgery center, we can convene like-minded and mission-driven people so that in time, the community and local health care professionals will be able to sustain it independently.

What educational resources do your efforts use?

I am working with the Society of American Gastrointestinal and Endoscopic Surgeons (SAGES) Global Outreach Committee. We are building the hospital to accommodate telemedicine capability for the purpose of conducting grand rounds and morbidity and mortality conferences.

Where do you see the future of the health care situation in the areas you serve?

We aim to supplement the existing infrastructure in the community, and invite others to join us. The academic partnerships need to cross country lines. We look forward to partnering with academic institutions in the Philippines so that the learning is cross-cultural. We anticipate that by bringing relationships, resources, and infrastructure to partner with the community, we may be able to invite people in the community to serve, as well. Ultimately, we believe that by working in this sort of international surgery center, we can convene like-minded and mission-driven people so that in time, the community and local health care professionals will be able to sustain it independently.

What advice would you give other health care providers who want to work with underserved patients or who are interested in starting similar programs?

I don’t think of any of us as experts in this work, as we have learned much and continue to learn every day, but I think the strength and depth of work is dependent on relationships and need. A great way to begin this kind of project is by listening to the people around you; be with the people you serve and get to know them. Try to understand and ask about their challenges, barriers, and needs. If this is domestic work, find partners who have similar interests, or other organizations that may serve your targeted community in a different way.

Find the gaps in the system, and consider whether you can mold or modify what you do to fill the void. If our mission is to serve, then we can allow the need and the people to shape how and where we serve. All that mission leaders bring is the “why.” I have found that every time we try to recruit surgeons and other physicians to serve with us, they never give “no” as their answer. The barriers that keep people from serving are the same challenges that affect any of our decisions: financial, family, work commitments, and so on. It is a matter of finding a mutually compatible time.

You mentioned a parallel between your international outreach work and serving low-income patients in Memphis. Could you expand on that concept a bit?

Domestically, I have worked in a private for-profit setting, then a private not-for-profit setting, and now I am in an academic-affiliated, hospital-employed practice. In working for a not-for-profit and now working for a hospital, I have been blessed with the opportunity to target my work to the under- and uninsured. While at the not-for-profit Church Health Center, we partnered with a hospital that gave us the financial backing to
write off the expenses we incurred providing care for the center’s surgical patients. When I transitioned to my present hospital-employed practice, I negotiated with the hospital chief executive officer to not only bring my entire uninsured practice from the Church Health Center with me, but also to remain the main surgical referral target for the Church Health Center and other faith-based not-for-profits that provide care to the poor in Memphis. It is wonderful to find like-minded institutions and leaders with a mission to care for the poor. The patient population continues to be around 85 to 90 percent uninsured, with the remaining being mostly Medicare or Medicaid patients.

My advice to anyone interested in serving domestically is to first find and surround yourself with professionals who think and work similarly, or who at least understand and support your mission. Second, don’t be afraid to negotiate volunteerism into your contract. We negotiate call schedules, vacation, Continuing Medical Education, and so on, so I think we can and should negotiate outreach and service with just as much gusto and enthusiasm. It is one of many ways we can bring our community and its needs to the table. When I negotiated the contract for my present position, my key stipulations were the ability to continue mission work abroad, and the ability to have an open door to my more than 800 patients from the Church Health Center, as well as new consults from the center and other providers with unlimited uninsured and Medicare/Medicaid patients. When I expressed surprise at the immediate affirmative response from our chief executive officer, he said that he spends more time negotiating “call schedules and Teslas,” so my requests came as a breath of fresh air. We should be careful in assuming that only physicians and nurses go into health care to help people.

What advice would you give other health care professionals who want to provide volunteer and humanitarian services more generally?

I co-facilitate a course called Serving the Underserved at UT for medical, pharmacy, dental, and other health care students. We teach that the foremost aspect of service and volunteerism is first to strive for excellence in all that you do. One of the most disparately distributed and unjust aspects of care for the poor is quality. Being involved in quality improvement does not necessitate that we be in high-resource settings. It requires that we care enough to see patients through to the end result and back around again. It asks us to be humble and to always learn from our work and patients’ experiences.

The other lesson I have learned is that we need to continually ask ourselves why we do what we do. Do I serve because I feel called to do so? Is this a way to live out my faith? Do I serve because I love humanity? Do I feel obliged? Once we have our why, we can set honest expectations. For me, working with poor and marginalized patients certainly is rooted in a sense of justice, but, more so, I have realized that my work is a way to truly live my faith. Working with the poor is
a way for me to love. With that in mind, especially in rough spots, I turn to the scriptures, and sometimes to this statement by Mother Teresa for clarity: “We are not called to be successful. We are called to be faithful.” This is my individual view of why I do what I do.

**What can the ACS and OGB do to help?**

The ACS and OGB are already helping by creating and inviting people to contribute to the database of volunteers and opportunities. I would love for us to have an ACS Surgeon Specific Registry for our international work. When we have the time, we enter our data into the database, but I am not sure volunteers do this consistently. It would be illuminating to compare my thyroid or hernia outcomes with those of surgeons doing similar work in similar contexts in other parts of the world. The data boxes would need to include some factors like water sources, operating room set up, availability of energy sources, and so on.

Also, with regard to the educational work, it would be helpful to share curricula across continents. SAGES is doing some work with an international laparoscopy curriculum, but I believe the College can contribute a quality improvement curriculum and other educational resources.

Lastly, *The Lancet* Commission on Global Surgery work gave us a beautiful map of surgeons and areas of shortage and challenge as part of the Global Surgery 2030 campaign. It would be great to be able to map the work that surgeons do through ACS OGB and compare it with those that the commission has identified. I can only guess that millions of private dollars are spent annually on work like ours. We need to work smarter.

I think it would be helpful for someone who is thinking about pursuing this work to look at the map, see what areas are not being served, and maybe go there and start learning. Similarly, it would be great to identify areas in which overlap occurs. We run into other volunteer health care provider groups at the Manila airport on occasion, and it makes me wonder about redundancy. If we are in this work then we have a responsibility to distribute resources in a way that not only demonstrates good stewardship, but more importantly, in a way that is most helpful to the community.
The Global Tracheostomy Collaborative: Multidisciplinary quality improvement in tracheostomy care

The members of the Global Tracheostomy Collaborative (GTC) assert that tracheostomy-related catastrophic events are like central line-associated infections—they can be eliminated. The GTC is working with health care providers, hospitals, patients, and families around the globe to make the vision of universal safe tracheostomy care a reality. At present, 45 hospitals around the world are members of the GTC, working to implement key drivers that help eliminate adverse events while tracking their outcomes in a worldwide database that already houses more than 2,500 patient admissions.

Responding to frequent adverse events

Many studies show that tracheostomy-related adverse events occur frequently (between 10 and 20 percent of patients)—including preventable complications that cause permanent injury or death.1-3 Surgeons who perform tracheostomies and provide care to patients who require the procedure have, at some point, encountered complications and, on occasion, poor outcomes. Strikingly few of these adverse events occur in the operating room. Catastrophic events are particularly unfortunate because most involve either the absence of preventive or rescue measures that could easily have been in place, or training and staffing deficits that could be readily eliminated.

As with central line-associated infections, it is not enough to “spread the word” on these measures or attempt to educate everyone on these processes. To eliminate tracheostomy-related morbidity and mortality, each hospital should do the following: build a robust system to ensure that clinical decision making for “trach” patients is unified and consistent; implement simple preventative and rescue measures; and ensure that staff trained in rescue measures are always available at the bedside within 3 to 5 minutes of an emergency to intervene before permanent hypoxic injury occurs.

The GTC was founded in July 2012, when the co-author of this article, David Roberson, MD, FACS, FRCS, invited 20 tracheostomy and quality improvement experts from around the world to meet in Glasgow, U.K. That group agreed to incorporate as a not-for-profit organization and to create a program that would disseminate best practices worldwide.

In the decade between 2000 and 2010, two hospitals in very different locations and clinical

HIGHLIGHTS

- Describes the GTC’s mission to disseminate safe tracheostomy care worldwide
- Summarizes the five “key drivers” of tracheostomy care improvement
- Discusses the benefits of implementing team-based care and standard protocols
environments—Austin Health in Melbourne, Australia, and St. Mary’s Hospital in London, U.K.—built hospitalwide care systems that reduced tracheostomy-related adverse events by 90 percent or more. Although these hospitals serve different populations with different clinical issues, the programs that they developed are strikingly similar in their key attributes.4,5 Similar programs aimed at reducing tracheostomy-related adverse events have been developed in the U.S., such as the program at Johns Hopkins Medicine, Baltimore, MD.6

**Keys to tracheostomy quality improvement**

Drawing on these experiences, the GTC has adopted five key drivers of tracheostomy care improvement:

- **Team-based care.** Representatives of all specialties involved in the care of these patients, including surgery (otolaryngology–head and neck, general, thoracic), pulmonology, intensive care, nursing, speech pathology, respiratory therapy, and others depending on hospital staffing, must meet face-to-face at least weekly to review the inpatient tracheostomy census and make joint decisions. With so many services involved, there is no practical way to have consistent and clear care decisions without regular in-person meetings. In addition, every hospital should have a tracheostomy committee that meets monthly to review adverse events and address systemic issues.

- **Standard protocols.** Hospitals must establish protocols so that—barring patient-specific needs or complications—every trach patient receives the same preoperative, perioperative, and postoperative care. When every department, and in some cases every physician, applies different postoperative care standards, important aspects of follow-up care will invariably fall through the cracks because so many different people are involved in tracheostomy care. For example, deaths have occurred because the night shift staff was unaware that in a particular patient, should the tracheostomy dislodge, oral intubation was still an option.

- **Staff education and assignment.** A hospital must develop a training and staff assignment system so that when a tracheostomy occludes at 2:00 am, someone trained to manage this emergency situation will be at the bedside within minutes, before hypoxic injury ensues. An informal poll of approximately 150 attendees at a tracheostomy seminar at the American College of Surgeons Clinical Congress in 2016 showed that less than 2 percent of respondents were confident that this type of training and assignment system was in place at their hospital.

- **Patient and caregiver involvement.** Patients and their families should be involved in all aspects of this process. In particular, patient and family representatives should be on the institutional tracheostomy committee. At Boston Children’s Hospital, the addition of a family member to our tracheostomy committee has prompted us to recognize and address many care vulnerabilities of which we were not previously aware. Due to the fact that the availability of tracheostomy emergency equipment in residential homes varies, we developed an institution-wide “Go Bag” with standard emergency equipment. Our nurses now unpack and review each family’s bag during each visit to the tracheostomy clinic to ensure they are always equipped for emergencies.

- **Data collection.** The GTC has a worldwide database that is compliant with protections in the Health Insurance Portability and Accountability Act, as well as with U.K. and Australian privacy laws. This registry contains key data from member hospitals on each admission for patients with tracheostomies. The GTC issues regular reports to member hospitals that allow them to track their own progress and compare their outcomes with similar hospitals.
Moving the GTC forward
When a hospital joins the GTC, they are encouraged to develop a multidisciplinary tracheostomy team, conduct weekly multidisciplinary rounds, develop or adopt tracheostomy care protocols, involve patients and families in the care plan, and enter their hospital admission data into the GTC database. The GTC began enrolling hospitals and collecting data in 2014, and many hospitals do not yet have enough data to draw statistically significant comparisons. Most member hospitals anecdotally report improved care. Our most robust data to date comes from a set of hospitals in Manchester, U.K., that demonstrated a 20 percent reduction in length of stay and a statistically significant reduction in major adverse events within 12 months of joining the GTC.

GTC membership includes community hospitals and academic medical centers, as well as multiple freestanding pediatric hospitals and hospitals that provide only adult care or a mixture of adult and pediatric services. Because of the inherent differences in pediatric and adult populations, the GTC does not compare pediatric and adult outcomes in its reports.

In addition to promoting localized quality improvement strategies to enhance hospital-level tracheostomy outcomes, the GTC hosts approximately six webinars annually on all aspects of tracheostomy care.

The GTC also hosts regular international meetings on tracheostomy care. The most recent meeting—the Third International Tracheostomy Symposium in April 2016 at Johns Hopkins University—drew more than 250 attendees from around the world. The GTC will co-host the Fourth International Tracheostomy Symposium, February 2–3, 2018, at the University of Texas Southwestern Medical Center, Dallas.

The GTC welcomes inquiries from any interested hospital facility or system and from any surgeon who would like to participate as an individual in one of the collaborative’s working groups. For more information, visit the GTC website at www.globaltrach.org or contact Dr. Roberson at droberson@globaltrach.org.

REFERENCES
Alternative Payment Models

Surgeons who participate in Medicare may have noticed a growing emphasis in recent years on the role of Alternative Payment Models (APMs). The Patient Protection and Affordable Care Act (ACA) of 2010 created the Center for Medicare and Medicaid Innovation (CMMI) within the Centers for Medicare & Medicaid Services (CMS), with the goal of testing, evaluating, and implementing new payment models. The U.S. Department of Health and Human Services (HHS) in January 2015 also set a goal of tying 50 percent of Medicare physician payments to quality through an APM by 2018. More recently, Congress passed the Medicare Access and CHIP (Children’s Health Insurance Program) Reauthorization Act (MACRA) of 2015, which created incentives for physicians to participate in APMs and a pathway for development of new payment models.

Although the relevance of APMs has grown, models that recognize the importance of surgeon leadership and the team-based nature of surgical care have been lacking, leaving many surgeons without meaningful opportunities for participation. In response, the American College of Surgeons (ACS) is in the beginning stages of a multi-year effort to develop a new model known as the ACS-Brandeis Advanced-APM (A-APM) proposal (see page 49).

What are APMs?
APMs provide a model for paying physicians that differs from the traditional fee-for-service construct. The goal of APMs is to improve the quality and value of care provided, reduce growth in health care spending, or both. On the Quality Payment Program (QPP) website, CMS describes APMs as payment models that create incentives for clinicians to provide high-quality, cost-efficient care for a specific clinical condition, episode of care, or population.

What is a MIPS APM?
CMS created a separate scoring standard in the Merit-based Incentive Payment System (MIPS) for certain APMs to avoid duplicative data reporting requirements for MIPS-eligible clinicians. The models to which this scoring standard applies are referred to as MIPS APMs. To be considered a MIPS APM, participating entities must maintain a participation list of MIPS-eligible clinicians, base payment incentives on clinicians’ performance with respect to cost and quality.
The ACS-Brandeis A-APM recognizes the team-based nature of surgical care and is flexible, allowing providers to design the care pathways that work best for each patient and practice. Quality is measured through an episode-based measure framework based on the College’s Surgical Phases of Care concept.

measures, and maintain a participation agreement with CMS or otherwise be approved as a model by law or regulation.

What is an A-APM?
MACRA created incentives for participation in certain qualified APMs that require participating entities to accept more financial risk, use certified electronic health record technology (CEHRT), and adjust payment based on quality measures equivalent to those in MIPS. CMS created the designation A-APMs, which is essentially a subset of APMs that have been certified by CMS to meet these three requirements.

What A-APMs are currently available?
CMS has approved the following A-APMs for the 2017 performance year:

• Comprehensive End-Stage Renal Disease Care—Two-Sided Risk
• Comprehensive Primary Care Plus
• Next Generation Accountable Care Organizations
• Medicare Shared Savings Program Tracks 2 and 3
• Oncology Care Model—Two-Sided Risk

• Comprehensive Care for Joint Replacement Payment Model Track 1 with CEHRT requirements

Other models may still be added for 2017, and additional models, including some recommended by the Physician-Focused Payment Model Technical Advisory Committee (PTAC), are expected to emerge in the future.

Why should surgeons participate in an APM or A-APM?
Surgeons should consider participating in an APM or A-APM, if one is available, for a number of reasons. First, these models may provide tools for improving clinical patient care and lead to increased efficiency. Furthermore, for MIPS-eligible clinicians, the reporting requirements are different for those participating in a MIPS APM and may be less burdensome. Depending on the payment model, shared savings or other financial incentives for participation may also be available. Surgeons who see enough patients or receive enough payments through A-APMs are considered qualified APM participants and are exempt from the MIPS program. For payment years 2019–2024 (based on performance
in 2017–2022), these qualified clinicians will receive a lump sum incentive payment equal to 5 percent of their previous year’s Medicare Part B charges.

What is the PTAC?
To provide more opportunities for physicians to participate in APMs, Congress created the PTAC as part of MACRA. This 11-member panel reviews APMs proposed by stakeholder groups, including the ACS and others, and makes recommendations to the Secretary of the HHS regarding whether the model should be tested or implemented. The PTAC began accepting proposals in late 2016, and the ACS submitted the first proposal in December 2016.

What is the ACS-Brandeis A-APM proposal?
The ACS-Brandeis A-APM proposal was developed by the ACS and a team at Brandeis University, Waltham, MA. It uses software known as the Episode Grouper for Medicare to group Medicare claims into episodes of care, which can then be risk-adjusted based on the care the individual patient has received or is receiving to set a patient-specific target price. Responsibility for care is automatically attributed to various providers based upon their role in delivering health care services to the patient, determined through claims filed.

The ACS-Brandeis A-APM recognizes the team-based nature of surgical care and is flexible, allowing providers to design the care pathways that work best for each patient and practice. Quality is measured through an episode-based measure framework based on the College’s Surgical Phases of Care concept. Health care professionals who provide quality care would be eligible to share in savings and, because the model is designed to meet the A-APM criteria, may qualify for the 5 percent incentive payment.

What is the status of the ACS-Brandeis A-APM?
The ACS-Brandeis A-APM was among the first two models that the PTAC approved at its April 2017 meeting. The PTAC sent its formal recommendation to HHS Secretary Tom Price, MD, on June 6. It is now up to the Secretary to decide how best to implement the model in Medicare. ACS staff will continue to update Fellows on the status of the ACS-Brandeis model and other APM opportunities that may be of interest.

Where can I learn more about APMs?
For information on APM options in the Medicare program, including approved A-APMs, visit the CMS QPP page dedicated to APMs (www.qpp.cms.gov/apms/overview). More information on the PTAC, including the ACS-Brandeis A-APM proposal and the PTAC’s letter of recommendation to Secretary Price, can be found on the PTAC website (https://aspe.hhs.gov/ptac-physician-focused-payment-model-technical-advisory-committee). The CMMI website has information about models currently being tested, including opportunities for enrolling in certain models (https://innovation.cms.gov/). Finally, the College will continue to provide updates on the ACS-Brandeis A-APM and other models available to surgeons both in the Bulletin and on the College’s website. ♦
Preoperative smoking cessation: Every patient, every operation

by Paul Preston, MD; Efren Rosas, MD, FACS; and Tammy Peacock, RN

Smoking adds approximately $200 billion in spending to the U.S. budget annually, mostly because of health care spending and lost productivity. Smoking remains one of the foremost preventable causes of mortality and morbidity and is the cause of close to half a million deaths per year. Smoking is a well-reported risk factor for most American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP®) complications, and the surgical event is potentially one of the most effective times to get patients to successfully stop smoking. Nonetheless, efforts to identify, counsel, treat, and measure successful smoking cessation often are sporadic in health care.

Identification of local problem
A 2014 analysis of ACS NSQIP complications at Northern California Kaiser Permanente—a 21-hospital integrated health care network that provides comprehensive care to 4 million patients in 21 medical centers and 12 ambulatory surgery centers (ASCs)—showed a 1.5- to two-fold increase in complications in patients who smoked. Internal data culled from an in-house questionnaire of hundreds of select postoperative patients suggests that only 50 percent of smokers remembered being advised to stop smoking and only 4 to 8 percent were given effective smoking cessation aids. Actual measurement of smoking cessation and clear referral pathways were unclear or nonexistent (see Table 1, page 51).

How was the QI activity put in place?
Surgical outcomes measures using data from ACS NSQIP, a consistent platform for electronic health records (EHRs) and orders, and a proactive health education group were all used to carry out this initiative. A foundational element was for our surgeons to recognize the impact they have on patient behavioral decisions and to take ownership of patient smoking cessation. Other critical planning steps included the following:

• Identification of best practices and tested workflows developed by David O. Warner, MD, professor of anesthesiology, Mayo Clinic College of Medicine, and co-director, Mayo Clinic Office of Health Disparities Research, Rochester, MN. These guidelines needed to be adapted to the needs of the network and its patients, but we determined it was an attainable goal.

• Development of a defined screening and referral process for surgical clinics and preoperative medical clinics.

• Clear definition of eligible patients: all smokers, all surgery types, inpatient and outpatient. Inpatient surgical patients, direct transfers from emergency to operating room, and cataract operations were exempt.

• Clear agreement on how to measure a successful quit, specifically, exhaled carbon monoxide (CO) reading day of surgery.

• Provision of equipment to measure CO preoperatively on all smokers coming from home.

• Development of clear and accountable workflows.

• Automated support of screening, referrals, and prescription of medications.
Provision of reports to facilities and departments showing percent compliance with these processes.

Automated CO orders in the EHR. EHRs prepopulate only for current and recent smokers. These triggers are created by medical assistant screening and documentation in the clinic.

Obtain support from smoking cessation experts in health education, who can provide over-the-phone smoking cessation counseling and can prescribe smoking cessation aids.

Consult the literature and regional practitioners to plan changes.3-6

Description of the QI activity
Based on our data, Kaiser leadership chartered a small group of smoking cessation champions, including surgeons, anesthesiologists, preoperative medicine clinicians, smoking cessation counselors, data analysts, and project managers. Conversations with all parties (referring physicians, surgeons, preoperative medicine clinics, clinic medical assistants, preoperative nurses, and anesthesiology personnel) revealed support, in principle, with this initiative, as well as the need for clear and simple workflows developed with maximum automation and support. Patients expressed a clear preference for hearing about the importance of smoking cessation from their surgeon. We agreed to use a hard measure, CO, to evaluate the effectiveness of smoking cessation and also decided to make all elective surgeries eligible.7

Several pilot facilities volunteered for this project, which greatly helped in refining the actual workflows that could be applied within our system. A linear workflow was tested. Using this system, clinic medical assistants screened for smoking, surgeons counseled and referred patients, and smoking cessation experts supported patient efforts to quit and prescribed appropriate cessation aids. The value of these smoking cessation educators is notable due to the fact that they both counsel and prescribe smoking cessation aids, which can triple the chance of success.8,9

Preoperative registered nurses were tasked with measuring CO upon admission, with referring providers and perioperative medicine clinics serving as a safety backup. This clear definition of workflows allowed documentation, orders, and discrete measurement fields to be added to the EHR. Pilot work showed that automating this process and requiring minimal extra work was critical to its success.

Necessary resources and skills
A regional task force of eight members led this effort. No additional staff was required at the local facility. Programmer resources and health education resources used were already in place.

The addition of CO measurement equipment cost each perioperative location approximately $2,000. Because these devices are not subject to Clinical Laboratory Improvement Amendment (CLIA) regulations, no extra training was required. Cost of complications far outweighs the cost of smoking cessation.

TABLE 1.
2014 ACS NSQIP COMPLICATION RATES FOR 21 NORTHERN CALIFORNIA KAISER PERMANENTE HOSPITALS

<table>
<thead>
<tr>
<th></th>
<th>Smokers</th>
<th>Nonsmokers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Postoperative complication</td>
<td>NCAL = 6.5%</td>
<td>NCAL = 5.3%</td>
</tr>
<tr>
<td></td>
<td>National = 9.1%</td>
<td>National = 7.6%</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>NCAL = 1.6%</td>
<td>NCAL = 0.7%</td>
</tr>
<tr>
<td>SSI</td>
<td>NCAL = 1.8%</td>
<td>NCAL = 1.4%</td>
</tr>
<tr>
<td>Unplanned intubation</td>
<td>NCAL = 0.8%</td>
<td>NCAL = 0.4%</td>
</tr>
<tr>
<td>Sepsis</td>
<td>NCAL = 3.3%</td>
<td>NCAL = 2.3%</td>
</tr>
</tbody>
</table>

NCAL: Northern California
Results
Figure 1, this page, is an overview of the key data over the course of the project.

We encountered several setbacks in implementing this program, including extreme time demands on clinic and perioperative areas and difficulty in capturing all smoking cessation referrals, with some direct local referrals leaving no signal in the EHR.

Selected workflows continue to be hard to measure, but we are probably doing better than we think. We also are finding that CO measure orders are inconsistently executed, and this is now a quality target for our perioperative areas. Some facilities are at 90 percent success with this measure.

And lastly, we need to clearly define when a case should be canceled based on CO results.

Solutions to these barriers include development of simple, automated workflow and decision support cards, which are based on the Mayo Clinic model and given to patients in the clinic to focus the conversation on the importance of preoperative smoking cessation (see Figure 2, page 53). Other effective means for addressing these setbacks include standardization of referral pathways and measurement and asking patient-specific queries when CO is not completed or documented.

In the near future, a single electronic smoking referral will be generated for all patients and should assist with reliability and data capture, and staff-specific reports will help managers identify and coach when CO measures are missed.

The cancelation of elective cases is evidence-based but highly disruptive and will be the focus for upcoming work. It is important to note that the initial phase of this activity is to get people to willingly stop smoking.

Kaiser has had to make minimal revisions to date in the original QI plan due to limitations encountered during the process.

Lessons learned
For those institutions and health care systems seeking to start a preoperative smoking cessation program, the authors offer the following recommendations:

- Identify a surgical champion and multidisciplinary team
- Have reliable data
- Ensure clear communication and protocols for referral processes
- Develop automated workflows for streamlined data capture
- Focus on patient education and engagement to improve compliance
- Monitor and evaluate outcomes to continuously improve the program
Surgery may already feel like a stressful time. You may be concerned that it will be too difficult to manage without smoking, that nicotine withdrawal may make recovery harder, or that there is just too much going on to focus on quitting.

We worry, too. Our patients who continue to smoke are more likely to:

• Have more infections.
• Heal more slowly.
• Have more breathing problems during and after surgery.

The choice to stop smoking before surgery is yours. We strongly advise you to stop and can help you along the way. Whatever you decide, remember that you cannot smoke while you are in the hospital for your surgery.

Even quitting for a bit can help you avoid complications and heal faster. Stop at least 24 hours before surgery and don’t smoke for at least one week after to reduce your chances of post-surgery infections.

Here’s why:

• Within 12 hours of not smoking, your heart and lungs start working better.
• Smoking reduces the amount of oxygen your blood carries to the rest of your body. This increases the chance that your surgical incision will get infected.

What’s your next step? Talk with your surgeon about Wellness Coaching for a plan, support, and medications.

Surgery is a great time to quit smoking. Here’s why.

People who quit before surgery:

• Have fewer cravings for cigarettes.
• Are more than twice as likely to stop for good than at other times.
• Heal better and faster after surgery.
• Have fewer breathing and circulation problems during and after surgery.

We have helped thousands of patients quit successfully. We’re confident that you can, too.

What’s your next step? Talk with your surgeon about Wellness Coaching for a plan, support, and medications to help you quit.

REFERENCES

Surgery has been used as a medical treatment for millennia, but the question about surgical skills and how to achieve them remains a matter of intense debate. Surgical curricula comprise a mixture of components aimed at covering all the surgical knowledge and skills necessary to conduct the clinical examination, diagnose diseases, make decisions about surgery, perform the operation, provide postoperative care, and handle surgical complications. Some attempts have been made to set standards for medical education. In the last 10 years, considerable focus has been on the use of simulation to help surgical residents and practicing surgeons become adept at performing specific techniques, such as laparoscopy and other specialized procedures. However, to the best of my knowledge, no description of a simple, basic, and generally applicable training model has been published.

In the last 10 years, considerable focus has been on the use of simulation to help surgical residents and practicing surgeons become adept at performing specific techniques, such as laparoscopy and other specialized procedures. However, to the best of my knowledge, no description of a simple, basic, and generally applicable training model has been published. Traditional time-based training with trainer and trainee still dominates over competency-based surgical training, and advanced surgical simulators are available only to a fraction of the world’s surgical residents. In addition, surgical training seldom includes a firm predefined structure, and the local variation is huge. The human anatomy is the same regardless of geography or socioeconomic status. Therefore, to have a sufficiently trained surgeon seems like a reasonable part of the Universal Declaration of Human Rights published by the United Nations in 1948. Many organizations today focus on “global surgery” by promoting access to qualified surgeons in underserved environments, often funded by industrial companies, scientific journals, or universities. However, the goals and the missions of these groups often vary widely, and different global surgery organizations seem to be competing. This led to the creation of the Surgicon Project.

### Surgicon
The Surgicon Project was initiated in 2010 as an independent, not-for-profit, scientifically driven global network focused on surgical training methodology. The cofounding group of Surgicon is listed in the sidebar on this page. A key mission of the founders was to organize a new congress in surgical training, which took place twice in Sweden in 2011 and 2013. One of the first conclusions

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**CO-FOUNDERS OF THE SURGICON PROJECT**

James C. Esch, MD  
Founder, San Diego Shoulder Institute, Carlsbad, CA

Carlos A. Pellegrini, MD, FACS, FRCS(Hon), FRCSI(Hon), FRCSEd(Hon)  
Past-President, American College of Surgeons, University of Washington, Seattle

Gerald O’Sullivan, MB, MCh, MSc, FRCSI, FRCSPGlas(Hon), FRCSEng(Hon), FACS(Hon)

Anthony G. Gallagher, PhD, DSc  
College of Medicine and Health, University College Cork, Ireland

Richard L. Angelo, MD  
Past-president, Arthroscopy Association of North America, WA

Kai Olms, MD  
Helios Hospital, Bad Schwartau, Germany

Spencer Beasley, MB, ChB  
Vice-President, Royal Australasian College of Surgeons (RACS), Christchurch, New Zealand

Richard M. Satava, MD, PrEm, FACS  
University of Washington

Richard Hanney, MD, FRACS  
Mount Druitt Hospital, Sydney, Australia

Aantje Aschendorff, MD  
Professor, Freiburg University, Germany
at these congresses was the need for structured competency-based surgical training to replace the time-based training type. In 2013, the World Health Organization (WHO) invited Surgicon to collaborate, through the WHO Global Initiative for Emergency and Essential Surgical Care group.

Professor Gallagher and colleagues have shown that surgical skills can be measured. As a result of the Surgicon network, a new research group was formed to develop a scientifically validated surgical training model for an arthroscopic Bankart procedure by doing a series of randomized, prospective, and controlled scientific studies between 2012 and 2015. One of their conclusions was that the described method generally could be used in different kinds of surgery. However, the method includes the use of virtual simulators and cadaveric training, which could be expensive and complicated to be applied universally. Despite the useful published data, the described methodology has yet to be accepted and implemented. In addition, the factor of practical examination during surgical training was not included in these studies, is generally seldom mentioned in the literature, and seems to be underestimated.

The generally applicable training method
A simple, generally applicable surgical training model is therefore suggested, where the simplicity in itself is regarded as a factor of importance for implementation. The method may be used in and adapted to multiple surgical specialties. The hypothesis is that such a basic model could easily be internationally accepted across “borders and boards,” meaning across the borders of high-income and low-income countries, as well as across surgical societies. It should be emphasized that any form of competition between organizations to take ownership of different surgical curricula is regarded as counterproductive when aiming at international agreements and standards. The aim of this model is to train new surgeons in a stepwise fashion, to obtain internationally equalized and comparable surgical skills.

The generally applicable surgical training model is illustrated by a staircase, here with four suggested competency levels (see Figure 1, this page). The steps could be smaller, and more levels can be added eternally. The red blocking lines in the staircase image represent the factor of practical examinations, meaning that an examination is necessary, to pass on to the next level.
The aim of this model is to train new surgeons in a stepwise fashion, to obtain internationally equalized and comparable surgical skills.

The content of the staircase steps are unique to each surgical specialty. Consensus regarding the definition of difficulty levels could initially be made between a few surgical societies of one specialty, or regionally, and could later be expanded to include more surgical organizations successively. In this way, the work toward an international standard for equalized surgical skills levels may start and slowly proceed.

A structured system like this might also have an impact on surgical quality. As a comparison, it is well known that the very registration of surgical infections will reduce the infection rate. The introduction of stepwise and mandatory practical examinations might therefore be helpful, just by their existence. Simultaneously, this model would create higher security for both trainer and trainee, as both parts would know the defined goals and what to expect at each step of the staircase.

Intentionally, the steps have no time limit. Some of today’s excellent surgeons have had a long learning curve, and some trainees will learn specific procedures in a shorter time. Some surgeons might specialize and get a license for steps A, C, and E (for example, spine surgeons). There is also a belief that such a model could shorten the total training period, as the very structure might reduce time gaps when residents are just hanging around.

REFERENCES


How can practical examinations be performed?
The crucial factor in this model is the stepwise practical examination necessary to proceed to the next level. The model does not state the exact form of the examination. Any kind of examination process might be used, and each training center needs to define the process from the start. It might, for example, be a live surgical procedure performed in front of two examiners or recorded on a video that is then reviewed by, say, three experienced surgeons or surgical assistants. As Gallagher, Angelo, and Pedowitz...
have observed, a surgical procedure could be divided into a number of mandatory steps. Using these steps as a checklist, it would be easy to confirm whether all steps were completed, either live through examiner dictation to a scribe in the operating room or through video replay. The actions taken to complete the steps are described as neither good nor bad; only indicated is that the mandatory steps were completed.

To qualify as an examiner it is suggested that steps A, B, C, and D have been passed, but for practical reasons, local variations would be permissible. In some cases, experienced surgical assistants have been used to check such surgical videos.

In this context, written surgical reports are likely to be replaced by videos in the not-too-distant future. Such a development supports the staircase model with systematic video examinations, which could increase both the patient’s safety and trainer and trainee confidence.

**Validation**

The staircase model needs to be scientifically validated in different ways, and could be used as a tool for scientific studies comparing the development of surgical skills among residents trained in a traditional way (time-based) or after this model (competency-based). The possible time-saving effect of the suggested training model might be studied, as well as other aspects.

**Conclusion**

The described stepwise surgical training model can be used for any kind of surgery. One crucial factor is mandatory practical examinations of the obtained surgical skills, to be allowed to pass on to the next level. The model is the result of 30 years of observation of lacking structures in this domain and of the costs to society for avoidable surgical complications.
The mission of the Alliance for Clinical Trials in Oncology (Alliance) and the American College of Surgeons Clinical Research Program (ACS CRP) is to reduce the impact of cancer through increased knowledge and awareness of new evidence and practice standards, greater participation of community oncology surgeons in cancer research and cancer care activities, development and implementation of evidence-based practices in surgical oncology, and expanded opportunities for meaningful health services research. The ACS CRP comprises four committees: Cancer Care Delivery Research, Cancer Care Standards Development, Dissemination & Implementation, and Education.

Sponsoring Panel Sessions at the annual ACS Clinical Congress is one way the ACS CRP helps Fellows stay ahead of the curve on the treatment of patients with cancer. Clinical Congress 2017, October 22–26 in San Diego, CA, will feature five Panel Sessions on an array of topics in oncology with a focus on increasing surgeon knowledge and elevating the care of oncology patients nationally.

**CRP sessions at Clinical Congress**

**Management of the axilla in breast cancer**
Laurie Kirstein, MD, FACS, surgical oncologist, Memorial Sloan Kettering Cancer Center, New York, NY, and Judy Boughey, MD, FACS, Chair, ACS CRP Education Committee, and co-author of this article, will moderate Management of the Axilla in Breast Cancer, 11:30 am–1:00 pm, Monday, October 23. This session, co-sponsored by the Commission on Cancer (CoC), will focus on management of the axilla both in patients treated with primary surgical resection and patients treated with neoadjuvant systemic therapy. Panelists will discuss the optimal approaches to axillary staging, how to avoid overtreatment of the axilla, associated comorbidities, and optimized accuracy of less invasive options.

**AJCC staging systems**
The AJCC [American Joint Committee on Cancer] Cancer Staging Manual, Eighth Edition, was released in October 2016, and the guidelines in it will be implemented in January 2018. The changes in the new edition are more significant than in the past, with the incorporation of tumor biology and additions to classic tumor/node/metastasis classifications. If you are not up to speed with the new staging system or have questions, plan to attend Evolving Concepts in the AJCC Staging Systems: Breast Cancer, Colorectal, and Melanoma, 2:30–4:00 pm, Tuesday, October 24, moderated by David J. Winchester, MD, FACS, general surgeon, NorthShore Medical Group, Evanston, IL, and David Byrd, MD, FACS, professor of surgery and section chief of surgical oncology, University of Washington, Seattle. This session, co-sponsored by the CoC, will provide an overview of the changes in the *AJCC Cancer Staging Manual*, Eighth Edition, as well as clinical staging examples. The session will be important to ensure that surgeons are aware of the changes and provide an opportunity for questions so that surgeons are ready for implementation in January.
In 2015, the ACS CRP published *Operative Standards for Cancer Surgery Volume I*, which reviews evidence-based optimal operative techniques for breast, colon, lung, and pancreatic cancer. Volume II is about to be released and covers operations for melanoma and esophageal, gastric, rectal, and thyroid cancers. Chaired by Matthew Katz, MD, FACS, associate professor, department of surgical oncology, division of surgery, the University of Texas MD Anderson Cancer Center, Houston, and Waddah Al-Refaie, MD, FACS, chief, surgical oncology, MedStar Georgetown University Hospital, Washington, DC, *ACS Operative Standards for Cancer Surgery* Volume I will be available for purchase and pre-purchase, respectively, at the Wolters Kluwer booth.

**Emerging technologies panel discussion**

If you are interested in new techniques in the surgical management of liver and pancreas cancer and want to learn how to incorporate some of these emerging technologies safely into your clinical practice, consider attending Controversies and the Appropriate Incorporation of Emerging Technologies in Multidisciplinary Treatment of Liver and Pancreatic Cancer. The Panel Session will take place 8:00–9:30 am, Wednesday, October 25, and is co-sponsored by the Committee on Emerging Surgical Education and Technology. Moderated by Clancy Clark, MD, FACS, general surgeon, Wake Forest Baptist Health, Winston-Salem, NC, and Georgios Tsoulfas, MD, FACS, President, ACS Greece Chapter, the session will review the efficacy of minimally invasive surgery, irreversible electroporation, and stereotactic body radiation therapy, and how to introduce them into practice.

**Understanding clinical trial results**

Many advances in patient care stem from clinical trial results. Understanding these trials and their findings and identifying how they can and should be incorporated into your clinical practice can be challenging. Learn more during Clinical Trial Results: Why and How You Should Incorporate Them into Your Practice, 4:15–5:45 pm, Wednesday, October 25. Moderator Kelly K. Hunt, MD, FACS, Director of the ACS CRP and co-author of this column, will review results from recent clinical trials in cancer.

**ACS CRP networking session**

If you are interested in getting more involved in the ACS CRP or learning more about the program, consider attending the Networking Session, 6:00–7:00 pm, Sunday, October 22, at the Manchester Grand Hyatt Hotel, America’s Cup A, Fourth Level. Hors d’oeuvres, beer, and wine will be served. Contact Amanda Francescatti, Senior Manager, ACS CRP, at afrancescatti@facs.org to RSVP or to learn about opportunities to participate in the ACS CRP.
Amidst the economic downturn that became known as the Panic of 1893, the American public looked to President Grover Cleveland for reassurance on the economic health of the nation. Little did they know, President Cleveland was privately occupied by his own health concerns.

In May of that year, the Commander-in-Chief noticed a rough spot along the roof of his mouth near his molars on his left side where he liked to chew his cigars.* At the time, the president was busy mediating debates with Congress about the benefits of the gold standard versus the silver standard, and he tried to avoid thinking about the rough spot growing inside his mouth.

The nation was shaken when former Union Army General and Past-President Ulysses S. Grant died from oral and esophageal cancer in 1885, and President Cleveland was acutely aware of the “cancer phobia” instilled in most Americans. For these social and political reasons, the president treaded lightly.

By June 1893, White House attending physician Robert Maitland O’Reilly, FRANKLIN MARTIN, MD, FACS, FOUNDER OF THE AMERICAN COLLEGE OF SURGEONS


Inset: President Cleveland; main photo: The Oneida
MD, examined President Cleveland and consulted leading pathologist William H. Welch, MD, Johns Hopkins Hospital, Baltimore, MD, and renowned maxillofacial surgeon Joseph Decatur Bryant, MD, Bellevue Hospital, New York, NY. The physicians uniformly agreed that the growing epithelioma must be removed. As the finest team of surgeons was assembled to perform the operation, President Cleveland continued to worry about the U.S. economy, insisting that his surgery and health remain a secret. His own Vice-President, Adlai Stevenson, was never informed.

The media tracked the movements of the Commander-in-Chief, so President Cleveland asked that the surgeons perform the operation aboard a friend’s private yacht named the Oneida. On July 1, 1893, while the president made the seemingly typical voyage from Manhattan to his summer home near Cape Cod, five surgeons sworn to secrecy worked to excise the president’s tumor in a makeshift operating room aboard the yacht.

Once the ether took hold, the surgeons rapidly removed five teeth, the hard palate, and part of the maxilla. Ultimately, they removed parts of the tumor that had invaded the maxillary sinus and cleared tissue superiorly to the floor of the left orbit (see Figure 1, this page).† The entire operation took place inside of 90 minutes as the yacht smoothly sailed along the East River that flanks Manhattan.

Because of his absence over the Fourth of July holiday, a flurry of reporters greeted President Cleveland outside his summer home in Cape Cod.

He immediately went inside to avoid any questions and secluded himself in the house. During this period of isolation, he began retraining his voice, as the operation had given him an acquired case of cleft palate. A prosthodontist fitted him with a rubber prosthesis that helped his speech tremendously. People were suspicious, and rumors surfaced, but the White House silenced them. Both President Cleveland and the economy became healthier, surviving into the 20th century without any recurrence of illness. Grover Cleveland died in 1908 of a cardiac illness unrelated to his cancer. ♦


![Figure 1](image-url)
The Joint Commission has released four new performance measures for advanced certification in total hip and knee replacement (THKR), which is offered to accredited hospitals, critical access hospitals, and ambulatory surgery centers (ASCs). These measures—which cover the whole patient care spectrum—will be of interest to orthopaedic surgeons, as the measures target areas related to the entire perioperative period.

The Joint Commission releases new measures for hip and knee replacement operations

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

The Joint Commission has released four new performance measures for advanced certification in total hip and knee replacement (THKR), which is offered to accredited hospitals, critical access hospitals, and ambulatory surgery centers (ASCs). These measures—which cover the whole patient care spectrum—will be of interest to orthopaedic surgeons, as the measures target areas related to the entire perioperative period.

The Joint Commission sought out experts recommended by their respective medical societies and professional associations, including the American Academy of Orthopaedic Surgeons (AAOS) and the Association of periOperative Registered Nurses.

The Technical Advisory Panel (TAP) composed of experts in orthopaedic surgery, anesthesia, rehabilitative medicine, internal medicine, physical therapy, perioperative nursing, social work, and joint program administration collaborated to develop these performance measures. When forming the TAP, The Joint Commission sought out experts recommended by their respective medical societies and professional associations, including the American Academy of Orthopaedic Surgeons (AAOS) and the Association of periOperative Registered Nurses.

The TAP developed draft measures that were published for public comment and evaluated the feedback before making the appropriate changes. Aspects of care appropriate for performance measure development were identified through a literature search and a review of clinical practice guidelines.

The measures were then pilot tested. Data were collected at 16 hospitals and two ASCs over a six-month period. Reliability testing was completed by Joint Commission staff at six of the organizations.

Starting January 1, 2018, all THKR-certified programs and programs seeking certification must collect monthly data on these performance measures and report the data quarterly via the certification measure information process section on The Joint Commission Connect secure extranet site.

THKR-1, regional anesthesia, evaluates whether the patient received neuraxial or other forms of regional anesthesia. Regional anesthesia is associated with fewer postoperative complications and deaths than general anesthesia. Research shows that patients who received neuraxial anesthesia had statistically significant fewer 30-day mortality and inhospital complications, including pneumonia, kidney failure, and the need for mechanical ventilation, than patients who did not receive neuraxial anesthesia. Additional studies show a decrease in operative blood loss and the need for blood transfusions. The AAOS clinical practice guidelines relating to management of osteoarthritis of the hip and knee state that in comparison with general anesthesia, neuraxial anesthesia can be used to improve select perioperative outcomes and complication rates.

THKR-2, postoperative ambulation on the day of surgery, is strongly supported in the literature. Early ambulation as close to the time of operation as possible can reduce the risk of complications associated with bed rest, such as deep vein thrombosis, pulmonary embolism, atelectasis, pneumonia, and urinary retention. Additionally, early ambulation results in decreased length of stay and lower patient risk for hospital-acquired infections and other complications. Early ambulation leads to improvement in V102 No 9 BULLETIN American College of Surgeons
A TAP composed of experts in orthopaedic surgery, anesthesia, rehabilitative medicine, internal medicine, physical therapy, perioperative nursing, social work, and joint program administration collaborated to develop these performance measures.

outcomes (range of motion, gait, balance, muscle strength, and pain) without an increase in adverse events.⁶

THKR-3, discharged to home, is based on the concept that home-based rehabilitation has been proven to result in better pain and functional outcomes, as well as increased patient satisfaction, than inpatient rehabilitation. This measure evaluates the percentage of patients who are discharged to home.⁷

Lastly, THKR-4 evaluates whether a general health and functional status patient-reported outcome (PRO) tool was completed preoperatively. Good orthopaedic care requires knowledge of the patient’s history of musculoskeletal pain and associated limitations in daily function. Integrating PRO data into routine orthopaedic patient visits can provide key information to monitor changes in symptom severity over time, support shared clinical decision making, and assess treatment effectiveness.⁸

In acknowledgement of the administrative burden associated with PRO data capture, The Joint Commission will implement PRO measures in a phased approach. During this first phase, the process of collecting preoperative data will be measured. During the second phase, pre- and postoperative data will be evaluated with the goal of calculating patients’ improvement scores.

While at present these measures are in a chart-based manual data collection format, The Joint Commission is testing electronic clinical quality measures for this measure set. For more information about the THKR certification program, visit www.jointcommission.org/certification/adv_cert_total_hip_total_kneeReplacement.aspx.

Questions about the performance measures may be directed to Marilyn Parenzan, associate project director, department of quality measurement, The Joint Commission, at mparenzan@jointcommission.org.

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
The human immunodeficiency virus (HIV), a retrovirus containing single-stranded ribonucleic acid (RNA), causes HIV infection, and if left untreated, can lead to acquired immunodeficiency syndrome (AIDS). HIV attacks the CD4 cells (T cells) of the immune system, which help the immune system fight off infections. If left untreated, a person is more prone to infections or infection-related cancers. Unlike other viruses, the human body cannot completely eradicate HIV, even with treatment. Once a patient has an HIV infection, he or she has it for life.

So, although there is no cure for HIV, with proper medical treatment, it can be controlled.

**HIV transmission and treatment**

HIV is transmitted through unprotected sexual intercourse; transfusion of contaminated blood or blood products, contaminated sharp instruments, and from mother to baby during pregnancy, childbirth, and breastfeeding. HIV infection is treated with antiretroviral therapy (ART). With proper compliance and when taken every day, this medicine can significantly prolong the lives of many people infected with HIV, keeping them healthy and reducing the risk of spreading the infection. ART was introduced in the mid-1990s. Until then, HIV infection rapidly progressed to end-stage AIDS within a few years. Today, if diagnosed with HIV before the disease is in an advanced stage, patients on ART can live nearly as long as uninfected individuals.¹

More than 1.1 million people living in the U.S. have HIV, and one out of seven are unaware that they have been infected. From 2008 to 2014, the estimated number of annual HIV infections in the U.S. declined 18 percent. The southern states bear the greatest burden, accounting for 50 percent of the new cases reported in 2014. The most at-risk population is young, gay, and bisexual African-American men.²

HIV/AIDS remains a significant global public health challenge, especially in low- and middle-income countries. According to the World Health Organization, at the end of 2015, approximately 36.7 million people were living with HIV, and by mid-2016, 18.2 million people (less than half) were on ART. Nearly 80 percent of pregnant women living with HIV are on ART.³

To examine the occurrence of injured patients with a diagnosis of HIV in the National Trauma Data Bank® (NTDB®) research dataset admission year 2015, medical records were searched using the International Classification of Diseases, Ninth and Tenth Revision, Clinical Modification codes. Specifically searched were records that contained either diagnosis codes of 042/B20, B21, B22, B23, B24 (HIV disease), or V08/Z21 (asymptomatic HIV/seropositive). A total of 34 records were found, of which 27 contained a discharge status, including 24 patients discharged to home and two to acute care/rehab; one died (see Figure 1, page 65). Of these patients, 73 percent were men, on average 47.4 years of age, had an average hospital length of stay of 4.9 days, an intensive care unit length of stay of 4.2 days, an average injury severity score of 9.8, and were on the ventilator for an average of 6.6 days.

**Take care**

Health care workers, especially those who care for acutely injured patients, often work with limited patient history information and must be prepared to offer intervention of extreme acuity and time.
Occupational transmission of HIV to health care workers remains extremely rare. As of December 2013, only 58 occupational transmissions of HIV had been confirmed, and 150 possible transmissions had been reported in the U.S. Of these cases, only one has been reported since 1999. Health care workers exposed to a needlestick involving HIV-infected blood at work have a 0.23 percent risk of becoming infected, if treated. Risk of exposure from splashed body fluids, even if bloody, is near zero. However, health care professionals who have been exposed to HIV must follow the postexposure plans in place at their institutions. Updated public health service guidelines on postexposure prophylaxis for occupational exposures are available at www.ncbi.nlm.nih.gov/pubmed/23917901.

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 Surgeons website as a PDF file at facs.org/quality-programs/trauma/ntdb. In addition, information is available on the NTDB web page about how to obtain NTDB data for more detailed study. To submit your trauma center’s data, contact Melanie L. Neal, Manager, NTDB, at mneal@facs.org.

Acknowledgment
Statistical support for this column was provided by Ryan Murphy, Data Analyst, NTDB.

REFERENCES
The Board of Regents of the American College of Surgeons (ACS) has chosen Richard J. Finley, MD, FACS, FRCSC, a general thoracic surgeon, Vancouver General and Surrey Memorial Hospitals, BC, and emeritus professor, department of surgery, University of British Columbia (UBC), Vancouver, to receive the 2017 Distinguished Service Award (DSA). The Regents will present the award—the College’s highest honor—Sunday, October 22, during the Convocation preceding Clinical Congress 2017 at the San Diego Convention Center, CA.

The Board of Regents is presenting the DSA to Dr. Finley in appreciation for his longstanding and devoted service as an ACS Fellow, the Chair (1993–1995) and Vice-Chair (1992–1993) of the Board of Governors (B/G), a member of the Board of Regents (2000–2009), and as ACS First Vice-President (2010). The award citation recognizes his “long-term commitment to improving graduate education for future generations” and his pioneering contributions in the area of health information technology, including his service as Chair of the ACS Web Portal Editorial Board (2005–2012) and Chair of the ACS Education Task Force on Practice-Based Learning and Improvement (2002–2009).

The citation acknowledges “his leadership as a driving force for change to better train future surgeons by electronic means and skills learning modules.” The award underscores “his natural leadership, integrity, vision, and services as a role model to surgeons everywhere to always do the right thing for patients.”

Commitment to education
Dr. Finley has devoted much of his career to surgical education. The many residents and fellows he has trained describe Dr. Finley as an outstanding teacher and mentor, enthusiastic and innovative, and an asset to residency education. Dr. Finley has participated in the training of 14 general thoracic surgeons who now practice in academic hospitals across Canada. He is the recipient of several teaching and scholarship awards, including the UBC department of surgery Master Teaching Award (1991) and Best Teacher, Interns and Residents, University of Western Ontario, London.


After graduating with honors from the University of Western Ontario Medical School, he did an internship at Vancouver General Hospital, followed by residency in surgery and cardiothoracic surgery at the
The award citation recognizes his “long-term commitment to improving graduate education for future generations” and his pioneering contributions in the area of health information technology, including his service as Chair of the ACS Web Portal Editorial Board and Chair of the ACS Education Task Force on Practice-based Learning and Improvement.

University of Western Ontario. He then completed a medical research fellowship at Harvard Medical School, Boston, MA, and another year of postgraduate training at the University of Toronto, department of surgery, division of thoracic surgery. Dr. Finley then returned to the University of Western Ontario, working his way up from assistant professor (1979–1983) to associate professor (1983–1989), department of surgery.

He has chaired multiple committees at the institutions where he has practiced and taught, including the faculty executive committee and surgical advisory committee at UBC and the surgical advisory committee, minimally invasive surgery, operating room council, and operating room executive team at Vancouver Hospital & Health Sciences Centre.

Dr. Finley’s areas of special interest and accomplishment include pulmonary and esophageal surgery; metabolic and cardiopulmonary responses to sepsis, trauma, and cancer; computed tomography-guided video-assisted thoracoscopic resection of small peripheral lung cancers; quality improvement of perioperative processes; and regionalization of thoracic surgery services in British Columbia. He has been awarded 12 competitive research or equivalent grants from the Canadian Institute of Health Research, the National Cancer Institute, and a number of health care organizations.

**Dedicated leader**


Dr. Finley has served as president of the International James IV Surgical Association (1998–2001), the British Columbia Surgical Association (2006), and the Canadian Association of Thoracic Surgeons (2004–2006). He also served as a Vice-President of the American Surgical Association and Chair of the Canadian Association of Surgical Chairs. He has been a member of the editorial boards for the Journal of the American College of Surgeons (1999–2006), Annals of Surgery (2002–2015), and Canadian Journal of Surgery (2004–2009). He has authored or co-authored 103 journal articles and 23 book chapters and has delivered 117 invited lectureships. ♦
The Board of Governors (B/G) Surgical Volunteerism and Humanitarian Awards Workgroup has announced the recipients of the 2017 American College of Surgeons (ACS)/Pfizer Surgical Humanitarian Award and Surgical Volunteerism Awards. As in previous years, the workgroup received exceptional nominations, reflecting the remarkable commitment of ACS Fellows to providing care to underserved populations.

The contributions of the award recipients are summarized in this article and will be formally recognized at the Clinical Congress 2017 in San Diego, CA, during the annual B/G reception and dinner October 24. Clinical Congress attendees are invited to hear the honorees speak at a Panel Session, Humanitarian Surgical Outreach at Home and Abroad: Reports of the 2017 Volunteerism and Humanitarian Award Recipients, October 23, 9:45–11:15 am, San Diego Convention Center, room 1AB.

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

This year, the award will be presented to two surgeons. **Robert E. Cropsey, MD, FACS**, a general surgeon from Ypsilanti, MI, will receive a Surgical Humanitarian Award for his work in establishing two hospitals and serving the needs of medically underserved patients in the West African country of Togo for the last three decades.

Dr. Cropsey intended from the beginning of his medical career to become a surgeon so that he could live in Africa and offer his services to those in need. After completing his general surgery training at St. Joseph Mercy, Ann Arbor, MI, he went to Togo with his wife and four children to provide care to the medically underserved people of the country. Upon his arrival he collaborated with locals and other medical professionals and missionaries to open the Karolyn Kempton Memorial Christian Hospital (KKMCH) in 1985, working with the Association of Baptists for World Evangelism. Dr. Cropsey has served as the hospital director, chief of staff, and chief of surgery since KKMCH opened.

KKMCH, known as Hôpital Baptiste Biblique to the Togolese, is several hours from Togo’s capital, Lomé, and situated deep in the jungle near the border of Ghana. As the only major medical center in a remote location, the 50-bed facility admits more than 3,000 patients annually, serving neighboring Ghana and Benin, as well. In addition to an adult intensive care unit (ICU), pediatric ICU, ultrasound rooms, and isolation rooms, the hospital has two operating rooms (ORs) that are capable of supporting most major operations. More than 1,250 operations are performed at KKMCH each year, including...
hernia, high-risk obstetric, soft-tissue infection, traumatic injury, and pediatric procedures.

KKMCH also trains medical students and surgical residents, and Dr. Cropsey and the hospital administration are working with the Pan-African Academy of Christian Surgeons (PAACS) to begin a five-year residency program to train local surgeons. The hospital recently started a $10 million expansion project that will double the number of beds and increase the capacity of all health care services.

In 2005, Dr. Cropsey and KKMCH were invited to open a hospital in Mango, a remote community in northern Togo lacking modern health care. Over the next 10 years, Dr. Cropsey traveled between Togo and the U.S. to plan, coordinate, fundraise for, lay out, and build the first real medical center in the area—the Hospital of Hope. When the Hospital of Hope opened in 2015, thousands of patients who were previously unable to receive care came to the hospital, and it has since remained busy. Other services available through the medical center include community health education, mobile clinics, and community development services.

Francis Robicsek, MD, PhD, FACS, a retired cardiothoracic surgeon from Charlotte, NC, will receive a Surgical Humanitarian Award for his more than 50 years of work to provide medical care, particularly cardiothoracic services, and establish a medical infrastructure in Central America.

Dr. Robicsek began his humanitarian work in the early 1960s in Honduras, treating surgical tuberculosis patients. He then expanded his surgical services to other countries, providing direct surgical care to patients in Belize, Guatemala, Nicaragua, as well as in Eastern Europe. His contributions to cardiothoracic surgery in Central America are particularly noteworthy. Dr. Robicsek performed the first open-heart operations in Honduras and Guatemala and initiated and assisted the first open-heart surgery by a native surgeon in Belize, where he maintains an active open-heart surgery program.

Even more influential than his direct surgical skill has been the sustainable medical aid that Dr. Robicsek has brought to the region through training, supplies, and infrastructure. He was a cofounder in 1959 of Heineman Medical Outreach, Inc., a one-time research organization in Charlotte, NC. As president of the organization for nearly 50 years, Dr. Robicsek has guided its evolution to becoming a local and humanitarian aid program in partnership with the Carolinas HealthCare System.

He has been instrumental in providing surgical and health services to a historically underserved region. In the 1970s, he arranged to have patients from Guatemala flown into Charlotte for operations, and he accepted Guatemalan surgeons for training fellowships. His ties with the Guatemalan
government and health care system eventually led to the founding of Unidad de Cirugía Cardiovascular de Guatemala—or UNICAR—the Guatemalan Heart Institute, where more than 700 heart operations are performed annually. These and other operations in Central America are, in part, made possible by the more than $1.5 million in new and refurbished hospital supplies that Dr. Robicsek arranges to have delivered to the region each year. UNICAR now serves patients from neighboring countries, as well.

A major component of Dr. Robicsek’s humanitarian activity centers on training Central American surgeons in Charlotte so they can return home with the skills necessary to care for their native populations. For many years, he has maintained a guest house at the Carolinas Medical Center for Central American and Caribbean surgeons and nurses to train at no cost. Dr. Robicsek’s efforts also have led to the establishment of burn units, mammography, echocardiogram networks, catheter labs, and more across Central America. Since 2010, when Heineman and the Carolinas HealthCare System established the International Medical Outreach Program, these humanitarian efforts have continued to grow in scale and effect.

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

Sherry M. Wren, MD, FACS, FCS(ECSA), a general surgeon in Palo Alto, CA, and professor of surgery and director of global surgery, Center for Innovation and Global Health, Stanford University School of Medicine, CA, will receive the International Surgical Volunteerism Award for her work with Médecins Sans Frontières (MSF, also known as Doctors Without Borders) in several African countries, as well as her work in the U.S. aimed at preparing surgeons to provide international humanitarian aid.

Dr. Wren began volunteering with MSF to provide humanitarian aid and surgical care to several African countries engaged in armed conflicts, including Côte d’Ivoire, Chad, and the Democratic Republic of Congo. In addition to surgery related to the trauma of war, her volunteer work with MSF included the spectrum of surgery, particularly general, obstetric, and orthopaedic surgery.

Beyond her clinical work, Dr. Wren has spearheaded research and training initiatives in the region that have had a significant effect on patient care.

Her first long-term project was at the University...
Teaching Hospital, Harare, Zimbabwe, where she created a bidirectional surgical residency exchange program with the University of Zimbabwe that was recognized by the American Board of Surgery and met Residency Review Committee requirements. She has directly trained more than 40 Zimbabwean surgeons in trauma, ultrasonography, low-resource laparoscopy, and other procedures. She started a medical student interest group in surgery for women in Zimbabwe, as all surgeons in the country are men.

Dr. Wren also partnered with the Mbingo Baptist Hospital in Bamenda, Cameroon, to conduct location relevant research with local staff. Dr. Wren’s experiences in Africa led to her election to the College of Surgeons of East, Central, and South Africa (COSECSA), an African surgery professional organization. She participates in the COSECSA’s certification and examination processes as well as examinations for advanced surgical designations (masters of clinical surgery and fellowship of clinical surgery). Dr. Wren also worked extensively with surgeons in Ebola-ravaged African countries during the 2014 outbreak of the virus.

Dr. Wren’s training and educational experiences led her to design the International Humanitarian Aid Skills Course at Stanford, a course dedicated to preparing surgeons for a role in providing humanitarian aid. The course involves didactics, case studies, simulation, and video-based teaching for the critical areas of tropical medicine, low-resource anesthesia, burns and wounds, orthopaedic trauma, and emergency obstetrics, among other topics. Dr. Wren teaches the course, which has been presented approximately 10 times to more than 400 physicians from around the world.

CAPT Zsolt T. Stockinger, MD, FACS, a U.S. Navy general surgeon, Fort Sam Houston, TX, will receive the Military Surgical Volunteerism Award for providing surgical care and training and developing surgical capacity while on voluntary deployment to austere environments.

In 2010, Dr. Stockinger volunteered for the U.S. military mission to Haiti to provide medical care after the earthquake that ravaged the country, but he also stepped in to fill some of the planning and organizational gaps in emergency response. The USNS Comfort served at the center of the military’s aid efforts, acting as the referral center for medical centers in Haiti. Seeing that the volume of incoming patients was too high to accept all, Dr. Stockinger developed acceptance criteria, strategies to guide patient flow, and a discharge plan. To enable the transfer and continuity of postoperative care for seriously injured patients aboard the Comfort, Dr. Stockinger
surveyed all of the functional civilian hospitals in Haiti. He was the only U.S. military general/trauma surgeon present for the Comfort’s entire seven-week mission.

Dr. Stockinger also has served on voluntary deployments to embattled regions of Afghanistan. He was in Kandahar in 2011–2012, when the local Afghan army hospital was understaffed, with all trauma patients going to the regional North Atlantic Treaty Organization (NATO) hospital. Dr. Stockinger was able to communicate with the Afghan Army corps commander to increase medical personnel and capability at the local hospital, which led to it becoming the Level I trauma center for both Afghan Army and civilian injuries in the region. This amplified medical capability became increasingly important as U.S. military presence in the country decreased.

He then volunteered as the North Atlantic Treaty Organization (NATO) Regional Command surgeon in Helmand province in 2013. This was the only region of the country without an Afghan Army hospital or any surgical capability. NATO funding for a planned hospital had been diverted, and no resources were available to build one. Without trauma treatment capability, Afghan Army forces were expected to experience severe losses as U.S. and coalition forces withdrew. Dr. Stockinger worked with coalition contacts, the Afghan surgeon general, and the Minister of Health, and within six weeks Afghan surgeon teams from Kabul were deployed to Helmand to operate in a tented facility. By the end of his tour, ground had been broken for a permanent facility and funding and equipment procured for the first-ever Afghan Army surgical facility in Southern Afghanistan.

In addition to his work in Haiti and the Middle East, Dr. Stockinger has provided direct surgical intervention, infrastructure development, and surgical training in Pakistan, Ukraine, Mauritius, Ghana, and Southeast Asia.

Yihan Lin, MD, a fourth-year general surgery resident at the University of Colorado Hospital, Denver, will receive the Surgical Resident Volunteerism Award for her efforts to provide, establish, and improve medical and surgical care to underserved populations around the world.

Dr. Lin has been active in surgical volunteerism since she was a medical student. She was the student director for the Stout Street Clinic for the homeless in Denver in 2009–2010, running weekly health clinics. From there, Dr. Lin started to work in an international capacity. In 2009, she offered workshops to educate women in Quito, Ecuador, about birth control. That same year, she spent a month in Uganda providing care to patients in ORs, wards, and clinics; performing needs
assessments for equipment; and compiling a dictionary of common conversational and medical phrases of the local dialect, Rukiga. She was in Leogane, Haiti, in 2013 assisting local surgeons and assessing patients in pre- and postoperative clinics and in the emergency ward.

In 2013, Dr. Lin was accepted as a Paul Farmer Global Surgery Research Fellow in the Harvard Medical School Program in Global Surgery and Social Change, Boston, MA. Since she began the fellowship, she has been involved in developing surgical capacity, infrastructure, and research capability in Zambia and Rwanda.

In Zambia, Dr. Lin has been one of the research fellows leading the effort to create a national surgical plan to increase surgical access, capacity, and equity for the population. To that end, she engaged with key stakeholders in the Zambian Ministry of Health and surgical care providers to understand their priorities, led several research assistants in performing a comprehensive review of all data on Zambia's surgical systems, and then facilitated weekly committee meeting workshops in the Ministry of Health to draft the plan. She also has been working with local stakeholders to create solutions in service delivery, the workforce, information management, and financing. The plan recently was signed into law, and Dr. Lin, her colleagues, and the Zambian government are now designing an implementation strategy.

Dr. Lin also has been working with the Rwandan Ministry of Health to create a national surgical plan in that country. In addition, she has been working to build local research capacity in Rwanda using the Operational Research Training program. In the course of one year, she was a research mentor and worked with seven providers in the Rwandan health care system, including surgeons, anesthesiologists, statisticians, and financing personnel, to design and implement research projects. Topics covered in the course included developing a research protocol, data collection and analysis, and manuscript preparation.

Beyond her work in Africa, Dr. Lin has recently been working with the World Health Organization on a variety of projects, including developing a manual on strengthening surgical systems, and leading a research project at Harvard to create a surgical hospital assessment tool for low- and middle-income countries. ♦
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ACS releases quality and safety manual

The American College of Surgeons (ACS) is pleased to announce that the **Optimal Resources for Surgical Quality and Safety** manual is now available for purchase. This manual is intended to serve as a trusted resource for surgical leaders seeking to improve patient care in their institutions, departments, and practices. It introduces key concepts in quality, safety, and reliability and explores the essential elements that all hospitals should have in place to ensure the delivery of patient-centered care.

Specific topics covered include the following: the domains and phases of surgical care, peer and case review, responsibilities of the surgical quality officer, institutional infrastructure, privileging and credentialing, high reliability, applications to the unique surgical disciplines, data analytics, clinical practice guidelines, quality collaboratives, and education and training. The manual also includes a look at some of the “soft skills” that influence quality and safety in health care, as well as the individual surgeon’s responsibility to patients, colleagues, and the next generation of surgeons.

**Optimal Resources for Surgical Quality and Safety** is available on the ACS website at [facs.org/quality-programs/about/optimal-resources-manual](http://facs.org/quality-programs/about/optimal-resources-manual) for $44.95 (includes shipping) for single copies (up to a quantity of nine) or $39.95 (includes shipping) per copy for 10 copies or more.

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Official notice:

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

In accordance with Article I, Section 6, of the Bylaws, the Annual Business Meeting of Members of the American College of Surgeons (ACS) is called for 4:15 pm the afternoon of Wednesday, October 25, 2017, at the San Diego Convention Center, CA.

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

Edward E. Cornwell III, MD, FACS
Secretary
American College of Surgeons
September 1, 2017
Dr. Jo Buyske to serve as next ABS executive director

The American Board of Surgery (ABS) has announced that Jo Buyske, MD, FACS, will be the next executive director of the ABS. Dr. Buyske was elected at the ABS semiannual meeting after a national search for a successor to longtime executive director Frank R. Lewis, MD, FACS, who will retire later this year. Dr. Buyske assumed the executive director position September 1 and will work with Dr. Lewis up to his retirement to ensure a smooth transition of duties.

Dr. Buyske has served as associate executive director and director of evaluation for the ABS since 2008, overseeing the development and administration of all ABS examinations and ensuring their clinical relevance. She continues to be clinically active and serves as an adjunct professor of surgery at the University of Pennsylvania, Philadelphia. Previously, she was chief of surgery and director of minimally invasive surgery at the University of Pennsylvania Perelman School of Medicine. Her clinical experience centers on applications of minimally invasive surgery to all areas of general and gastrointestinal surgery.

As executive director, Dr. Buyske will lead all organizational areas of the ABS and partner closely with its board of directors. In addition, she will serve as the ABS’ primary liaison to diplomates, surgical training programs, and the larger surgical community, including the full range of organizations involved in surgical education and board certification.

“It is a tremendous honor to be named executive director,” Dr. Buyske said. “I look forward to working with ABS directors, diplomates, and staff, as well as other surgical organizations, to continue our work to protect the public and enhance the profession.”

With the ABS recently announcing revised requirements for continuous certification (read about the new requirements at www.absurgery.org/default.jsp?news_mocchange0717), she also spoke of the direction of the organization going forward. “The ABS is committed to changing its policies regarding lifelong learning and certification in the interests of better serving both our diplomates and the public. Our goal is to have the best combination of practice-pertinent, timely, and valuable assessment tools to assure our patients that board-certified surgeons are knowledgeable and up to date,” Dr. Buyske said.

Read more about Dr. Buyske in the ABS press release at www.absurgery.org/default.jsp?news_buyske0617.

OGB convenes informational meetings at Clinical Congress 2017

Operation Giving Back (OGB), the volunteerism initiative of the American College of Surgeons (ACS), will host two informational meetings at Clinical Congress 2017 in San Diego, CA. A Global Surgery Program Leaders informational meeting will take place October 23, 3:00–5:00 pm, and will focus on creating a platform for future collaboration between individual programs and OGB.

In addition, OGB will host a Resident Interest Group informational meeting, October 24, 11:30 am–1:00 pm. Residents interested in learning more about OGB and how to get involved are encouraged to attend. For more information and to RSVP for both informational meetings, contact ogb@facs.org.
Dr. Britt awarded NIH grant to develop strategies to address health care disparities

L. D. Britt, MD, MPH, DSc(Hon), FACS, FCCM, FRCSEng(Hon), FRCSEd(Hon), FWACS(Hon), FRCSI(Hon), FCS(SA)(Hon), FRCSGlasg(Hon), Henry Ford Professor and Edward Brickhouse Chairman, department of surgery, Eastern Virginia Medical School, Norfolk, and a Past-President of the American College of Surgeons (ACS), was recently awarded a multimillion-dollar National Institutes of Health (NIH) research grant. The grant will be used to develop strategies to address health care disparities in the various surgical specialties.

Specifically, the emphasis of this research is “to determine the specific measures of health care disparities in the various surgical specialties in order to develop targeted interventions to mitigate such disparities,” said Dr. Britt, principal investigator of the research project.

The NIH R01 grants are among the most competitive awards in scientific research. Dr. Britt’s research team comprises experts in the field who work in medical organizations and academic institutions, such as the ACS; Harvard Medical School, Boston, MA; and the University of California, Los Angeles.

Dr. Britt has dedicated his career to patient care and addressing the multifaceted disparities in health care, and he believes that this research grant is a pivotal step toward countering one of the greatest challenges facing this country. He is particularly thankful for the unwavering support of David B. Hoyt, MD, FACS, ACS Executive Director; the Board of Regents; and the ACS Committee on Health Care Disparities, which he chairs. Adil Haider, MD, MPH, FACS, professor and director of the Center for Surgery and Public Health, Harvard Medical School, serves as Vice-Chair of the committee.

“This is a big step for the American College of Surgeons,” Dr. Britt said. “With its 100-plus year history of using data to address quality of care in surgery, if the College, in collaboration with the NIH, can’t solve this problem, no one can.”

Dr. Britt added that he anticipates that the College’s efforts to address disparities in health care with the help of the NIH will serve as a template for other professional organizations so that all patients have access to the services they need, from primary care to obstetrics-gynecology, and from cardiology to psychiatry. “Dr. Hoyt and I hope this is the start of movement to address health care disparities in all specialties, but it starts with the College.”

Coming next month in JACS and online now

Combination of oral antibiotics and mechanical bowel preparation reduces surgical site infection in colorectal surgery

Salima S. Makhani, MS; Frances Y. Kim, MPH; Yuan Liu, PhD, MS; et al found that implementation of an infection prevention bundle was successful in decreasing surgical site infection (SSI) rates in colorectal surgery patients. The combination of oral antibiotics with a mechanical bowel preparation was the strongest predictor of decreased SSI.

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Mark W. Bowyer, MD, FACS, Chair of the American College of Surgeons (ACS) Committee on Trauma’s Surgical Skills Committee, received the 2017 Robert Danis Prize from the International Society of Surgery/Société Internationale de Chirurgie (ISS/SIC) at the 2017 World Congress of Surgery in Basel, Switzerland. This award is presented to a surgeon who has made important contributions to trauma, burns, or critical care. Dr. Bowyer was selected for his “broad contributions to the field of trauma covering all aspects from basic and clinical science research to clinical application and futuristic planning,” according to the society’s announcement.

Dr. Bowyer, the Ben Eiseman Professor of Surgery and surgical director of simulation, division of trauma and combat surgery, department of surgery, Uniformed Services University of the Health Sciences–Walter Reed National Military Medical Center, Bethesda, MD, spent more than 22 years as an Air Force surgeon. He has taught trauma skills to medical students and physicians the world over and served as the U.S. Air Force’s “trauma czar” while deployed in Iraq.

Stephen A. Deane, MB, BS, FACS, a general surgeon in Fennell Bay, New South Wales, Australia, was appointed a Member in the Order of Australia (AM) in June for significant service to medicine in the field of trauma surgery.

As a clinician and academic, Dr. Deane was instrumental in improving trauma surgery outcomes in Westmead Hospital, New South Wales, and around the world. He recognized that trauma specialists should interact with patients as soon as they arrive in the hospital, rather than called in after excessive time has passed since an injury occurred. To that end, Dr. Deane imported the ACS Advanced Trauma Life Support® course to help train Australian surgeons in effective trauma care. Through
the International Association for Trauma Surgery and Intensive Care, he also co-developed the Definitive Surgical Trauma Care course, now operational in approximately 30 countries.

Richard A. Isaacs, MD, FACS, assumed new roles as the chief executive officer (CEO) of the Permanente Medical Group and president and CEO of the Mid-Atlantic Permanente Medical Group in June. The Permanente Medical Group and Mid-Atlantic Permanente Medical Group are two of the largest medical groups in the nation, with more than 10,000 physicians delivering care to nearly 5 million Kaiser Permanente members in Northern California, Maryland, Virginia, and Washington, DC.

Dr. Isaacs, an otolaryngologist who received his bachelor’s degree from University of Michigan, Ann Arbor, and his doctor of medicine degree from Wayne State University, Detroit, MI, has served as physician-in-chief with the Kaiser Permanente South Sacramento Medical Center, CA, since 2005. In that position, Dr. Isaacs played a critical leadership role in helping his medical staff pioneer several initiatives that Kaiser Permanente adopted nationwide, including the implementation of an electronic health record system.

Christine Laronga, MD, FACS, was elected president of the Association of Women Surgeons in December 2016 for a one-year term. Dr. Laronga is a senior member of the Comprehensive Breast Program at the Moffitt Cancer Center, Tampa, FL, and Secretary of the Florida Chapter of the ACS. Her other leadership roles include serving as an ACS Governor, the Florida State Chair for the Commission on Cancer, and on the Florida Division Board of the American Cancer Society.

Dr. Laronga is a principal investigator for studies on several significant surgical procedures, including nipple- and areola-sparing mastectomy and liposuction for arm lymphedema from breast cancer treatment. She also is a member of the National Comprehensive Cancer Network breast cancer risk reduction panel that reviews guidelines for treating women at risk for breast cancer.

Amy E. Liepert, MD, FACS, an acute care surgeon and assistant professor of surgery, University of Wisconsin, Madison, received the Wisconsin Medical Society Foundation’s Kenneth M. Viste, Jr., MD, Young Physician Leadership Award earlier this year. The award is presented annually to a young physician who demonstrates commitment to patients, the medical profession, and the community.

The award recognized Dr. Liepert’s success in engaging physicians and legislators in the discussion of issues relevant to patients and surgeons. As a member of the ACS Health Policy and Advocacy Group, Dr. Liepert has been a leader in efforts to prioritize the College’s advocacy goals.

Jacob Moalem, MD, FACS, endocrine surgeon and associate professor of surgery, University of Rochester Medical Center, NY, received the Jewish Federation of Greater Rochester’s Elmer Louis Award in June for his efforts to bring the Stop the Bleed® program to the Rochester area. The award specifically recognizes a program that is of broad social significance and has had a significant impact on the Jewish community—in this case, Stop the Bleed.

The goal of Stop the Bleed is to ensure that public institutions have bleeding control stations in the event of a life-threatening bleeding emergency, as prompt control of bleeding is the single most important predictor of
survival in such an event. Dr. Moalem brought the program to Rochester, raised funds to purchase bleeding control kits, and scheduled training sessions at local Jewish community centers.

Brian Santin, MD, FACS, RPVI, a vascular surgeon in private practice and president, Ohio Vein & Vascular, Inc., Wilmington, OH, was recognized by the Ohio Senate in July for his patient and physician advocacy efforts. This honor is bestowed upon physicians who have gone beyond providing clinical treatment to their patients by advocating for the well-being of the profession, patients, and communities they serve. State Sens. Charleta Tavares (D) and Bob Peterson (R) recognized Dr. Santin for his work.

Dr. Santin has testified before the Ohio House Finance Subcommittee on Health and Human Services to oppose changes to health care delivery to patients who qualify for both Medicare and Medicaid and has been involved in other Ohio health care advocacy efforts. He is an at-large councilor for the Ohio State Medical Association and Membership Committee Chair for the Ohio Chapter of the ACS.

Tehemton E. Udwadia, MB, BS, FACS(Hon), a gastroenterologic surgeon in Mumbai, Maharashtra, India, was awarded the Padma Bhushan, the third-highest civilian honor in India, for his contributions to Indian medicine. The award is conferred for service in any field rendered by government servants, including physicians and scientists. Dr. Udwadia received the award from then-President of India Pranab Mukherjee.

In 1972, Dr. Udwadia became the first surgeon to perform laparoscopic surgery in India, which led to him being known as the nation’s “father of laparoscopy surgery.” He also was the first surgeon to perform a laparoscopic cholecystectomy in the developing world. He was the founding president of the Indian Association of Gastrointestinal Endo-Surgeons (1993–1998), and in 2004 the organization awarded him their Lifetime Achievement Award. Dr. Udwadia was previously awarded the Padma Shri, India’s fourth-highest civilian honor, for his medical service. ♦
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The Board of Directors of the American College of Surgeons Professional Association (ACSPA) and the Board of Regents (B/R) of the American College of Surgeons (ACS) met June 9–10 at the College’s headquarters in Chicago, IL. The following is a summary of their discussions and actions.

**ACSPA**
The following is an update on activities from January 1, 2017, through May 18, 2017, for programs conducted by the ACSPA and its political action committee (PAC), the ACSPA-SurgeonsPAC. In addition to reporting $262,972 in donation receipts from more than 770 individual College members and staff, SurgeonsPAC disbursed more than $219,220 to 50 congressional candidates, leadership PACs, and political campaign committees. In line with congressional party ratios, 60 percent of the amount given was to Republicans and 40 percent to Democrats.

**Division of Education**

**Clinical Congress**
The total number of physician attendees at the 2016 Clinical Congress was 8,781, of whom 1,792 were residents and 748 were guest physicians. Other attendees included 638 medical students, 201 allied health professionals, and 106 doctors of philosophy.

The 2017 Clinical Congress program, which was approved during Clinical Congress 2016, includes 24 Tracks, 118 Panel Sessions, 19 Didactic Courses, 12 Skills Courses, 45 Meet-the-Expert Sessions, and 21 Town Hall Meetings. In early 2017, 1,797 abstracts were submitted for the Clinical Congress—the highest number of abstract submissions in recent years and a 33 percent increase from the 1,347 abstracts submitted in 2016.

**SESAP**
The Surgical Education and Self-Assessment Program (SESAP®) remains the premier self-assessment and cognitive skills education program for practicing surgeons. The new edition, SESAP 16, was released in October 2016, marking the 45th year of SESAP. The latest edition includes more questions than were in the past editions and features an innovative Self-Assessment model. The 850 questions and critiques may be used to earn up to 90 Category 1 Continuing Medical Education (CME) Self-Assessment Credits. SESAP 16 can be applied to fulfill requirements for Part 2 of Maintenance of Certification (MOC) as defined by the American Board of Surgery (ABS) and is useful in preparing for the recertification examination to fulfill the requirements of Part 3 of MOC. SESAP is available in web, mobile-friendly, and print versions.

**Comprehensive General Surgery Review Course**
The annual ACS Comprehensive General Surgery Review Course is a 3.5-day intensive review of the essential content areas in general surgery. The course uses a robust educational design, with online pre- and posttests, and includes a unique, interactive educational model. A combination of didactic and case-based formats is used to create an efficient review while enhancing comprehension and retention. The course is designed to help practicing surgeons fulfill requirements for Part 2 of MOC and to help surgeons prepare for the ABS General Surgery MOC Exam to fulfill requirements of Part 3 of MOC. The course
offers 30 Category 1 CME Self-Assessment Credits. The 2016 course had 192 participants.

**Selected Readings in General Surgery**

In January 2017, *Selected Readings in General Surgery (SRGS®)* entered its 10th year. It continues to publish evidence-based reviews of the medical literature with a cycle of topics that is designed to cover the field of general surgery in 48 months. The SRGS education and self-assessment model aims to promote expertise in surgery. SRGS offers the opportunity to earn 80 Self-Assessment Credits per year. SRGS has 2,350 subscribers, 500 of whom are surgery residents.

**Evidence-Based Decisions in Surgery**

Evidence-Based Decisions in Surgery includes concise, focused modules derived from practice guidelines. Modules are developed based on diagnoses that are relevant to the operations that general surgeons perform frequently. Each module includes information on the source of the guideline, an analysis of the strength of the evidence supporting the recommendations, a flow diagram of a typical patient (when appropriate), a page summarizing the resources necessary to implement the guideline in a surgeon's practice, and a listing of the data necessary to determine whether the guideline is working in practice. A list of items to facilitate patient education is included. Each module concludes with a list of recommended articles that provide additional information. The modules are intended to be used at the point-of-care and may be accessed through handheld devices. In all, 60 modules are available.

**Fundamentals of Surgery Curriculum**

More than 1,500 residents from more than 230 programs are enrolled in the *ACS Fundamentals of Surgery Curriculum®*. Assessment models are in development for each of the 14 modules to provide program directors with information regarding resident performance, and pilot testing of these models is under way. The addition of advanced cases to address the needs of senior residents is in the planning stages.

**MyCME**

The number of ACS Members using the MyCME Program to request transfer of their CME Credits to the ABS has been steadily increasing. In 2016, a total of 3,974 members sent 5,885 records to the ABS. There are plans to explore similar opportunities with other surgical specialty boards.

**Division of Research and Optimal Patient Care**

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

**ACS NSQIP**

A total of 782 hospitals participate in the College's National Surgical Quality Improvement Program (ACS NSQIP®), 682 of which participate in the adult option. At present, 87 hospitals outside of the U.S. participate in ACS NSQIP—about 11 percent of all participating hospitals—and interest from international sites continues to build. Sites in Australia, Canada, Kuwait, and Vietnam have shown significant interest.

ACS NSQIP has 53 established collaboratives, with several more in development. ACS
NSQIP is in the final stages of hospital enrollment for The Military Health Service Strategic Partnership American College of Surgeons (MHSSPACS), with 41 enrolled hospitals, one pending enrollment, and four awaiting applications. After full enrollment, the goal will be to ramp up the military’s systemwide collaborative with the assistance of the hospital commanders and ACS leadership.

The ACS Quality and Safety Conference (formerly the ACS NSQIP Conference) took place July 21–24 at the New York Hilton Midtown, NY. This year’s theme, Achieving Quality: Present and Future, reflected a more comprehensive approach to quality, with the perspectives of adult, pediatric, geriatric, and bariatric specialties, with surgeons, nurses, anesthesiologists, and hospital administrators all represented. The conference included specialty tracks and breakout sessions relevant to participants from multiple ACS quality programs including ACS NSQIP Adult and Pediatric, the Children’s Surgery Verification (CSV) Quality Improvement Program, the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP), and the Surgeon Specific Registry (SSR).

MBSAQIP
A total of 828 facilities participate in MBSAQIP. From October 2014 through April 2017, 796 site visits were completed using the MBSAQIP standards. In 2016, the program performed 291 site visits with 67 surgeon surveyors.

CSV
In January 2017, the ACS CSV Quality Improvement Program officially released its verification program with the goal of ensuring that pediatric surgical patients have access to quality care. This new program defines the resources required to achieve optimal patient outcomes for children receiving surgical care at verified health care facilities. The program has garnered key endorsements from multiple specialty societies, including the American Academy of Pediatrics, American Pediatric Surgical Association, and Society of Pediatric Anesthesiology. Five sites have been verified and 11 have applied for verification. The Children’s Hospital Association, based on its own analysis, estimates that 200 hospitals will participate in the CSV Program.

MBSAQIP
The Coalition for Quality in Geriatric Surgery Project
The ACS is nearing completion of the second year of the Coalition for Quality in Geriatric Surgery Project. Funded by the John A. Hartford Foundation, this project aims to systematically improve surgical care of patients older than 65 years of age by establishing a verification program in older adult surgery.

SSR
The new platform for the ACS SSR launched this spring. More than 8,000 users of the former SSR were moved to the new SSR platform, hosted by QuintilesIMS, in mid-April 2017. The new SSR is an online software application and database that allows surgeons to track their cases and outcomes in a convenient, streamlined, and easy-to-use manner from their computer or mobile devices. The SSR builds on the ACS Case Log system, enabling surgeons not only to log and track their cases, but also to participate in an increasing number of regulatory programs for the individual surgeon. The system supports Part 4 of MOC and provides electronic transmittal of cases to the ABS. The ACS has worked 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 (QCDR) for the former Physician Quality Reporting System (PQRS) and, moving forward, under the Quality Payment Program (QPP). The SSR has been approved as a Merit-Based Incentive Payment System (MIPS)-qualified entity for 2017.

Cancer programs
The Commission on Cancer (CoC) has accredited a total of 1,508 programs, and 41
cancer programs surveyed in 2016 received the Outstanding Achievement Award.

The National Accreditation Program for Breast Centers (NAPBC) has accredited more than 600 U.S. centers and had received 60 new applications for 2017 as of June.

A soft launch of the Oncology Medical Home Accreditation Program took place during the Community Oncology Alliance conference in April. The program is in the process of recruiting medical oncologists who are familiar with the program’s standards to become surveyors.

**National Accreditation Program for Rectal Cancer (NAPRC)**

NAPRC standards have been finalized, and final work on the manual is being completed. Accreditation staff exhibited at the American Society of Colon and Rectal Surgeons Tripartite meeting June 10–14, where publication of the manual was announced. A preapplication will be released to interested programs in mid-summer.

**American Joint Committee on Cancer (AJCC)**

More than 400 individuals across 18 expert panels and several disease-specific groups have developed the content for the *AJCC Cancer Staging Manual*, Eighth Edition. The eighth edition was published October 15, 2016, and more than 18,000 copies of the book had been sold as of May 19. The *Cancer Staging Manual* protocols take effect January 1, 2018.

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**Trauma programs**

**Committee on Trauma (COT)**

The ACS COT convened a two-day conference in Bethesda, MD, in April in response to the recent publication of the National Academies of Science, Engineering, and Medicine (NASEM) Report, *A National Trauma Care System: Integrating Military and Civilian Trauma Systems to Achieve Zero Preventable Deaths after Injury*, released in June 2016. The meeting brought together a multidisciplinary group of approximately 170 professionals from the spectrum of the trauma care system with the goal of creating the framework for building a National Trauma Care System Action Plan.

**TQIP**

As of May 15, a total of 716 hospitals were participating in Trauma Quality Improvement Program (TQIP). As of May 2017, a total of 477 hospitals were participating in the ACS trauma center verification program.

The 2017 TQIP Annual Scientific Meeting and Training will convene November 11–13 at the Hilton Chicago, IL. To accommodate the growth in meeting attendance, the number of breakout sessions was increased for all members of the TQIP team, pediatrics centers, Level III centers, and hospitals participating in all COT quality programs. Last year, 1,579 trauma professionals attended the TQIP, representing more than 500 hospitals and collaboratives—a 37 percent increase from the previous year.

**Bleeding Control**

The Bleeding Control program has experienced rapid growth in the short period since its inception. The number of instructors trained, as well as the number of classes held and locations, has indicated the trauma community’s commitment to this valuable effort. The Stop the Bleed® program is now located in all 50 states, with instructor requests from 30 countries.

Integral to this growth is the expansion of the website, bleedingcontrol.org, to become a larger portal for materials, marketing, and instructor/community resources. The website is now home for materials, instructor resources, listing of classes, and the purchase of bleeding control kits and training materials. The website, with more than 140,000 unique views since its inception, has become a trusted home for articles and information on bleeding control worldwide.

♦
Register for ACS TQIP Conference
November 11–13 in Chicago

The eighth annual Trauma Quality Improvement Program (TQIP®) Scientific Meeting and Training will take place November 11–13 at the Hilton Chicago. Register online for the meeting at facs.org/tqipmeeting.

This meeting will bring together trauma medical directors, program managers, coordinators, and registrars from participating and prospective TQIP hospitals. The conference will have multiple presentations from TQIP participants highlighting how they are using the program to improve care in their hospitals. Breakout sessions focused on registrar and abstractor concerns, matters that relate to the trauma medical director, and trauma program manager-focused issues will enhance the learning experience and instruct participants about their role on the TQIP team. In addition, dedicated sessions for staff who are new to the TQIP program will take place and may be invaluable to medical centers joining TQIP in the near future.

Conference topics of note for 2017 will include TQIP Collaboratives, Pediatric TQIP, management of bleeding pelvic fractures, and the continued integration of verification, TQIP, and performance improvement and patient safety. The TQIP Best Practices project team will present on adult and pediatric imaging, followed by a discussion by a panel of experts. The keynote address will be given by Lenworth M. Jacobs, Jr., MD, MPH, FACS, Chair, Hartford Consensus Joint Committee to Enhance Survivability from Active Shooter and Intentional Mass Casualty Events.

Visit the TQIP annual meeting website at facs.org/tqipmeeting to view the conference schedule and to obtain information about lodging and transportation options.
Two countries, eight cities, four hospital visits, nine talks, one Royal Australasian College of Surgeons (RACS) Congress, a meeting with a former patient, numerous kind hosts, and countless kangaroo sightings—that description does not come close to summing up my amazing experience as the American College of Surgeons (ACS) Australia and New Zealand (ANZ) Traveling Fellow. I am truly honored to have had this experience and I enjoyed the hospitality of so many surgeons.

Arrival in Auckland
My husband Paul and I arrived and were greeted at the airport by our hosts Prof. Ian Civil, MB, BCh, FACS, and his wife Denise; they were kind enough to meet us after our more-than 12-hour flight out of San Francisco, CA, landed at 5:50 am. That night at a team dinner with Professor Civil’s trauma faculty, I began to learn about everything from the surgical structure of ANZ residency (registrar) training to trauma system development.

I spent the following day at Auckland City Hospital with Professor Civil. We started the day with morning rounds with the trauma team, including the trauma fellow, second-year house staff, and a trauma nurse coordinator. We saw myriad conditions, including elderly patients with rib fractures and pulmonary embarrassment, a patient with left lobar hepatic necrosis after angioembolization, and a patient with a complex pelvic fracture with an associated perineal laceration, which required diverting colostomy. I saw many parallels between the U.S. and ANZ trauma systems (patient-centered care, trauma team and nursing coordination, imaging review) and a few differences (closed intensive care unit [ICU], patient care run by intensivists because there are no surgically trained critical care specialists, different dosages of standard medications). I was struck by the minimal number of penetrating trauma (approximately 5 percent), and those such patients we did see had stab wounds rather than gunshot wounds. The effect of graduated autonomy afforded to residents during their six-month rotations was a notable contrast to our much shorter rotation length of one to three months. The faculty noted that these longer rotations really allow them to get to know and mentor the residents.

“Kiwis” are known for their love of coffee, and a mid-morning Flat White was a mandatory part of my hospital experience. What could have been a routine beverage break actually served as an opportunity for a collegial interaction between medical specialists in the open atrium; one could easily catch up with any consultant who was involved in the care of your patient.
Given my interest in blunt cerebrovascular injuries (BCVI), we then met with one of the chief radiologists and interventionists to discuss several recent cases and their screening algorithm for BCVI. Rather than the trauma surgeon driving the decision for computed tomography angiogram (CTA) imaging of the vasculature, the radiologist determines whether the patient has an injury pattern that triggers BCVI screening during their initial trauma CT scans. If such an injury is identified, CTA to evaluate for a BCVI is done while the patient is still on the CT scanner. With the implementation of a radiology-driven screening process, the identification of injuries has markedly increased.

I rounded out the day with a lecture at a noontime conference. The trauma group, emergency medicine physicians, intensivists, house staff, and registrars were in attendance.

**RACS Annual Scientific Congress**

The 2017 RACS Annual Scientific Congress took place in Adelaide. I attended the convocation of the Congress at the opening of the meeting, and sitting between RACS Past-Presidents Profs. Civil and Bruce Barraclough, MB, BS, FACS, FRACS, I learned of the interesting history of RACS. The RACS is particularly focused on surgical education and training and emphasizes a varied training experience that provides exposure to a range of patient populations, hospital environments, and locales. Many in the RACS leadership spoke about the importance of mentorship and educating the next generation, particularly in the area of professionalism. As mentioned previously, I think RACS surgeons are particularly effective in this regard given the length of resident rotations, which afford trainees an in-depth experience.

The themes of collaboration, respect, and professionalism were echoed in the address by RACS President Prof. Philip Truskett, MB, BS, FACS, FRACS. He reminded us that, as surgeons, we should be willing both to ask for help and to answer the call for help, emphasizing that there is more to being a surgeon than technical skill.

Before performing my official duties at the RACS Congress, I spent a morning with the trauma service at the Royal Adelaide Hospital (RAH). Cases from the trauma service for the last week were presented, and we discussed the indications for resuscitative thoracotomy, the role of resuscitative endovascular balloon occlusion of the aorta, and the utility of laparotomy in the trauma bay. The RAH serves as the Level I trauma center for the state of South Australia (one of seven states in Australia). The trauma team described the transport...
process used to move trauma patients to the hospital. Under this tiered response system, regular ambulance/paramedic teams carry out most transfers, but a MEDStar team, which is composed of both paramedics and physicians, is used for high-level trauma transfers. Interestingly, paramedics are equipped to initiate red blood cell transfusions in the field. I spoke at the morning conference about pelvic trauma and discussed the Denver Health trauma team’s algorithm of care for multiply injured patients.

My host at RAH, Christopher Dobbins, MB, BS, FRACS, arranged my trauma surgery program visit at the RACS. On the first full day of the conference, I gave a lecture on Management of the Open Abdomen in 2017 as part of the Trauma on the Cutting Edge session. My talk included the topics of temporary abdominal closure, enteral nutrition in the open abdomen, peritoneal resuscitation, and sequential fascial closure techniques. Other speakers discussed rib fracture fixation, junctional trauma, and the Adelaide experience with resuscitative thoracotomy. That evening I attended the Women in Surgery networking event and had a delightful conversation with the current leader, Melissa Bochner, MB, BS, MS, FRACS, and the incoming leader, Pecky De Silva, MB, BS, FRACS.

On successive days of the Congress, I gave two additional lectures. First, I delivered the ACS lecture on Hemorrhage Control in Complex Pelvic Fractures. ACS President Courtney M. Townsend, Jr., MD, FACS, attended the lecture, and Professor Civil introduced me. My final lecture of the Congress, Blunt Cerebrovascular Injuries, was presented during the joint Trauma and Vascular Surgery session. Following my talk, incoming RACS president John Batten, FRACS, graciously acknowledged my contributions to the Congress meeting.

On to Sydney
Following the week in Adelaide for the RACS Congress, we enjoyed some sightseeing en route to Sydney. We drove along the southern coastline of Australia to Melbourne, stopping along the Great Ocean Road to admire different limestone formations, including The Twelve Apostles, The Loch Ard Gorge, The Bay of Martyrs, and London Bridge.

Arriving in Sydney was joyous for two reasons. First, I had never before been to Sydney. It is simply a wondrous city filled with the iconic Sydney Opera House, Circular Quay, and many other fascinating sights. Second, my parents and our daughter arrived to join us for the final portion of our trip. While my family was recovering from a bit of jet lag, I had a wonderful few days in Sydney.
lag, I continued my tour of ANZ trauma centers. My first stop was the famed Liverpool Hospital, where my host, Scott D’Amours, MDCM, FRACS, FRCSC, organized a delightful day. I spent the morning with the residents and trauma fellows, making rounds and discussing patients. During rounds, a trauma activation was issued. I accompanied the team to the trauma bay to care for a patient who was crushed by a steer. Team coordination was one of the critical elements I noted. All members of the resuscitation team have self-stickered tags that identify their respective roles: trauma surgeon, airway physician, circulation nurse, emergency department (ED) registrar, anaesthetist, procedure physician, orthopaedic specialist, and scribe. The team efficiently evaluated the patient with the intensivist managing the airway, the trauma fellow calling out physical findings, the trauma nurse performing the FAST (focused abdominal sonography for trauma) exam, and the ED registrar reviewing bedside imaging. The day concluded with an afternoon televised trauma symposium, during which I gave three lectures: Acute Care Surgery: The American Training Experience; Chest Tube Debacles; and Pelvic Trauma. The following morning I visited Westmead Hospital at the invitation of Jeremy Hsu, MB, BS. I again discovered that much of trauma care is universal—from protocols, system development, and patient conundrums, to training perspectives.

One of the most memorable days of the entire trip was traveling by train north to Gosford to visit a former patient, Scott Parry-Jones, and his wife Kim. Scott had suffered significant trauma after a ski accident in the Rocky Mountains and had been flown to Denver Health for care. Admittedly, I almost didn’t recognize him compared with his weeks in the hospital. It was wonderful to spend a day with them and see his ongoing recuperation.

We concluded our ANZ adventure with snorkeling at the Great Barrier Reef and exploring the Daintree Rainforest.

The investment and collaboration of the ACS and RACS on this Traveling Fellowship are to be commended. I feel incredibly fortunate to have had this opportunity and I thank everyone for a magnificent trip. It was truly a once-in-a-lifetime experience, and I hope to visit again soon. ♦
Participate in the Sponsor a Medical Student initiative and help support the Medical Student Program at CLINICAL CONGRESS 2017.

Your gift of $250 per student will ensure that medical students can participate in this career-enhancing program to build their knowledge of surgical career options and enhance their engagement with the College.

Your tax-deductible gift is made to the American College of Surgeons Foundation, and it supports the ACS Division of Education, which organizes this and other innovative programs for medical students.

TO SUPPORT THE MEDICAL STUDENT PROGRAM, VISIT facs.org/acsfoundation OR CALL 312-202-5338.
Applications for international 2019 ACS Traveling Fellowships due November 15

The International Relations Committee of the American College of Surgeons (ACS) has announced the availability of traveling fellowships in 2019 to Australia and New Zealand (ANZ), Germany, and Japan. The closing date for receipt of completed applications for all three destinations is November 15, 2017.

The traveling fellowships are intended to encourage an international exchange of information concerning surgical science, practice, and education and to establish professional and academic collaborations and friendships. These are exchange fellowships. For example, a U.S. or Canadian ACS Traveling Fellow will visit Japan for the annual meeting of the Japan Surgical Society, and a Traveling Fellow from Japan will visit the U.S. for the ACS Clinical Congress.

Basic requirements
The traveling fellowships are available to Fellows of the ACS in most of the surgical specialties who meet the following requirements:

• Have major interest and accomplishments in basic sciences related to surgery
• Hold full-time academic appointments in U.S. or Canada
• Are younger than 50 years of age on the date the application is filed
• Are enthusiastic, personable, and possess good communication skills

Activities
The Traveling Fellows are required to spend a minimum of two or three weeks in the countries that they visit and engage in the following activities while abroad:

• Attend and participate in the annual scientific meeting of the host country:
  – Royal Australasian College of Surgeons, Bangkok, Thailand (May 6–10, 2019)
  – Germany Society of Surgery, Munich (March 26–29, 2019)
  – Japan Surgical Society, Osaka (April 18–20, 2019)
• Participate in the formal convocation ceremony at that annual meeting
• Attend and speak at the local ACS chapter meeting
• Visit at least two medical centers in the country before or after the annual meeting to lecture and to share clinical and scientific expertise with the local surgeons

The academic and geographic aspects of the itinerary will be finalized in consultation and mutual agreement between the Fellow and the President or designated representative of the local chapter of the ACS. The surgical centers to be visited depend to some extent on the special interests and expertise of the Fellow and his or her previously established professional contacts with surgeons in the selected country.

The Traveling Fellow’s spouse is welcome to accompany the successful applicant. There will be many opportunities for social interaction in addition to professional activities.

Financial support
The College will provide $10,000 U.S. to each successful applicant. The awardees must meet all travel and living expenses as appropriate to the country visited. Senior chapter representatives will consult with the Fellows about the centers to be visited, the local arrangements for each center, and other advice and recommendations about travel schedules. The Fellows are advised to make their own travel arrangements in North America to take advantage.
The traveling fellowships are intended to encourage international exchange of information concerning surgical science, practice, and education and to establish professional and academic collaborations and friendships.

of reduced fares and travel packages for travel overseas. The ACS International Relations Committee will select the three Traveling Fellows after review and evaluation of applications. A personal interview may be requested prior to the final selection.

The successful applicants and alternates will be selected and notified by March 2018. Full requirements and links to the application forms are available on the ACS website at facs.org/member-services/scholarships/traveling. Send the application form plus the additional required documents in a single PDF to kearly@facs.org or via post to International Liaison Section, American College of Surgeons, 633 N. Saint Clair Street, Chicago, IL 60611-3211. ♦

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The National Ultrasound Faculty of the American College of Surgeons has developed Ultrasound for Surgeons: The Basic Course, 3rd Edition, an online course for physicians and medical professionals that:

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AMERICAN COLLEGE OF SURGEONS | DIVISION OF EDUCATION
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2018–2020 Faculty Research Fellowships available

The American College of Surgeons (ACS) is offering two-year Faculty Research Fellowships to surgeons entering academic careers in surgery or a surgical specialty. The closing date for receipt of the completed online application and all supporting documents is November 1.

The fellowships will assist surgeons in establishing their research program under mentorship with the goal of transitioning to becoming independent investigators. Applicants should have demonstrated their potential to work as independent investigators. Each fellowship award is for $40,000 per year for each of two years—July 1, 2018 to June 30, 2020—and is made possible through the generosity of Fellows, chapters, and friends of the College.

The specific fellowships are as follows:

• The Franklin H. Martin, MD, FACS, Faculty Research Fellowship of the ACS honors Franklin H. Martin, MD, FACS, founder of the ACS.
• The C. James Carrico, MD, FACS, Faculty Research Fellowship for the Study of Trauma and Critical Care honors C. James Carrico, MD, FACS, ACS Past-President, and is designated for research in trauma and critical care.

Two additional undesignated Faculty Research Fellowships will be awarded.

General policies
The following criteria are applied in awarding the ACS Faculty Research Fellowships:

• The fellowship is open to Fellows and Associate Fellows of the College who have done the following:
  – Completed the chief residency year or accredited fellowship training within the preceding five years, not including time off for maternity leave, military deployment, or medical leave
  – Received a full-time faculty appointment in a department of surgery or a surgical specialty at a medical school accredited by the Liaison Committee on Medical Education in the U.S. or by the Committee for Accreditation of Canadian Medical Schools in Canada.

• Recipients may use the award to support their research or academic enrichment in any fashion that they deem maximally supportive of his/her investigations. The fellowship grant is to support the research of the recipient. Indirect costs are not paid to the recipient or to the recipient’s institution.

• Application for this fellowship may be submitted even if comparable application has been made to organizations such as the National Institutes of Health (NIH) or industry sources. If the recipient is offered a scholarship, fellowship, or research career development award from such an agency or organization, it is the responsibility of the recipient to contact the College’s Scholarships Administrator to request approval of the additional award. The Scholarships Committee reserves the right to review potentially overlapping awards and adjust its award accordingly.

• Applicants who have previously won an award from another professional society or the NIH are ineligible for this fellowship.

• Supporting letters from the head of the department of surgery (or the surgical specialty) and from the mentor supervising the applicant’s research effort must be submitted. This approval would involve a commitment to continuation of the academic position and of facilities for research. Only in exceptional circumstances would the committee consider waiving this requirement.

SEP 2017 BULLETIN American College of Surgeons
The fellowships will assist surgeons in establishing their research program under mentorship with the goal of transitioning to becoming independent investigators.

circumstances will more than one fellowship be granted in a single year to applicants from the same institution.

• The applicant must submit a research plan and budget for the two-year period of fellowship, even though renewed approval by the Scholarships Committee of the College is required for the second year.

• At least 50 percent of the Fellow’s time must be spent in the research proposed in the application. This percentage may run concurrently with the time requirements of NIH or other accepted funding.

• The Faculty Research Fellows are expected to attend the ACS Clinical Congress in 2020 to present a report to the Scientific Forum and to receive a certificate at the annual meeting of the Scholarships Committee.

For further information regarding this fellowship and to apply, go to the scholarship web page at facs.org/member-services/scholarships/research/acsfaculty. Contact scholarships@facs.org with additional questions.

The fellowships will assist surgeons in establishing their research program under mentorship with the goal of transitioning to becoming independent investigators.
The American College of Surgeons (ACS) and the American Society of Breast Surgeons (ASBrS) are offering the ACS/ASBrS International Scholarship to surgeons performing breast cancer surgery in countries other than the U.S. and Canada to improve the quality of breast cancer surgical services. Preference will be given to applicants from developing nations. All applications for 2018 and supporting documentation must be received by the International Liaison by November 15, 2017.

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

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

- Medical school graduates who have completed their surgical training and are practicing attending surgeons.
- Members in good standing of both the ACS (Associate Fellow or Fellow) and the ASBrS (active or associate member).
- At least 30 years old, but younger than age 50 on the date that the complete application is filed.
- Have been in surgical practice, teaching, or research for at least one year at their intended permanent location following completion of all formal training (including fellowships and scholarships).
- Show evidence of commitment to high-quality breast cancer surgery, to surgical teaching, and to improving access to breast cancer surgical care in their community.
- Submit a completed application form, located on the ACS website at facs.org/member-services/scholarships/international/acsasbrs-intl. The application and accompanying materials must be prepared using a computer and submitted in English. Submission of a curriculum vitae only is not acceptable.

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

**Other guidelines**
Preference will be given to applicants who have not already experienced training or surgical fellowships in North America. The scholarship must be used in the year for which
The ACS and the ASBrS are offering the ACS/ASBrS International Scholarship to surgeons performing breast cancer surgery in countries other than the U.S. and Canada to improve the quality of breast cancer surgical services.

it is designated. It 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 to the breast cancer patients in the country of origin. Unsuccessful applicants may reapply only twice and only by completing and submitting a new application form provided by the College together with new supporting documentation.

All applicants will be notified of the selection committee’s decision in January 2018. Applicants are urged to submit their completed applications and supporting documents as early as possible to ensure sufficient time for processing. Supporting materials and questions should be addressed to the ACS International Liaison at kearly@facs.org or via fax at 312-202-5021. ♦

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| Ring | | #S14 Solid 14K Gold | $2250 | #S14.1 Solid 10K Gold | $1750 (Indicate finger size) |
| Tie Bar | | #S15 Gold-Filled Emblem | $85 |
| Necktie | | #S16A Dark Blue | $35 | #S16B Light Blue | $35 |
| | | #S17 Maroon | $35 | Extra long add $5.00 |
| Diploma Plaques | | #S18 Satin Gold Finish | $360 | #S19 Satin Silver Finish | $360 |
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| Rollerball Pen - Chrome | | #S25 Cross Townsend Medallist with 23K Gold Plated Emblem | $135 |
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| Desk Set (Not Shown) | | #S27 Solid Walnut with Cross Gold-Filled Pen & Pencil/Gold-Filled emblem; name and year elected a Fellow engraved on gold polished plate | $350 |
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Visit facs.org/associate
Calendar of events

*Dates and locations subject to change. For more information on College events, visit www.facs.org/events or www.facs.org/member-services/chapters/meetings.

**SEPTEMBER**

**Jordan Chapter**
September 7–9
Amman, Jordan
Contact: Dr. Abdalla Bashir, aybashir@gmail.com

**Kentucky Chapter**
September 8
Lexington, KY
Contact: Linda Silvestri, lsilv2@uky.edu, kentuckychapter.facs.org

**New Mexico Chapter**
September 8–9
Albuquerque, NM
Contact: Melissa Davis, mdavis@nmms.org

**Arizona Chapter**
September 9–10
Scottsdale, AZ
Contact: Joni Bowers, jonib@azmed.org, www.azacs.org

**Egypt Chapter**
September 14–15
Cairo, Egypt
Contact: Dr. Mohey Elbanna, moheyelbanna@yahoo.com

**Kansas Chapter**
September 23
Overland Park, KS
Contact: Denise Lantz, dlantz@kmsonline.org, www.kansaschapteracs.org

**Kuwait Chapter**
September 30–October 1
Kuwait City, Kuwait
Contact: Dr. Salman Al-Sabah, salman.k.alsabah@gmail.com

**NOVEMBER**

**South Korea Chapter**
November 2–4
Seoul, South Korea
Contact: Dr. Hyung-Ho Kim, hhkim@snubh.org, ackss.or.kr

**Keystone Chapter**
November 3
Allentown, PA
Contact: Lauren Newmaster, lnewmaster@pamedsoc.org, www.keystonesurgeons.org

**Wisconsin Surgical Society**
November 3–4
Kohler, WI
Contact: Terry Estness, wisurgical@att.net, www.wisurgicalsociety.com

**FUTURE CLINICAL CONGRESSES**

2017
October 22–26
San Diego, CA

2018
October 21–25
Boston, MA

2019
October 27–31
San Francisco, CA