Presidential Address:
The joy and privilege
of a surgical career
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The American College of Surgeons (ACS) had another eventful year. A comprehensive overview of the College’s activities is provided in the Executive Director’s Report on page 43. In this column, however, I would like to point out a few highlights.

**Advocacy and Health Policy**

Efforts to overturn the Affordable Care Act reemerged this year. ACS staff reviewed these proposals to determine likely effects on surgeons and surgical patients, including potential changes in access to surgical care and physician reimbursement. Taking into account expected ramifications of the proposed bills, the ACS reiterated and revised its principles of health care reform and expressed to Congress our priorities and concerns.

Another advocacy issue of considerable concern to ACS Fellows is the Centers for Medicare & Medicaid Services (CMS) efforts to implement the payment reforms in the Medicare Access and CHIP (Children’s Health Insurance Program) Reauthorization Act (MACRA) of 2015. Specifically, 2017 is the transition year for implementation of the Quality Payment Program’s (QPP’s) Merit-based Incentive Payment System (MIPS), and MIPS data collected in 2017 will be used to determine annual payment updates in 2019.

The ACS has been monitoring implementation of MIPS, and Division of Advocacy and Health Policy (DAHP) staff has worked with consultants and stakeholders to draft a legislative proposal to grant additional flexibility to the Secretary of the U.S. Department of Health and Human Services (HHS) in implementing MIPS. Staff also has worked with staff of the House Energy and Commerce and Ways and Means Committees, the Senate Finance Committee, and other key congressional offices to ensure MIPS flexibility.

In addition to MIPS, the QPP calls for the establishment of Alternative Payment Models (APMs). In December 2016, the ACS submitted a surgical APM proposal to the Physician-Focused Payment Model Technical Advisory Committee (PTAC). This proposal, the ACS-Brandeis Advanced APM, was among the first two proposals that the PTAC recommended for CMS testing. The HHS Secretary reviewed the proposal and made recommendations for improvement. Efforts to develop the model continue, and the ACS is working with private insurers and entities that may implement the APM model once available.

**Education**

The Division of Education continues to play a leadership role in surgical education, training, validation, credentialing, and accreditation. A significant effort is aimed at addressing the needs of surgeons who are looking to update their skills. The new Steering Committee for Retraining and Retooling of Practicing Surgeons is focused on defining standards and establishing a national infrastructure to achieve optimal outcomes. The ACS Accredited Education Institutes are at the core of this infrastructure.

Another major development this year was the launch of the ACS Academy of Master Surgeon Educators at Clinical Congress. The goals of the academy are to recognize master surgeon educators, advance the science and practice of leading-edge surgical education and training, foster innovation and collaboration, support faculty development and recognition, and underscore the importance of surgical education and training.

Also at Clinical Congress, the ACS Committee on Ethics unveiled Ethical Issues in Surgical Care, a landmark resource that defines a framework for the field of surgical ethics as it has evolved over the last decade. The book is organized into four sections that address the broad areas of general consideration, the surgeon-patient relationship, the surgeon and the surgical profession, and the surgeon and society.

In addition, the ACS launched ACS Case Reviews in Surgery, which is published six times per year. Each issue features 10 peer-reviewed case reports from an array of surgical specialties.

**Quality**

The College released Optimal Resources for Surgical Quality and Safety this year. This manual provides a guide for surgical quality leaders seeking to improve quality and
The ACS has been monitoring implementation of MIPS, and DAHP staff has worked with consultants and stakeholders to draft a legislative proposal to grant additional flexibility to the Secretary of HHS in implementing MIPS.

safety in their institutions, departments, and practices. Exploratory work is under way to evaluate the feasibility of developing adjunctive or integrated resources/standards and of establishing a Surgical Quality Verification Program.

The quality manual was released at the inaugural ACS Quality and Safety Conference, formerly the ACS National Surgical Quality Improvement Program (ACS NSQIP®) Annual Conference, which took place in July in New York, NY. The conference boasted a record-breaking attendance of more than 1,800 attendees. This year’s theme, Achieving Quality: Present and Future, reflected a more comprehensive approach to quality and safety and included the perspectives of adult, pediatric, geriatric, and bariatric surgeons; nurses; anesthesiologists; and hospital administrators.

The new Children’s Surgery Verification (CSV) Program, which seeks to improve surgical care for pediatric surgical patients, officially launched in January. The first non-pilot site visits occurred this summer, with 16 sites going through the verification process.

The new Surgeon Specific Registry was the first ACS database to launch as part of the College’s integrated registry of the future, which ultimately will allow users to share relevant quality data across individual ACS Quality Programs, such as ACS NSQIP and the Trauma Quality Improvement Program (TQIP®). The ACS is creating this integrated database in partnership with QuintilesIMS.

Other new quality initiatives include the Agency for Healthcare Research and Quality (AHRQ) Safety Program for Improving Surgical Care and Recovery (ISCR), which the ACS is conducting in collaboration with Johns Hopkins Medicine Armstrong Institute for Patient Safety and Quality, Baltimore, MD. This program supports hospitals in implementing perioperative evidence-based pathways to improve clinical outcomes, reduce hospital length of stay, and improve the patient experience.

The ACS also became the new home for Strong for Surgery, which was originally developed by surgeons in Washington State. This program empowers hospitals and clinics to integrate checklists into the preoperative phase of care.

In addition, the ACS was awarded a three-year, multimillion dollar R01 grant from the National Institute on Minority Health and Health Disparities. ACS Past-President L.D. Britt, MD, MPH, DSc(Hon), FACS, FCCM, FRCSEng(Hon), FRCSEd(Hon), FWACS(Hon), FRCSI(Hon), FCS(SA)(Hon), FRCSGlasc(Hon), is the principal investigator on this award, which is aimed at eliminating variances in access to surgical care.

The Committee on Trauma (COT), in collaboration with military partners and the National Highway Traffic Safety Administration (NHTSA), held a conference in April to advance the recommendations in the National Academies on Science, Engineering, and Medicine report, A National Trauma Care System: Integrating Military and Civilian Trauma Systems to Achieve Zero Preventable Deaths after Injury. The meeting brought together approximately 170 trauma care professionals with the goal of creating the framework for a National Trauma Care System Action Plan.

In addition, the COT Injury Prevention and Control Committee (IPCC) is advocating for a public health/trauma system approach to firearm injury prevention that would implement evidence-based firearm violence prevention programs through its network of trauma centers. These institutions are fostering and providing a forum for a professional dialogue with the goal of moving toward a consensus approach to reducing firearm injuries and deaths.

The Stop the Bleed® program continues to grow and garner support from members of Congress. Leaders of the ACS and the COT hosted a congressional briefing February 28 to highlight the training program. ACS leaders also offered Stop the Bleed training on Capitol Hill October 12 for members of Congress and their staffs.

Member Services
A total of 1,827 surgeons were welcomed into the College this year, making it the largest Initiate class ever. The continued growth in Fellowship can be attributed not only to the programs described previously, but also the College’s specific recruitment and retention activities. Examples of these efforts include release of the
A total of 1,827 Initiates were welcomed into the College this year, making it the largest Initiate class ever. The continued growth in Fellowship can be attributed not only to the programs described previously, but also the College’s specific recruitment and retention activities.

Physician Well-Being Index—a validated screening tool that helps members better understand their overall well-being and identify areas of risk—and outreach to Fellows with lapsed or lapsing membership.

The Board of Governors (B/G) continues to implement initiatives through its Pillars and Workgroups. Specific examples from this past year include the release of a white paper on out-of-network billing; production of the now biannual e-newsletter, The Cutting Edge; conduct of the 2017 Board of Governors Annual Survey, which focuses on the Stop the Bleed Campaign, the opioid crisis, work-related injuries/surgical ergonomics, and advanced practice providers in surgery; and development of a standardized letter of recommendation for applicants to surgery training programs. In addition, the B/G received a historically high number of Surgical Volunteerism and Humanitarian Awards nominations—54 versus 44 in 2016.

The Excelsior Surgical Society has been resurrected and is now a formal society within the ACS. The Society has elected officers, developed a charter, and convened a full-day meeting at the last three ACS Clinical Congresses.

The Women in Surgery Committee (WiSC) developed an ACS Statement on Gender Salary Equity, which the Board of Regents approved in June, and selected the second recipient of the second Mary Edwards Walker Inspiring Women in Surgery Award. The WiSC also offered a successful leadership program for 18 women surgeons in conjunction with the ACS Leadership & Advocacy Summit 2017.

Looking forward to 2018
As these few examples demonstrate, the ACS is constantly moving forward to offer surgeons and the other members of the patient-care team the tools, resources, and educational opportunities they need to succeed in practice and to provide optimal patient care. As always, you are encouraged to contact the ACS leadership, and let us know how we can best serve you. ♦

If you have comments or suggestions about this or other issues, please send them to Dr. Hoyt at lookingforward@facs.org.
Presidential Address:
The joy and privilege of a surgical career

by Barbara Lee Bass, MD, FACS, FRCS(Hon)
Editor’s note: The following is an edited version of the Presidential Address that Dr. Bass delivered at the Convocation Ceremony at the American College of Surgeons (ACS) Clinical Congress 2017 in San Diego, CA. The presentation has been modified to conform with Bulletin style.

At risk of being too personal, I want to ask each of you to ponder some fundamentals on this occasion of being inducted as a Fellow in our American College of Surgeons (ACS).

Have you at this moment of accomplishment, or perhaps at some other time fogged by fatigue in years past, considered how hard you have worked to have come to this accomplishment? Sleepless nights, thousands of hours in the hospital, endless hours of study and practice? What price have you paid for the privilege of becoming a surgeon? Have you missed dinners, parent-teacher conferences, dates, soccer games, anniversaries, quiet moments, workouts?

And, for you family members here with your loved one this evening, have you missed this person at times over these last 5, 10, 15 years? Times when you really wanted her or him to be with you—maybe even needed this person to be present? I hope you know he or she missed you, too, and suffered that missed moment like you—a moment often laced with the pain of guilt, of having chosen a career that at times holds the prevailing vote.

Why, young surgeons, would you have let these things happen?

The joys and hardships of surgical training

Let’s consider, from some perspectives, why those unthinkable missed moments may have happened. What were you doing during those years of training and practice that asked so much of you, far more than many careers?

Actually, any of us on this stage and, indeed, each of you could answer that question. You were learning—a lot! You were doing remarkable things with your hands and minds. You were developing fundamental and then advanced surgical and professional skills. You were witnessing life’s simple miseries, life’s greatest tragedies. You were learning about human kindness, anger, frustration, and joy.

You were building that remarkable portfolio of skills that we call surgery. Learning when and why to operate, developing technical skills to combat a surgical disease, to repair the human body.

Over this last decade or two, you often worked under the watchful eye of trusted mentors who brought you along all those years. Keep in touch with them, by the way, and pass on what they gave to you.

During those, at times, missed years, you were busy becoming knowledgeable, skilled, and emotionally prepared to care for a patient that was yours. I suppose someone else could have been there instead; you could have made a different career choice. But, no—surgery chose you, and you dove in. So in those away times, you were doing important work—deep experiential learning and intensely personal immersive patient care.

I hope during those, at times, challenging years, you found a brother- and sisterhood of shared experience with your colleagues, a net in which to share both challenges and joys. It may not have always felt that you were making good progress, or even that you made the correct choice on some days, but recall day one of your training—day one after graduation from medical school and then day 1,500, 2,000, or 3,500—whatever day it was when you “finished” your training. An astonishing transformation, yes? Yes! Not good enough to last you a lifetime in this business, but a fabulous foundation for the next 30, 40, maybe 50 years.

No matter where in the world you experienced this pathway to becoming a Fellow—and we have surgeons from 68 nations from around the globe joining our College as Fellows tonight—this transformation from student to surgeon is a magnificent, if at times arduous, shared experience for all of us.

The surgeon-patient bond

But, remember please, please, the lives you have touched during these “lost” times: Injured people, previously unknown neighbors with deadly diseases, or simply those needing a little “repair.” People who are afflicted with a surgical disease, who are our special
and often routine joyful opportunity, are experiencing a rare life event—an operation.

In fact, most of us will have only a few of these in our lifetimes. So what for us, who have done many thousands of operations, seems ordinary, to each of our patients is often a major life moment. And while we all know we can’t do what we do without our incredible teams, always remember that individual, that patient, came to you—you personally—to help them.

And never forget to pause and recognize that our often fearful but brave patients allow us this trusting moment while they sleep in a room surrounded by strangers.

So, what I hope you and your loved ones who did the most waiting and missing, like those family members in our waiting rooms, can understand is that those years of training, those years as you begin your practice, those times going forward when you are honoring that commitment to your patient, are not only part of an important and critical mission but also a rare, rare privilege. What we get to do for the people who need us is a joy and a privilege for us!

The greatest reward in our profession is the gift of trust we receive from our patients when we are allowed to help them. It’s priceless.

So with all of this, I can’t absolve you of those missed personal moments past and future, and perhaps there were fewer than my own. I’ll have to ask my Wes, Wyatt, and Richard but never trust their answers; each graced or cursed with the affinage of life years. But in my mind, your choice to become a surgical servant is a most noble calling. As I’ve said many times to my residents, we aren’t surgeons because we want to be, we are surgeons because the citizens of our communities need us to be.

The challenges of a surgical career

So when you get in the doldrums, as I promise you will or have been, remember this calling, this privilege, and this joy. I trust it will pull you through.

Except when it doesn’t.

This bond between a surgeon and a patient can get lost in our busy, burdened lives. It can get lost in fatigue, in regulatory hoops, in the frustrations of our electronic medical records. Lost in demands fueled by wRVU (work relative value unit)-driven contracts and our compensation expectations, by a sense of a loss of control in our health care delivery machine.

It can get lost in nights on call, when we should be having resuscitating moments with those we love the most, and in skipped periods of caring for ourselves, our minds, and our bodies.

I get it. Where is the privilege and joy in this? We have to dig deep on many days.

And, if we are heading down a foxhole of negative disruptors in our careers, let’s add a few others that will be real challenges in the years ahead. You will face various forms of threatened obsolescence in knowledge, skills, technologies. On a very personal level, you will age. You will suffer personal tragedy and loss. You will become ill, sometime or the other. These facts will challenge your will and resilience.

That you may stumble when facing such challenges during your career is not a sign of weakness. It’s life. And while you will do your best to maintain your personal resilience tool kit, it is also our profession’s responsibility to craft solutions for our members, or at least bumpers, to soften the impact and to enhance personal performance and wellness as we face these challenges.

I believe there is a bit of light ahead as our health care industry begins to recognize that this thing we call burnout is not a personal failing, but rather a function of our flawed work environments. Yoga and mindfulness or grit can get you only so far.

Our health care systems are beginning to acknowledge systematic repair is in order as the real costs of surgeon and other health care provider burnout is recognized as a threat not only to the individual within the system, but also to our bottom lines of patient safety, quality of care, and financial stability.

An active voice and action in this essential domain of working environment restructuring is mission critical for our profession and most assuredly one that is being pursued on many fronts by individuals and programs in our College. Jump in, help craft some solutions.
Our communities need surgeons

Let’s tackle a few other challenges. To frame this, be aware of just how valuable each of us is to our community as an asset. First, getting you to this skilled and knowledgeable point reflects an investment of well more than $1 million: medical school, graduate medical education, and time and effort calculations. Your money, our society’s investment—a lost opportunity for another.

Second, the dire anticipated shortage of surgeons of many stripes—general surgeons, orthopaedists, urologists—appears to be real. Fueled by us aging baby boomers, with our failing bones, bellies, genes, and hearts, we can anticipate that surgeons will remain in high demand in the years ahead. We need every one of you.

The gender gaps

Let’s take a look at our incoming cohort. In this entering class of 1,857 Initiates, 448 are women. Now, that’s progress! However, knowing that medical schools around the globe are reaching gender parity, if we are to keep our surgical pipeline full, we need to offer careers that are equally attractive to men and women.

While the U.S. general surgery pathway has entering classes of 40 percent women, the other surgical disciplines have not so far attracted women to their ranks in sufficient numbers: neurosurgery, orthopaedics, cardiothoracic—very important and high-demand specialties of the future. Work to do for our College, our profession, and indeed, each of us.

While much has changed for women in surgery since surgery claimed me, there are still differences in the lives of many women surgeons compared to their male colleagues: differences in marital status, childbearing age, partner employment, and other factors that may seem at first blush to be personal matters, but differences that actually have substantial impact on our professional lives as well.

Women still hold primary responsibility for much of making a home in most families: meals, shopping, child and aging parent care, health care, gatherings. In all honesty, many of us will not give up those roles—they are a chosen responsibility, a gift to make a home for one’s family. We may not make home the way our mothers did, and we will gladly share these roles with our willing partners in new ways, but we will not give them up.

But let’s separate home for a bit from the reality of women surgeons’ professional lives. A sharp look shows that women surgeons are still compensated 10–17 percent less for equal work than their male colleagues. Poor negotiation skills, diminished personal expectations, implicit bias from prospective partners and health care organizations, or overt residual inequity?

The answers are not clear, but the data speak clearly. Women, as we have seen for the last 20 years, are less likely to rise to leadership roles in their group practices, hospital structures, and professional organizations or through the academic ranks. The ripple effect of this is passed on to our medical students who don’t see women surgeons in leadership roles, but rather as entry-level, stretched young surgeons starting their careers at perhaps the busiest times of their lives, as long-deferred children begin to arrive.

But, the changing face of surgery is astonishing when we look back over the last three decades. And we can thank our founding mothers for their resilience, remarkable surgical talents, and commitment for the fact that women continue to grow in the surgical ranks, with satisfaction in our careers equal to that of our male colleagues.

Each of that primary cohort, a few most important to me and to many others—Olga M. Jonasson, MD, FACS; Kathryn D. Anderson, MD, FACS; and Patricia J. Numann, MD, FACS—found their way independently, carving and crafting a pathway; each and every one, adopted and guided and challenged by the men, and an occasional woman surgeon, just as I was, who formed them into the surgeons, leaders, and contributors they became.

Mentorship is not gender-specific. Visible role models, however, may be. One wants a glimpse of
what one’s life might be like as a surgeon, not only
as a professional but as a wife or partner, a mother,
or friend.

We surgeons, of course, are not the only cohort of
working women and families who suffer for the failure
of our American society to embrace pregnancy, parent-
ing, and child care as a common good. Our College,
with the guidance of the Women in Surgery Committee
and the Association of Women Surgeons (join it, by the
way), has endorsed a statement that acknowledges the
need for appropriate pregnancy and parental leave and
clearly articulates that the choice to become a parent
in no way diminishes a woman surgeon’s commitment
to her career.

Our profession must commit to forging meaningful
maternity and child care policies and practices so that
this issue will not be a factor that may defer prospec-
tive students from choosing our disciplines or restrict
the career aspirations of women surgeons—more work
for our College.

Staying at the top of your surgical game:
Retooling reimagined

Let’s ponder another challenge. It took each of you
between four and 10 years of formal training to get to
your current level of proficiency and knowledge. You’re
actually getting even better during these early years in
independent practice.

But then five, 10, 15 years from now, you are going
to realize that while your foundational training is
durable, you need to add a piece to your repertoire, a
new potentially transformative skill. You are in a busy
practice doing the best you can every day, and then
something new must be added.

In my lifetime, I’ve seen numerous transformative
technologies rock our surgical world: laparoscopic sur-
gery, endovascular surgery, robotic computer-aided
surgery. Theoretically and in reality, each has brought
incremental and sometimes transformative improve-
ments in how we treat our patients.

Thematically, these advances have introduced new
technologies, interfaces between our hands and our
patients’ bodies: image guidance, computer-aided
procedures, augmented visualization, and minimal
access sites—fundamentally delivering us to “preci-
sion surgery.”

But, how do we safely retool? We all recognize the
potential harm that comes with a surgeon’s learning
curve, which in our past and present is largely borne
by our trusting patients. You can’t keep doing the old
stuff if the new stuff is better. But premature adop-
tion without proper training and supervised practice
is unfair to our patients and can, we know, come
with harm.

Twenty years ago, in the flawed early adoption of
laparoscopic surgery, which left harmed patients in
its wake, the ACS Committee on Emerging Surgical
Technology and Education articulated the principles
of new skills acquisition. And no, it is not see one, do
one, teach one. Rather, the cycle of didactic learning,
coupled with simulation-based training, and then proc-
tored early experience leading to independent practice
and assessment of outcomes, was framed. We know the
principles. But when it comes right down to it, we still
have a long way to go in implementing this pedagogic
model for surgeons in practice.

In this matter, we’ve had visionary leadership in
the College with the establishment of the Accredited
Education Institutes (AEI) program. The premise was
to develop a network of centers leveraging emerging
simulation technologies to enhance surgical training.
Now numbering 96 national and international sites, the
AEIs have served as both educational and research cen-
ters to teach surgical skills—technical and nontechnical
skills—to surgeons and others in our surgical pipeline.

A prototype facility: MITIE

At my hospital home, the Houston Methodist
Hospital, we have built a center known as MITIE—
Methodist Institute for Technology Innovation and
Education—a beautiful, comprehensive center with
a sharp focus on retooling surgeons in practice. We
have hosted more than 12,000 surgeons in practice
for retooling hands-on courses in all disciplines of
surgery. We built MITIE as a prototype facility to
determine how best to craft an efficient educational
When faced with, at times, aggravating moments at work, I insist on recalling that individual surgeons, banding together within our College, have created some of the most effective systems in the world to improve surgical care.

center for busy surgeons in practice and to study how best to deliver the retooling mission.

To begin to address this need, our College has gathered the stakeholders with vital interests in maintaining a skilled surgical workforce. The parties include our payors and consumers, liability carriers, surgical technology industries, the executive leadership of the hospitals where we deliver care, and of course, us surgeons. This group has started to define the infrastructure components—facilities, faculty, curricula, assessment tools—and, importantly, to consider financial models to incorporate retooling and training into our health care budget.

We’ve got great medical schools and teaching hospitals in this nation. How about the infrastructure for those next 40 years in practice?

This retooling reimagined initiative is driven by a need, a need we surgeons identified. It is our duty as members of an essential profession to craft a solution. This is but one example of how we can shape our professional futures.

Creating solutions: Individuals matter

I have often been amazed, and somewhat concerned, at how well we surgeons can express our frustrations, or even fury, on bad days. Can’t we transform that energy into a positive? Well, if College history has relevance, which, of course, I believe it does, then on a good day, I can see what happens when a surgeon or a group of surgeons begins to craft a solution based on real needs in the work environment.

Remember, the ACS was founded 104 years ago by a group of surgeons with the explicit goal of improving the care of the surgical patient. This is still our mission today.

So when faced with, at times, aggravating moments at work, I insist on recalling that individual surgeons, banding together within our College, have created some of the most effective systems in the world to improve surgical care.

In 1922, surgeons dismayed by unnecessary deaths from injury formed the Committee on Fractures, which later blossomed into the Committee on Trauma, producing the Advanced Trauma Life Support program, trauma system verification programs, and military partnerships to translate lessons learned in war zones to the care of the civilian injured, programs that time and again prove invaluable in saving lives when the unthinkable happens in our communities.

The Commission on Cancer, originally the Committee on Cancer, also formed in 1922—whose programs now guide the delivery of integrated cancer care and research throughout our nation—was founded based on a need identified by surgeons caring for patients with dread diseases without solutions.

The ACS National Surgical Quality Improvement Program was born in the Veterans Affairs (VA) health care system with the vision of a single surgeon, Shukri Khuri, MD, FACS, who when tasked with a perceived problem in surgical care in the VA health care system launched a research study to measure quality. Soon thereafter, he led a collaborative army of surgeons to improve surgical care in their own hospitals—the founding of a nationwide movement that now flourishes in thousands of hospitals as the world’s most effective surgical quality measurement and improvement system.

These College programs and systems have saved hundreds of thousands of lives.

We can go on and on—a surgeon identifies a gap and with a good idea and abundant College focus and the engagement of our Fellows, a valuable new program is made: the Surgical Education and Self-Assessment Program, Fundamentals of Surgery, the Journal of the American College of Surgeons, and, most recently, the newly released manual on defining the Optimal Resources for Surgical Quality and Safety. I believe it will soon be our guiding manual for all aspects of surgical care delivery in our ever-changing health care system.

The point? These programs were not delivered from on high. They were created by regular surgeons, like you and me, who saw gaps in their professional worlds and took steps to effect a meaningful change.

So, be engaged. Participate in those initiatives in your home institutions so that you too will have an
impact beyond yourself. Look to the College and other professional organizations to help you. Don’t just talk—engage.

Caring for each other

In closing, I have one more request, and it is a hard one. I want you to be aware of your colleagues. I want you to watch them for signs of stress, disturbances in their forces. And, if you see something, please, offer a chat—a supportive question, an offer of possibly needed assistance. We need to start the dialogue with someone who may be in trouble. We need to be proactive.

Be aware of help that is available in your institution; know how to move a concern up the chain with sensitivity but also with compassionate concern for your colleague.

These are not easy discussions and may prove fruitless, but it is worth the effort that we try, for we, regrettably, are a high-risk group for depression, substance abuse, and suicide—yes, all of these—and for failing to seek assistance. This situation must change.

We must remove the stigma of mental illness and personal struggle from our profession. We can’t allow our colleagues to suffer, and indeed to lose them, to their own hand or to violence or oppression at the hand of an intimate partner, without having tried to help.

Yes, these things happen to us, we professional women and men, and we need to start a discussion together to create new more effective methods to extract those in harm’s way, without judgment, without stigma: another vital mission for our College and for each of us.

Looking forward

But, for now, on this happy evening when we celebrate your induction into our College, I hope you are excited and most satisfied in your near future. I hope you enjoy the love and warmth of family, friends, and community in the decades ahead. I urge you to be kind and generous, humble and wise.

I hope you are proud of your new fellowship in the American College of Surgeons. I hope you will draw endless support and friendship from those around you and that you will contribute more than you receive.

And I hope that you will forever treasure your opportunity to practice as a surgeon, an exceptional joy and privilege.

BIBLIOGRAPHY


ACS LEADERS VISIT CUBA

ACS leaders visit Cuba, discover opportunities for collaboration

by Mika N. Sinanan, MD, PhD, FACS; Carlos A. Pellegrini, MD, FACS, FRCSI(Hon), FRCS(Hon), FRCSEd(Hon); and Daniel Riojas

HIGHLIGHTS

- Outlines the observations of an ACS delegation to Cuba this spring, including the challenges of facing the country’s health care system
- Describes the strengths of the Cuban health care system, including the provision of cost-effective care and the ability to organize and prioritize services based on need
- Summarizes what the College can do to support education and training in Cuba
A delegation of 51 American College of Surgeons (ACS) leaders visited Cuba this spring in an effort to strengthen ties with surgeons of the island nation. This article offers some general observations on Cuba and its health care system, followed by more detailed insights into what the delegation learned during meetings with leaders of the Cuban health care system. It also describes the needs of Cuban health care professionals and outlines ways the ACS can help.

General observations
Cuba is a study in contrasts—contrasts between expectations and the facts on the ground. Although it is a resource-rich environment, it can feel constrained, even austere.

The average salary is approximately 700 pesos per month, equal to about $30 U.S., although health care, education, and housing are provided by the Cuban government. Some Cubans clearly have more financial means than others, yet this society seems to be remarkably class free.

The iconic sights of the Cuban experience are most evident in Havana with the Malecón and old-world charm of a crumbling infrastructure that is kept together with baling wire and duct tape. The Cubans celebrate their people and their heritage, including the 1959 revolution—which they say improved the way of life for most Cubans—and its leader, Fidel Castro, as well as cultural touchstones such as vintage cars, rum, cigars, music, and Ernest Hemingway.

The Cuban people attribute any shortages of goods and services largely to the U.S. embargo that has been in effect for more than 50 years and makes trade with the U.S. impossible and the purchase of American-made innovations unaffordable. As a result, medical supplies and medications are often expensive and in limited supply, and many medical devices are old and outdated. Nonetheless, the Cubans have developed an efficient health care system that functions at a national level with apparently excellent results. Ensuring access to quality health care is a big part of the Cuban government’s commitment to its people.

However, a range of health care-related challenges face Cuban health care providers. Cancer is the leading cause of death in Cuba, and thus a priority area of research is cancer care augmented with radiation therapy equipment and positron emission tomography/computed tomography scanners. At present, these services are available only at a few centers. Medication for pediatric cancer care is unavailable, and due to a lack of staplers, anastomoses are done mostly with sutures. Lung transplantation is impossible because of the lack of access to organ preservation solutions. Notably, there is interest in developing robotic surgery.

The Cubans have developed an efficient health care system that functions at a national level with apparently excellent results. Ensuring access to quality health care is a big part of the Cuban government’s commitment to its people.
Health care training also is an export commodity and part of the foreign policy of Cuba. Health care professionals from all over the world, including the U.S., train in Cuba. Many of these students come from low-income communities in their respective countries and are trained free of charge. Medical teams are sent to disaster areas gratis or as purchased services. The country’s international “medical brigades” travel around the world to provide relief services. For example, Cuba sent 85 physicians to West Africa in 2014 during the Ebola outbreak, two of whom died after contracting the disease. Surgeons also traveled to Haiti after the earthquake in 2010.

For the most part, health care starts in the community with a physician/nurse/health care technician primary care provider (PCP) triad, which provides the core of a tiered system of care. PCP triads are embedded in the community and the health care professionals who comprise it often live in the same housing complexes or neighborhoods as their patients. Each triad is responsible for the care (including preventive health) of approximately 1,500 residents. This structure is what is called “tier 1 care,” or the most basic care. Groups of 15 to 20 triads are linked to a community-based polyclinic, which offers specialty care and more sophisticated imaging and lab testing. The entire community-based polyclinic and its dependent triads provide what the Cuban health care system recognizes as “Level 1 care.”

Commodity surgical services, including acute care surgical services, are provided in district hospitals—known as tier 2 centers. Some more specialized services are offered regionally, as needed. High-level tertiary and quaternary specialized services, such as advanced minimally invasive surgery (MIS), trauma care, transplantation, and hepatopancreatobiliary surgery, are centralized in Havana at several tier 3 hospitals. Transfer of patients for higher levels of expertise is based on protocols and is at the discretion of local physicians and surgeons.

Patient records are paper-based due to the lack of computers in Cuba. Electronic health records (EHRs) are expected in the future but are not yet available. Decisions on physician- and nurse-training class size and clinic and hospital bed distribution are made centrally, based on input from experts at local sites across the 15 provinces of Cuba. Similarly, these educational and health care paradigms are replicated in each of these provinces.

The health care specialists with whom we interacted are proud of the system in which they work and their role in it. They seem supportive of the way it has been organized and staffed. They take their work seriously and care deeply about the quality
of care they deliver. We heard of multiple levels of quality review and oversight, similar to North American systems.

**Cuban Surgical Society**

The first morning in Cuba, we met with leaders of the Cuban Surgery Society (CSS), including Manuel Cepero, MD, president; Simon Antonio Collera, MD, vice-president; and Armando Leal, MD, secretary. They provided us with a general overview of the organization and the Cuban health care system.

The CSS has 16 chapters, and more than 90 percent of Cuba’s 1,200 surgeons are members. Each chapter of the CSS has a focus area of work or research. MIS surgery is the most technologically advanced area, followed by transplant surgery. Examples of areas of research include hernia and breast surgery. Once the areas for development are identified, physicians are sent to international centers to learn techniques. The Cuban Ministry of Health has a relationship with more than 160 countries in Europe, Africa, and Asia.

**Surgical training in Cuba**

We gained insights into the surgical training process during our visit. Like all forms of education in Cuba, surgical training is free, given at a high level and at low cost to the government. It is financed by the Ministry of Public Health (Ministerio de Salud Publica). Surgical residents train across the country in the specialties identified by the ministry as having the greatest need.

After six years of medical school, surgeons undergo four years of general surgery training, which includes three core rotations: obstetrics/gynecology, pediatric surgery, and trauma. Residents are in the operating room (OR) from day one and given graduated responsibility under supervision. Each resident has a training tutor and a residency tutor and is expected to complete a set number of procedures annually. Achievement of these milestones is required to be eligible for annual exams that determine if a resident moves on to the next year.

At the completion of training, residents must present a thesis based on the needs or focus area of their parent hospital and district. Residents also must undergo an examination that is given at a center other than where they trained. After training and successful passage of the examination, surgeons may begin practice under supervision of a senior mentor.

Between 40 and 50 surgeons enter practice each year. At present, 14 percent of all surgeons are women, but certain specialties, such as plastic surgery, have more women in practice. Many Cuban surgeons are from one of the 160 South American, African, or European countries with which Cuba collaborates. Cumulatively, 145 U.S. surgeons have graduated from Cuban medical schools. Although initially all international medical students trained for free, with a requirement that graduates return to deliver services in their community, foreign students now must pay $15,000 to $20,000 per year or $180–$250 per week for shorter training periods. These fees are usually covered by the countries of origin but sometimes they are paid by individuals. At present, 85–90 foreign students are training in Cuba—10 on scholarships.

The leaders of the CSS expressed strong interest in pursuing the following opportunities:

- Collaborating with U.S. medical schools and with the ACS in training and research
- Finding U.S. residency positions for Cuban medical school graduates
Gaining fair access to technology, pharmaceuticals, and equipment

Reducing restrictive banking, credit, immigration, and international commercial regulations that they believe disproportionately disadvantage Cuba and the Cuban health care system

**ICAP**

Next, the College delegation met with representatives of Instituto Cubano de Amistad con el Pueblo (ICAP), which was established in 1960. ICAP interacts with more than 150 countries and more than 2,000 organizations in supporting innovative approaches to trade and education, such as the Latin American School of Medicine, which has graduated more than 100 African students. This organization helps navigate investments, business transactions, legal issues/interpretations of laws, and donations to various programs.

ICAP representatives offered a plea for closer ties with diverse groups in the U.S., including the ACS. They provided more details about how the embargo affects Cuban commerce, particularly the health care system’s ability to offer advanced clinical care and to pursue research and educational opportunities. Our Cuban counterparts stressed that any differences they have with the U.S. are with the American government and not its citizens.

**Cuban Ministry of Public Health**

The ACS delegation’s second day in Cuba began with a meeting with representatives from the Cuban Ministry of Public Health, including Aldo Grandal, MD, Executive Director, International Relations, who provided us with a history of the Cuban health care system. Dr. Grandal explained that before the revolution in 1959, Cuba did not have a national health care system. Mr. Castro, the leader of the revolution, wrote of deplorable health care in Cuba in his book *La Historia me Absolverá (History Will Absolve Me)*, which he wrote in 1953 while he was in prison. Under his leadership, the Cuban constitution includes an article that establishes health care as a right, and Law 41 specifies that health care for all Cubans without regard to social class is the responsibility of the government. Thus, medical care is free for all inhabitants. We also learned that pregnant women are cared for in a standardized and state-of-the-art way to reduce premature births and guard against the costs associated with providing neonatal intensive care.

Today, the overall life expectancy for a Cuban citizen is 79. Cuba has 13 medical schools, and 19 percent of its gross domestic product goes to health care. According to the physicians with whom we met, national efforts at organizing and coordinating systems of care have significantly improved the health of the public. In 2016, Cuba had 85,563 physicians providing care throughout the country. In a 50-year time span, the infant mortality rate dropped from 60/1,000 to 4.3 per
1,000. Today, infant mortality in Cuba is one of the lowest in the world.

National areas of health care focus include control of communicable and infectious diseases, rural health care, national health status information, and sanitation from a public health standpoint. Over the last 56 years, polio, smallpox, rubella, diphtheria, and neonatal tetanus have been eliminated. Human immunodeficiency virus (HIV), meningococcemia, hepatitis B, and rabies are controlled thanks largely to a mandatory vaccination program. Special discussion was made of the Heberprot-P vaccine, a Cuban development with a 70–90 percent success rate in healing diabetic ulcers and reducing amputation.

With respect to safety and quality of inpatient care, the goal is to achieve international standards. To this end, systems and rule changes are being put in place and health care professionals who are noncompliant are subject to disciplinary measures.

The Ministry of Public Health has developed a financial model to support the Servicios Médicos Cubanos, through which physicians offer medical assistance to other low-resource countries. Volunteer surgeons go on medical services trips that can last up to three years. These are done in rotation. At present, 51,000 Cuban health care professionals are working in 67 other countries; 28,000 are physicians.

**Hermanos Ameijeiras Hospital**

During our meeting with the CSS described earlier, we learned more about the tiering systems for hospitals in Cuba. Stage 3 hospitals offer standard general surgery procedures. Stage 2 hospitals offer more specialized care but do not perform thoracic procedures. Stage 1 hospitals offer all types of surgical care, including cardiac and thoracic procedures, and transplantation.

After the meeting with the Ministry of Health, we visited Hermanos Ameijeiras Hospital (Hospital Clínico Quirúrgico Hermanos Ameijeiras), a Stage 1 hospital in Havana, where we met with a general surgeon, an MIS surgeon, a thoracic surgeon, a cancer surgeon, the surgical intensive care unit and transplant coordinator, and the chief of transplant surgery.

The Hermanos Ameijeiras Hospital opened in 1982 and now has 42 different clinical service areas that are managed by protocols, similar to care maps or pathways. The hospital has the resources to offer CT and magnetic resonance imaging, digital subtraction angiography, and ultrasound services.

Surgeons perform more than 20,000 operations per year at this institution, which houses three intensive care units (ICUs)—burn, cardiac, and stroke. More than 1,000 patients receive care in the hospital’s clinics per day, and all services are available daily, except obstetrics, gynecology, and pediatrics, which are provided three times a week.

At present, 500 residents of all specialties train at the Hermanos Ameijeiras Hospital, and 50 percent of these residents are international medical school graduates. Surgical services at this facility include transplant surgery, hepato-pancreato-biliary, thoracic, gastrointestinal, and other procedures. This was the first hospital to offer MIS in Cuba.

In 1986, the first liver transplant at the hospital was performed after Jose Antonio Copo, MD, trained in Pittsburgh, PA, under the tutelage of Thomas Starzl, MD, PhD, FACS. Notably, Cuba has a national program for organ retrieval, including nascent living-related donor and pediatric transplant programs. Donor rates are 12 per 1 million population, and donor livers are in scarce supply. Nonetheless, technology is the principal limitation preventing expansion of the transplant program, particularly...
the lack of preservation solutions and coagulation/hemostatic tools.

In addition, surgeons at the Hermanos Ameijeiras Hospital perform 20 to 25 Whipple procedures annually, for a cumulative total of 179 in the past 10 years. More than 100 liver tumor resections are also performed at this hospital each year.

Wait times for elective surgery can be long—up to a year for a hip prosthesis. Surgical cases are only sent out of the country if no facility in Cuba has the necessary resources. These decisions are made by the Ministry of Health, since the ministry covers the costs of all health care services for the Cuban people, regardless of where they undergo treatment.

Plastic surgery covers a range of services, including burn care, microsurgical reconstruction, craniofacial surgery, and implants. The hospital has 13 faculty in plastic surgery, each responsible for a group of up to 10 residents. At present, plastic surgery has 40 residents; four are women, and only two are Cuban.

Quality is tracked by many mechanisms. We learned that 10 percent of surgical cases are audited for necessity. Procedure (care map) manuals are kept up-to-date, and health care professionals are expected to follow these protocols when delivering care. Pathology, infection control, trauma, and other committees track short-term outcomes using objective measures that are then discussed at a service chief’s meeting.

**Centro Nacional de Cirugía de Mínimo Acceso**

On day three, the ACS delegation toured Centro Nacional de Cirugía de Mínimo Acceso with our host, C. Julian F. Ruiz Torres, MD. This institution focuses on MIS operations, though some of these procedures are performed at 118 other sites in Cuba, including every hospital. The Centro Nacional, completed in 2016, is the only dedicated MIS center in Cuba, however.

Centro Nacional has four ORs and suites for performing procedures such as endoscopy. This facility also houses two dedicated gastrointestinal (GI) bleeding rooms, and two endoscopic retrograde cholangiopancreatography (ERCP) rooms, a four-bed ICU area for complex postoperative care, and a total of 47 staff physicians. These surgeons perform 15–20 general surgery, otolaryngology, neurosurgery, and gynecology operations each day and 15 ERCP cases per week.

Advanced procedures include bariatric surgery, MIS pancreatectomy, adrenalectomy, total colectomy, low anterior resection, myotomy for achalasia, and anti-reflux procedures. A transmission electron microscope is available for specialized pathology.

Young surgeons from all over the country train at Centro Nacional, using animal models, and their skills are verified before they start providing clinical patient care.

The tour included Centro Nacional’s soon-to-open state-of-the-art training and simulation center. We observed what appeared to be technical proficiency and a high degree of skill in the surgeons, demonstrated via their leading edge audio-visual network. All four ORs are networked through a control room, with audio-visual signals forwarded to training conference rooms.

**Universidad Ciencias Médicas de La Habana**

Next, we visited the Havana Medical Sciences School, Universidad de Ciencias Médicas De La Habana, where we learned more about surgical education in Cuba. Oliver Peres, MD, president, scientific committee, and head of immunology, and Enrique Cabrera, MD, were our hosts.

After the revolution, Cuba was left with only slightly more than 300 physicians, most having left for the U.S. Consequently, the overall health care reform effort
included a strong medical education component. Today, Cuba has 13 medical schools with more than 2,000 professors and more than 5,000 students in training, including students from abroad at the Latin American School of Medicine. These are open-entry schools with elimination testing. The curriculum focuses on integrating cognitive and skills, early interaction with patients, and preventive medicine. Each graduate must take licensing exams.

To expand the opportunities for medical education, the Cuban surgeons who we met would appreciate the opportunity to attend the ACS Clinical Congress and to participate in educational conferences and residency training.

Calixto García Hospital
As we learned during our meeting with the Ministry of Public Health, automobile collisions, accidents in the home, industrial accidents, falls, and other unintentional traumatic injuries are the fifth most common cause of death in Cuba. Hence, the third day of our trip also included a visit to the Calixto García Hospital (Hospital Universitario General Calixto García) traumatology services. We toured the emergency department (ED) and ICU. Our guides were the president of the trauma division, the first deputy director, and the training director. We met other members of the staff in charge of international relations, research, ED, the coordinator of trauma, the surgeon-in-chief, and the Advanced Trauma Life Support (ATLS®) program coordinator.

Founded in 1896, Calixto García Hospital is a top-tier facility, offering the full range of services. The hospital is responsible for a population of 483,000 in a district of Havana. The hospital complex covers 13 hectares, with each specialty having its own pavilion. Calixto García Hospital houses 23 ORs and offers care in 37 specialties, 28 of which are certified for teaching.

The hospital’s main focus is on trauma, surgery, and care of the seriously ill patient—in other words, acute care—offering training in 28 health care specialties. It is not the only trauma hospital in Cuba. In fact, trauma surgery and care are provided across the country at hospitals in each province.

Trauma patients may be transported by family or ambulance. Ambulances are staffed by nonmedical transport personnel who have limited capability to treat a trauma patient. On arrival at the hospital, trauma teams are led by a surgeon.

Calixto García Hospital is growing; in 2016, surgeons there performed 3,016 major operations, almost double the 1,528 operations carried out in 2011. Cardiac surgery is only performed on an emergency basis. A number of U.S. surgeons have helped with training and development of services, including ATLS training. Training and development relationships with Michigan State, East Lansing; Stanford, CA; and Albert Einstein College of Medicine, New York, NY, in various specialties were highlighted. The staff appreciate this support and look forward to expanding it to other institutions with the College’s help.

University Polyclinic
The ACS delegation’s last visit was to the University Polyclinic (Policlinico Universitario)—one of seven polyclinics in Havana. Our host was Marisol Pio, MD, director.

Polyclinics like this one are the backbone of the Cuban national health care paradigm, as they are where patients receive primary care and referrals. The cornerstones of the polyclinics are prevention and rehabilitation, public health research, and
assessment of frequency and intensity of visits for at-risk populations.

The University Polyclinic was established in 1984 and encompasses the triad of health care professionals mentioned earlier in this article: a family physician, a nurse, and a hygiene technician/epidemiologist in a group practice setting (including a professor). The emphasis is on meeting the unique needs of the surrounding population, conducting screening visits, performing house calls, and providing in-home care. This is a family practice model with training in integrated medicine, which includes pediatrics, internal medicine, psychiatry, nutrition, and epidemiology.

All patients live within a two-block radius, and the clinic serves approximately 1,500 people. The health care professionals at the clinic have office hours and make house calls. The health care professionals at the clinic live in the community they serve, and they are viewed as extensions of the family for many of the patients. Specialists, such as obstetricians, gynecologists, and pediatricians, visit every two weeks.

Polyclinic patients may receive referrals for specialty care, including internal medicine, obstetrics-gynecology, pediatrics, psychiatry, dentistry, social work, and so on. A staff statistician manages the data critical to the national health system and epidemiologic data.

In addition, the clinic provides around-the-clock emergency care, including immediate life support, observation, nursing, radiology (X-ray and ultrasound), laboratory, dentistry, endoscopy, and ophthalmology services. It also offers vaccination, family planning, geriatric, HIV counseling, and advanced screening services.

This global health care and wellness approach has resulted in a significant decrease in infant mortality, earlier detection of prostate and GI malignancy, and the introduction of innovative treatment for diabetic foot infections. Heberprot-P is a locally developed vaccine which, in early studies in Cuba, has decreased the limb amputation rate by 85.4 percent.

Summary and next steps

The U.S. can learn much from Cuba about preventive care, the provision of cost-effective services, coordinated care, and the organization and prioritization of services based on national needs. This system, however, has had some challenges, including overproduction of physicians, nurses, and other providers, who are then rented out to other low-income countries. It is worth noting that some tertiary outcomes are weak. For example, the mortality rate for Whipple operations is 11 percent.

So, what can the ACS do to help? Members of the College can encourage and facilitate enrollment of Cuban surgeons as Fellows of the ACS—starting with the leaders of the CSS and of the Calixto García Hospital. The establishment of a Cuba Chapter of the ACS and its participation in a regional collective is another way the ACS can support health care providers in this country. Perhaps College leaders can explore ways to provide some of our ACS educational materials, including ATLS manuals, at low or no cost, possibly through the ACS Foundation.

The leaders of the ACS are committed to building a closer relationship with surgeons in Cuba. This relationship would benefit patients both in the U.S. and in Cuba.

Acknowledgment

The photos in this article are courtesy of Mr. Riojas and Lawrence W. Way, MD, FACS.
Blockchain technology in health care: A primer for surgeons

by Alexander W. Peters, MD; Brian M. Till; John G. Meara, MD, DMD, MBA, FACS; and Salim Afshar, MD, DMD, FACS
Blockchain technology—the platform underpinning Bitcoin, a global digital payment system—has attracted more than $1.2 billion of investment from some of the world’s leading corporations for its security and immutability. More than 130 million secure Bitcoin transactions have occurred since the digital currency launched in 2009. Today, Bitcoin can be used to make purchases from Microsoft, buy food in neighborhood cafes, book flights and hotel rooms, and even pay for medical care.

For the health care industry, blockchain technology stands to revolutionize the interoperability, security, and accountability of electronic health records (EHR) and health information technology (HIT), medical supply chains, payment methodologies, research capabilities, and data ownership. In fact, in the 2015 report "Connecting Health and Care for the Nation, a Shared Nationwide Interoperability Roadmap," the Office of the National Coordinator for Health Information Technology set a goal of establishing full EHR interoperability by 2024.

As blockchain technology continues to develop, it is important that surgeons and other stakeholders understand both its capabilities and its limitations. This article describes blockchain technology’s implications for health care, research, and the practice of surgery, and introduces the term “electronic health chain” (EHC).

**What is blockchain technology?**

In the wake of the 2007 financial crisis, an anonymous individual or group of individuals, using the pseudonym Satoshi Nakamoto, published a white paper proposing a peer-to-peer electronic payment system. The proposed system eliminated trusted third parties, such as banks and credit card companies, from online financial transactions and replaced them with secure, peer-to-peer financial networks. The concept, called Bitcoin, was based on decades of advances in cryptography and network science, and incorporated secure digital signatures, timestamps, and a form of cryptographic “evidence of work” called an “unknown hash,” a process used to at once approve the legitimacy of transactions and generate new units of currency in exchange for the work of this validation (see sidebar, pages 29–30). The record of each peer-to-peer transaction was to be recorded on a digital “block,” a kind of digital receipt. By stringing together each of these receipts in a chain—a blockchain—a user could create a comprehensive history of every transaction involving a given unit of digital currency, something that is impossible with paper- and coin-based currencies.

Nakamoto proposed that these blockchains, rather than being stored in a single, central repository, should be distributed to multiple locations, thus making blockchain theft or alteration impossible. Each node, or computer system involved in supporting the blockchain network, holds its own identical copy of the blockchain, in what is known as a shared ledger. This distributed ledger offers a number of advantages over centralized banking systems:

- **Transparency:** Centralized financial ledgers are subject to fraud and misuse, as evidenced by a range of recent financial scandals. Blockchains offer transparent, verifiable records for every transaction, both validating the underlying currency and protecting holders from counterfeit “coins,” pyramid schemes, and other forms of fraudulently duplicated value.
- **Immutability:** In the current paradigm, centralized ledgers offer rich targets for hackers, who regularly attack such IT systems, costing the global economy hundreds of billions of dollars each year. With blockchain technology, an attack on a single node has little network-wide ramification. Because each member of the network, or node, holds an identical copy of the shared ledger, the loss of one node has little impact on the system as a whole.
What is Bitcoin?

Bitcoin is the original and most widely known cryptocurrency. Launched in 2009, more than 9,000 nodes (or computer systems) are actively involved in its network. As of August 2017, Bitcoin’s market capitalization was more than $45 billion. Bitcoins can be purchased on an open market like any currency, received as payment, or earned through “mining” (see sidebar continuation, next page). In recent years, other cryptocurrencies have proliferated, each of them built atop blockchains. They include Ethereum and Ripple and, most recently, Bitcoin Cash.

Every Bitcoin transaction is recorded as a block. Blocks include information about both buyer and seller, a timestamp, and proof of the legitimacy of the transaction, referred to as the hash. These blocks are strung together in a “chain,” which records the history of every transaction involving the given unit currency.

David pays Ann, Ann pays Rick, Rick pays Chris

What is a shared, public ledger?

In centralized data networks, data are vulnerable to failure at a single focal point or node. Decentralized data networks are vulnerable at branch points, but no one nodal failure dooms the entire network. In distributed data networks, however, data are stored securely across many interconnected nodes, so that individual nodal failures are contained and no single failure can affect the network, much in the way a single line outage does not take down an entire power grid.

Centralized data  Decentralized data  Distributed data

Blockchains are shared publicly as ledgers, or record books, across peer-to-peer distributed data networks. Each node of the participating network holds its own identical copy of the ledger, detailing every transaction that has ever occurred. Because new data are added by extending the chain, rather than overwriting it, any attempt to change the history of the chain (for example, by a hacker) will be immediately invalidated by the rest of the distributed network. This makes theft, destruction, or unverified changes to the blockchain impossible.

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What is a cryptographic hash?

Blockchains rely heavily on hash algorithms, which allow for data inputs of any size to be converted into a coded sequence output of fixed length, called a hash. When new data transactions are recorded to the blockchain ledger, a new hash algorithm must be created that incorporates the new data, a timestamp, and information from the previous block. To function securely, a hash algorithm must do the following:

- Generate outputs that are entirely unique.
- Generate outputs that are irreversible, meaning that inputs cannot be derived by computing backward from the resulting hash.
- Be deterministic, meaning the same input generates the same hash, no matter when, where, or by whom the inputs are plugged into the algorithm.

Solving the hash takes significant computing power. So-called miners who solve these hashes are rewarded for their hard work in the form of bitcoin currencies and cryptocurrencies.

What is Bitcoin mining?

New bitcoins enter circulation through the work of miners, nodes that lend their computational power to the network. These miners validate new data transactions on the blockchain by competing to solve the hash. If the solution is recognized and validated across the network, the transaction is executed and a new block—a record of the transaction on the ledger—is added to the chain. The miner earns new units of currency as a reward for its work and contributed computing power.

How could health care benefit from blockchain technology?

Interoperability: EHRs lack interoperability and are exceedingly costly. Because EHRs are unable to effectively communicate with each other, physicians and surgeons often treat acutely ill patients without access to medical histories, current medications, and prior imaging studies that could influence patient care. Achieving full interoperability has been projected to save the U.S. health care system $77.8 billion per year, largely by avoiding redundant tests and imaging studies, and by decreasing administrative expenses.

An EHC that uses blockchain technology could be a convergence point for a patient’s health information (see Figure 1, page 31). In a truly interoperable network, data gathered over the course of a patient’s life through personal health and wellness activity, and diagnostic and therapeutic activities such as patient encounters, procedures, laboratory testing, radiology, smart devices, and even third-party genetic testing services, could all be securely incorporated into a patient’s unique EHC.

Personalized medicine: At the patient care level, common clinical data integration would allow providers to seamlessly use the entirety of a patient’s health data to provide individualized care quickly and easily. For example, blockchain technology could facilitate and streamline the use of tools like the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP®) Surgical Risk Calculator, as the necessary clinical data inputs could be automatically gathered with access to a patient’s EHC.
Research: A health care data supply chain could revolutionize the next generation of scientific research. Surgical and medical research today is encumbered by the difficulty of building large datasets across existing silos of patient data. The cost, labor, and error associated with manually updating databases like ACS NSQIP, the National Trauma Data Bank, or the National Cancer Database can be avoided if clinical data are integrated into a common, searchable EHC. Moreover, the power of these data will be amplified in coming years if the troves of genetic data from public online sources and phenotypic data from wearable devices can be effectively incorporated into the EHC.

Security: Blockchain technology also stands to improve the security of health care delivery. Fraudulent Medicare billing, for instance, costs the health care system more than $60 billion per year. Establishing an immutable blockchain in which patients are informed of all changes to their health care records and bills would eliminate the possibility of such abuse. Establishing such a system would also increase the safety of drug and device supply chains. Counterfeit drugs are understood to pose both a public health threat and a significant cost to the pharmaceutical industry, costing the Eurozone 10 billion Euros per year. Blockchain-based systems that aim to track each step of pharmaceutical procurement and delivery—with each intermediary contributing a cryptographic key to a final product hash—are already being developed to eliminate this problem.

Data ownership: Moving from today’s information exchange paradigm to an EHC has the potential to return ownership of health care data to patients themselves (see Figure 2, page 32). Health care providers would need encrypted keys to request information from patients, and patients could, in turn, select who has access to their medical records and when. Patients could potentially preauthorize information sharing with legitimate providers in unforeseen emergencies without actually pre-sharing that data, and choose to which, if any, research entities to lend their data.

Similarly, institutions (see Figure 3, page 33) could choose to share de-identified institutional-level data with the following: government agencies, such as the Centers for Disease Control and Prevention, to track pandemics, or the U.S. Preventative Services Task Force, to improve public health outcomes; research
collaborators, to drive innovation and discovery; and with other organizations that seek to drive quality improvement.\textsuperscript{16,18,24}

In its entirety, data gathered across a range of personal health and wellness activity, diagnostic and therapeutic services, procedures, laboratory testing, radiology, smart devices, and genetic testing services could all be securely incorporated into a patient’s unique EHC, accessible to both patients and health care institutions. Patients control their own data, while institutions control institutional-level data. Each party involved could give encrypted access keys to providers, researchers, or any other parties they choose, providing a range of access—from minimal amounts of de-identified data to individual-level full-chain access—that can be revoked at any time (see Figure 4, page 33). Every data interaction is appended to the chain in a time-stamped and immutable manner, adding to the system’s intrinsic security.

**What needs to be done to build the health care blockchain?**

Significant challenges and limitations to implementing health care blockchains remain. These challenges are most pronounced with regard to EHR. To achieve a universal EHR blockchain, the following must occur: common data standards must be adopted, appropriate software or “middleware” must be built to interface with blockchain ledgers, incentives must be aligned to attract the processing power for the network, and important decisions must be made with regard to how much data will be fully incorporated into an individual’s EHC.

**Common data standards:** To achieve interoperability, it is imperative that health data generation and storage become standardized.\textsuperscript{25} Such a system, in which every health update—such as new prescriptions, clinical diagnoses, test results, medication reactions, and so on—are sent to a trusted, encrypted ledger, could yield a real-time perfectly reconciled personalized record.\textsuperscript{26} Although common data protocols have been proposed, there is not yet a uniform, interoperable data system for the health care industry.\textsuperscript{16,26} There are likely to be strengths and weaknesses across different platforms, and experimentation and testing must occur before a standardized EHC can be established. Only then will the health care industry achieve meaningful interoperability, allowing for industry-wide development and scalability.\textsuperscript{25}

*continued on page 34*
Data gathered through personal health and wellness, diagnostics, therapeutics, procedures, smart devices, genetic testing, and other sources could all be securely incorporated into a patient’s unique EHC, accessible to both patients and health care institutions. The EHC could be patient-controlled data and institutional-level data, each with encrypted access keys for selected sharing and access levels—from minimal level de-identified data to individual full chain access. Every interaction is time-stamped and immutably appended to the chain, adding to its intrinsic security.
Middleware: The Internet currently rests on platforms such as the transition control protocol/Internet protocol (TCP/IP) and domain name system protocols, which serve as the networking foundation for applications like e-mail, voice-over-IP, and web content; and blockchain technology offers a new platform with a new networking infrastructure. For health care, as with other industries, the adoption of blockchain will rely on the development of innovative applications, or middleware, that harness blockchain-based coding infrastructure and create meaningful user interfaces—in this case, for patients and providers. As with any developing technology, this barrier to adoption will fade as more middleware applications are developed for the EHC and it is used more widely.

Processing power: Furthermore, it will be important to incentivize those that might invest computer processing power to the support network. Bitcoin and other cryptocurrencies continue to run by offering those who contribute processing power the ability to earn currency. For a health care blockchain, a similar incentive will be necessary to promote a distributed network and realize the true security and speed of blockchain applications. A working group at Deloitte has suggested that this incentive could be achieved through government incentives, similar to the Centers for Medicare & Medicaid Services EHR meaningful use program. Others have argued that participants may be attracted to the idea of supporting a blockchain network by offering access to chain data for research purposes. Regardless of how these incentives are offered, their success is fundamental to the development of a health care blockchain.

Data storage: The volume of data included in a modern EHR (including computed tomography scan files, magnetic resonance imaging files, and,
increasingly, genomic and epigenomic data) makes having shared, common ledgers impractical and likely impossible. Establishing a comprehensive, common ledger would mandate that the totality of every individual’s health data be stored on each node of the network, an impossible feat with existing processing power. Some argue that even the inclusion of a full physician’s note within a single block could create unnecessarily large blocks and adversely affect the overall system performance.27 To solve this problem, some have proposed creating “data lakes” or off-chain data stores, whereby health information is encrypted and deposited in data warehouses that live off of the blockchain.18,25 Each deposit would be accompanied by the addition of a new block to a patient’s EHC, noting the timestamp of the patient’s interaction with the health care system and the type of data that was deposited into the lake (such as an encounter summary, a pathology report, and so on).18

What will be the role of government?

The federal government can and should play an active role in ushering forward blockchain innovation. The U.S. Department of Health and Human Services (HHS), under the leadership of Vindall Washington, MD, held a contest in August 2016 for innovative ideas related to blockchain technology.28 The contest generated white papers on an array of potential blockchain applications, including clinical trials, claims processing, patient-reported outcome measures, records, and alternative payment methods.29 Moving forward, HHS has a critical role to play in developing administrative policy objectives that clearly define how the HHS Health Insurance Portability and Accountability Act policy rule might govern over the distributed networking essential to a blockchain health record system. Clearly delineating how existing legislation might be amended to conform to a securely encrypted but distributed system will provide a powerful signal to those

REFERENCES, CONTINUED


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considering substantial investment in blockchain technology. The federal government should not shy away from playing a role in funding pilots and experiments to further explore blockchain applications.

**Conclusion**

Several industries, from finance to food to mining to education, could adopt blockchain technology in the coming years. In health care, opportunities exist to not only revolutionize electronic health information, supply chains, and data ownership, but also to assimilate expansive tranches of data for research purposes by creating EHCs that are transparent, digital, immutable, secure, and controlled by institutions and, more importantly, by patients.

This is the beginning of the blockchain revolution, and significant obstacles to implementation remain. It is imperative that further research and advocacy efforts led by clinicians underscore potential advances in research and innovation as a result of blockchain technology. Similarly, the federal government must shepherd innovation and standardization in this space so that patients and providers alike can benefit from blockchain technology’s enormous potential. For its part, the ACS can play a role in promoting the use of blockchain technology to improve access to quality surgical care, education, and research.

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**REFERENCES, CONTINUED**


While Congress is in a stalemate on federal health care reform legislation, state legislators introduced and enacted numerous pieces of legislation that directly affect the practice of medicine and quality of patient care. The American College of Surgeons (ACS) monitored more than 1,000 bills introduced in 2017 in all 50 states and engaged with policymakers on such issues as scope of practice, trauma, and cancer-related legislation, as well as increasing engagement on Maintenance of Certification (MOC) legislation.

In 2017, ACS surgeon-advocates responded to 15 action alerts, sending nearly 750 messages to state legislators using the Surgery State Legislative Action Center (www.capwiz.com/sslac), as well as making phone calls and participating in individual meetings with legislators as part of state chapter lobby days. All of this activity supported the College’s state legislative priorities of ensuring access to safe and quality surgical care.

**Scope of practice**

This past year included several efforts by nonphysician groups pushing state legislation to expand their scope of practice. Optometry advocacy initiatives, in particular, engaged in a significant scope-of-practice expansion effort, introducing legislation in Alaska, Florida, Georgia, Iowa, Maryland, Nebraska, and North Carolina that would enable optometrists to perform surgical procedures on and around the eye without increasing their level of education or training. ACS chapters in Florida, Georgia, North Carolina, and Maryland, with support from ACS State Affairs, wrote letters opposing the expansion of practice for nonphysicians and engaged state surgeon-advocates to contact their state legislators to oppose passage of the bills.

Although all of the optometry scope-of-practice bills introduced were defeated, optometrists were able to add a provision to a separate bill in Georgia that will allow them to perform injectable procedures. In Pennsylvania, H.B. 706 was introduced to define the procedures that comprise “ophthalmic surgery,” as well as to statutorily state that the practice of optometry does not include ophthalmic surgery. That bill was referred to committee in March but had not received further consideration from the legislature.

ACS chapters also supported efforts of other physician organizations to defeat scope-of-practice legislation and regulations by writing a letter to oppose independent practice for certified registered nurse anesthetists in Alaska, as well as lobbying state legislators during the Metro Chicago and Illinois Chapter Lobby Day to oppose independent practice for advance practice registered nurses in Illinois. The ACS anticipated an increase in the number of bills introduced to expand the scope of practice for nonphysicians in 2018, including a significant effort by national and state physician assistant organizations to gain independent practice through legislative means.
Contentious debate on MOC arose in 20 state legislatures in 2017, pitting physicians on different sides of the issue against one another and challenging legislators to decide on public policy that could adversely affect the quality of patient care.

**MOC**

Contentious debate on MOC arose in 20 state legislatures in 2017 (Alaska, Arizona, California, Florida, Georgia, Maine, Maryland, Massachusetts, Michigan, Mississippi, Missouri, New Jersey, New York, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Tennessee, and Texas), pitting physicians on different sides of the issue against one another and challenging legislators to decide on public policy that could adversely affect the quality of patient care. Some physicians assert that MOC has proven ineffective or unwieldy. Others recognize that certain aspects of the MOC process can be improved, but that the verification process is integral to ensuring health care professionals have the rare privilege of self-regulation. Those physicians who oppose MOC have called on state legislatures to take action to prohibit the use of MOC for licensure, hospital privileging, reimbursement, and employment. Of the 20 states, Georgia, Maine, Maryland, Tennessee, and Texas succeeded in passing MOC legislation, with several others still considering bills.

In Texas, S.B. 1148 was signed into law June 15. The law prohibits the use of MOC for licensure, reimbursement, employment, and, in some cases, admitting privileges. Maine, Maryland, and Tennessee also enacted laws restricting the use of MOC, but only for the limited purpose of medical licensing. The Tennessee law created a task force to review the overall MOC process and its use by hospitals, insurance companies, and entities that license Tennessee physicians. On October 5, the Tennessee Chapter submitted written testimony to the task force explaining why MOC is important in maintaining the highest standards of patient care and preserving physician self-governance, and the ACS provided written comments reiterating the ability of the medical profession to set professional standards through self-governance.

In May, Georgia enacted a law prohibiting the use of MOC for hospital employment privileging, insurance network membership, reimbursement, and state licensure. The first draft of the bill would have affected all Georgia hospitals. However, in response to ACS concerns, H.B. 165 was amended to affect only state-run hospitals. This change effectively limited the scope of the law to six hospitals.

In Ohio, H.B. 273 is under consideration in the Ohio House Health Committee. The measure proposes to restrict private and publicly run hospitals and health care plans from using MOC to make credentialing and payment decisions. Not only would this bill potentially compromise patient care and interfere with physician self-governance, it could invite scope-of-practice expansion for nonphysician clinicians, given the absence of sustained credentialing and continuing education.

In Florida, H.B. 81 was filed in advance of the 2018 legislative session. The bill would restrict the use of MOC as a condition for licensure, reimbursement, and admitting privileges. H.B. 81 was introduced as a follow-up to Florida S.B. 1354, which died in the House Health and Human Services Committee during the 2017 session. Florida surgeons are strongly encouraged to contact their local chapters or members of the ACS State Affairs team and make sure their voices are heard regarding this important effort to protect physician self-governance.

Another MOC bill that may see some activity in 2018 is California S.B. 487, which prohibits the use of MOC in awarding physicians hospital or clinical privileges. The ACS and other medical organizations opposed S.B. 487 on the grounds that the measure interferes with the right of the profession to set its own professional standards, and the ability of hospital medical staffs to set quality standards for their institutions. While the California legislature adjourned September 15, S.B. 487 is a two-year bill and is expected to be considered by the legislature next year.

The Louisiana Chapter also weighed in on MOC by providing comments at the request of House Committee on Health and Welfare staff. ACS State Affairs staff worked with the chapter to develop these comments.
Injury prevention
With the proliferation of handheld electronic devices in the U.S., distracted driving has become a serious public safety concern. California, Connecticut, Delaware, Hawaii, Illinois, Maryland, Nevada, New Hampshire, New Jersey, New York, Oregon, Rhode Island, Vermont, Washington, West Virginia, and the District of Columbia have banned handheld cell phone use by all drivers. Other states have banned cell phone use for minors and school bus drivers. Several states successfully passed distracted driver legislation this year. Arizona, Arkansas, and Rhode Island all passed legislation prohibiting drivers from using handheld wireless communication devices in nonemergency situations. Iowa enacted a law that establishes refutable evidence of reckless driving if a person is using a handheld communication device behind the wheel. North Dakota passed legislation that prohibits any activity other than driving that demands the driver’s eyesight, unless he or she is interfacing with a built-in vehicle accessory. In Tennessee, it is now a Class C misdemeanor to talk on a handheld mobile telephone while driving, and Vermont has banned the use of handheld devices when driving through school or work zones.

In Texas, the state legislature took on distracted driving by making it a misdemeanor for a driver to use a handheld wireless communication device to read, write, or send messages in a moving vehicle. The ACS supported the bill by sending ACS Action Alerts to Texas surgeons to help garner support for the measure. Ultimately, the bill passed and was signed into law June 6.

Distracted driving was not the only highway safety issue to arise in 2017. Nineteen states and the District of Columbia require all motorcycle riders to wear helmets, and this year, several additional states introduced similar motorcycle helmet laws. Bills in Delaware and Connecticut that would have required all riders to wear helmets failed. Alternatively, West Virginia and Nebraska introduced bills allowing riders age 21 and older to operate a motorcycle without a helmet, and Missouri introduced a similar bill exempting riders older than the age of 18. The West Virginia and Missouri bills failed to gain traction and died in committee, but the Nebraska bill warranted more attention. The ACS worked with its partners to oppose the Nebraska bill, and it was defeated through the combined efforts of the ACS and other member organizations.

Nevada S.B. 259, another injury prevention bill, was signed into law June 12. Nevada is the 29th state to require mandatory ignition interlock devices for all first-time drunk driving arrests. The College supported the Nevada Chapter’s efforts to advocate in support of the measure. Deborah Kuhls, MD, FACS, FCCM, Nevada Chapter President, took the lead, providing testimony and working with the ACS State Affairs team to draft letters and establish grassroots support for the bill. Dr. Kuhls’ efforts demonstrate the significant role member activism plays in passing surgeon-backed legislation.

Both Maine and West Virginia introduced bills adopting the Uniform Emergency Volunteer Health Practitioners Act (UEVHPA) during the 2017 regular session. The UEVHPA allows providers to obtain temporary reciprocal practice privileges in a state where they are not licensed during a declared emergency. The West Virginia bill passed both chambers and was signed into law April 18. The Maine bill passed the Committee on Labor, Commerce, Research and Economic Development but was tabled and will be revisited during the 2018 legislative session.

Trauma
The ACS Committee on Trauma and state chapters promoted Stop the Bleed® training events in several state capitals this year. Stop the Bleed is a national campaign to train and empower ordinary people to save lives in the event of a traumatic injury.

The Georgia Society of the American College of Surgeons (GSACS) held Stop the Bleed training in
There was significant movement on cancer prevention legislation, as the ACS CoC and ACS chapters supported efforts to permit students to possess and use sunscreen in school.

numerous locations in the state capital as part of Georgia Trauma Day. In recognition of the event, the legislature passed special resolutions declaring February 7, as Trauma Awareness Day. Following the training, the GSACS successfully lobbied for $1 million to purchase bleeding control kits to be installed in public schools.

The San Diego, Northern, and Southern California Chapters advocated for a bill requiring the installation of trauma kits in public buildings throughout the state. The bill was promoted by chapter leaders, who offered testimony at a committee hearing during the chapter state lobby day, and sponsored a Stop the Bleed training at the capitol building. The measure passed the Assembly Committee on the Judiciary before being revised by the Assembly Committee on Appropriations. Since the bill did not advance further in the 2017 session, it is now a two-year bill and will be considered in 2018.

In addition to procuring funding for bleeding control kits, the ACS supports legislation that helps fund state trauma systems. This year, Alabama, Mississippi, and Virginia passed measures affecting funding for state-run trauma hospitals. Virginia’s 2016–2018 omnibus spending bill requires the Virginia Department of Health to conduct a study of the commonwealth’s current trauma funding and make recommendations for the future. Though it is unclear at this time what the net impact of the study will be, the Virginia legislature is committed to protecting trauma funding in the state. In Alabama, Gov. Kay Ivey (R) allocated $4 million from an economic development bond to cover costs associated with renovating and expanding the state’s only Level I trauma center. The governor said, “This service is vital to our state’s economic development efforts, as corporations demand this level of care when they look to relocate to our state.”* Finally, Mississippi H.B. 1511 allocated $7 million in fees collected from traffic tickets toward the state’s trauma care system. At the same time, however, the bill reduced trauma funds awarded to the Mississippi State Department of Health from $40 million to $20 million. The net result is an overall reduction in trauma funding from the previous year.

Cancer

There was significant movement on cancer prevention legislation, as the ACS Commission on Cancer (CoC) and ACS chapters supported efforts to permit students to possess and use sunscreen in school. The SUNucate campaign, led by the American Society for Dermatologic Surgery Association and the American Academy of Dermatology, is a coalition committed to enacting state legislation that would allow young students to possess and apply sunscreen products on school grounds or at school functions without a note from a physician.† Some school districts have established policies to prohibit the possession and use of sunscreen products by students without a physician’s note because the products are regulated by the U.S. Food and Drug Administration as over-the-counter drugs. SUNucate pushed for the state legislation to establish a statewide policy for sunscreen in schools. In 2017, the legislation was successfully enacted in Alabama, Arizona, Florida, Louisiana, Ohio, Utah, and Washington, while bills are pending in Massachusetts, New Jersey, Pennsylvania, and Rhode Island.

Other skin cancer prevention legislation achieved success this year. Efforts continued in 2017 to enact and strengthen prohibitions for children under the age of 18 from using tanning beds. Oklahoma and West Virginia enacted the tanning bed regulations, and the state legislature in Maine passed a bill that Gov. Paul LePage (R) vetoed. Nine states introduced tanning bed

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*USA Medical Center–University of South Alabama Medical Center, Mobile & Gulf Coast, Alabama. News release—USA Medical Center receives $4 million to expand Level 1 trauma services. Available at: www.usahealthsystem.com/usamc. Accessed September 19, 2017.
legislation: Arizona, Arkansas, California, Iowa, Kentucky, Mississippi, Montana, New York, and Virginia.

State tobacco regulation saw an uptick in activity in 2017 as well. The Kansas Chapter of the ACS joined an effort to increase the state’s tobacco tax to $1.50 per pack, though the effort had too little support to pass in the legislature. Nearly 100 bills were introduced in 32 states dealing with tobacco tax rates, or aligning taxes on electronic cigarettes and vapor products with traditional tobacco products. Delaware, New York, Oklahoma, and Rhode Island enacted increases in tobacco taxes, while Kansas lowered the tax on vapor products, and Minnesota Gov. Mark Dayton (D) vetoed legislation that would have lowered the tax on premium cigars from $3.50 to $0.50.

The campaign to raise the legal smoking age to 21 gained notable victories this year. Maine, New Jersey, and Oregon joined California and Hawaii in passing age restrictions. Legislation was introduced in 18 other states (Arizona, Connecticut, Florida, Idaho, Illinois, Indiana, Iowa, Maryland, Massachusetts, Mississippi, Nebraska, New Mexico, New York, Tennessee, Texas, Vermont, Washington, and West Virginia) to raise the minimum age to purchase tobacco products. The ACS has been monitoring the progress of the tobacco age-restriction legislation. The enactment of the laws in three states will provide momentum to the effort in 2018.

The ACS engaged in a regulatory issue in Massachusetts, submitting comments to the Massachusetts Board of Registration in Medicine. The board proposed revisions to its regulations governing the practice of medicine, which would have added a provision mandating that physicians treating a cancer patient provide the patient with certain information, including available alternative treatments. In consultation with the CoC, the ACS comments opposed the proposed regulation based on the vague definition of “alternative medicine,” and to deter the government from dictating patient-physician conversations. No final action has been taken on the proposed regulation.

Opioids

The opioid abuse epidemic continued to be a major focus in state legislatures, with all 50 states introducing legislation to address the issue. In 2017, more than 1,000 bills were introduced concerning prescription drug abuse. New Jersey enacted one of the nation’s most stringent laws limiting initial opioid prescriptions to a five-day supply while allowing for a 25-day prescription refill if determined necessary by the prescribing physician. The law requires insurance coverage for addiction treatment and exempts cancer patients from the prescription limits.

Missouri was the last state to implement a prescription drug monitoring program (PDMP). Gov. Eric Greitens (R) signed an executive order to create the PDMP after the state legislature failed to pass legislation to enact a statewide program. The Missouri Department of Health and Senior Services will work with pharmacy benefit managers to analyze data on written and dispensed opioid prescriptions, to identify patterns of abuse. Several cities and counties in Missouri have local PDMP programs that prescribing physicians can use on a voluntary basis.

In addition to state legislative activity, the ACS published a statement on the opioid epidemic available at facts.org/about-acs/statements/100-opioids-abuse.

Out-of-network/surprise billing

Twenty-nine states (Alaska, Arizona, Colorado, Connecticut, Georgia, Hawaii, Illinois, Indiana, Louisiana, Maine, Massachusetts, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Oklahoma, Oregon, Pennsylvania, Rhode Island, Texas, Utah, Virginia, and West Virginia) introduced legislation in 2017 to address out-of-network and surprise billing. ACS chapters in Georgia, Nevada, and New Jersey engaged in grassroots advocacy to lobby on legislation that would be harmful to patients and providers.
Engagement is the most important action that ACS Fellows can take to ensure that the surgical profession continues to be a leader in patient safety and quality health care outcomes.

The Georgia Society joined the state’s medical community to fight against two bills, H.B. 71 and S.B. 8, which would have required physicians to accept the same insurance plans as any hospital where they provide care as a condition of medical staff participation. Additionally, the legislation would have set the maximum payment to the Medicare rate. The Senate passed its bill, but it and the House bill were tabled in that chamber.

The Nevada Chapter participated in a successful campaign to persuade Gov. Brian Sandoval (R) to veto legislation that would have set reimbursement rates for out-of-network providers to 125 percent of Medicare fee-for-service rates or the average rate negotiated by insurers with in-network providers and hospitals.

The New Jersey Chapter also engaged in grassroots advocacy and participated in a statewide Access to Care Coalition to oppose legislation that would cap payments for out-of-network physicians using Medicare reimbursements as a benchmark. The legislation had not received a vote in the legislature as of press time.

Medical liability
The ACS chapters in New York, led by the Brooklyn/Long Island Chapter, engaged in grassroots advocacy efforts to defeat legislative proposals to change the state’s medical liability system in ways that would increase costs and possibly destabilize the state’s liability insurance market. A series of bills were introduced on medical liability, including S. 6800 and A. 8516, which would extend the time available to file a liability claim for negligent failure to diagnose cancer or a malignant tumor. The bills passed the state’s legislature but had not been sent to the governor for final action at press time.

Elsewhere, Iowa enacted comprehensive medical liability reforms that include a $250,000 cap on noneconomic damages with some exceptions, strengthening of expert witness standards, a certificate of merit requirement in all medical liability suits, and an expansion of the state’s policies on communication and resolution.

Get engaged
Uncertainty still looms at both the federal and state levels on the future of health care policy. The debate on the role of the federal government in health care will likely extend into 2018 and state legislatures will undoubtedly continue to introduce legislation that could have an impact on the ability of surgeons to provide quality patient care. Therefore, it is vital that surgeons be involved in the public policy debate.

Engagement is the most important action that ACS Fellows can take to ensure that the surgical profession continues to be a leader in patient safety and quality health care outcomes. There are several ways that Fellows can support ACS advocacy initiatives, including responding to ACS Action Alerts from the College, participating in state chapter meetings and lobby days, building relationships with elected officials, talking about public policy issues with colleagues, and attending the annual ACS Leadership & Advocacy Summit, May 19–22, 2018, in Washington, DC. In addition, state advocacy resources, including issue toolkits, are available on the State Affairs web page at facs.org/advocacy/state/resources.

The ACS State Affairs team is available to answer questions and provide pertinent information on state issues and policy programs. For more information, e-mail state_affairs@facs.org, or call 202-337-2701.

Executive Director’s annual report:
2016–2017:
A year of transformational growth

by David B. Hoyt, MD, FACS
It is my pleasure to offer this annual report on the American College of Surgeons (ACS) activities. This account is presented as I near the end of my eighth year as Executive Director of the ACS and provides information on the major initiatives carried out by the ACS staff and volunteers from October 2016 to October 2017. It points to our accomplishments and to the areas in which we are striving to better meet the needs of surgeons and their patients.

**Division of Advocacy and Health Policy**

Renewed efforts to overturn the Affordable Care Act (ACA) have reemerged, ranging from efforts to eliminate only contentious portions of the law to more far-reaching repeals with no immediate replacement. ACS staff has reviewed these proposals to determine likely effects on surgeons and surgical patients, including potential changes to access to surgical care and in physician reimbursement. Taking into account expected ramifications of the proposed bills, the ACS revised its Statement on Health Care Reform and reiterated to Congress our priorities.

Another advocacy issue of considerable concern to ACS Fellows is the Centers for Medicare & Medicaid Services (CMS) efforts to implement the payment reforms in the Medicare Access and CHIP (Children’s Health Insurance Program) Reauthorization Act (MACRA) of 2015. Specifically, 2017 is the transition year for implementation of the Quality Payment Program’s (QPP’s) Merit-based Incentive Payment System (MIPS), and MIPS data collected in 2017 will be used to determine annual payment updates starting in 2019.

The ACS has been monitoring implementation of this payment system, and the Division of Advocacy and Health Policy (DAHP) staff has worked with consultants and stakeholders on a legislative proposal to grant additional flexibility to the Secretary of the U.S. Department of Health and Human Services (HHS) in implementing MIPS.

In collaboration with Division of Research and Optimal Patient Care (DROPC) staff and the Performance Measurement Committee, the DAHP has developed an updated 2017 version of the ACS Phases of Surgical Care Measure, which was approved as Qualified Clinical Data Registry (QCDR) measures for use in the ACS Surgeon Specific Registry (SSR). These measures will be available to SSR participants to satisfy the Quality component of MIPS.

One area of concern relates to a portion of the MIPS composite score Performance Threshold, which, beginning in 2019, will be based on the mean or median of the MIPS Final Scores from all MIPS eligible professionals from a prior period. As a result, approximately half of all Part B providers will be penalized. The ACS has written to HHS expressing concern about the policy, and DAHP staff has had in-person meetings with both CMS and the HHS Secretary.

In addition to MIPS, the QPP calls for the establishment of Alternative Payment Models (APMs). In the last year, DAHP staff has continued to address the lack of meaningful opportunities for surgeons to participate in APMs. In December 2016, the ACS submitted a surgical APM proposal to the Physician-focused Payment Model Technical Advisory Committee (PTAC). This proposal, the ACS-Brandeis Advanced APM (A-APM), was among the first two proposals that the PTAC recommended for CMS testing. The HHS Secretary reviewed the proposal and made recommendations for improvement. Efforts to develop the model continue, and the ACS is working with private insurers and potential APM entities that may implement the model once it is available.

The ACS, furthermore, has championed the development of patient-reported outcomes (PROs) as performance measures as part of the ACS Phases of Surgical Care Measure framework starting in 2018. As a starting point, the ACS seeks to use these PROs to confirm that, from the patient’s perspective, the surgeon provided value-based care. We envision these measures will be used for participation in the QPP as part of the SSR QCDR for MIPS reporting and as part of the ACS-Brandeis A-APM. The ACS has developed a
framework for evaluating patient experiences of care during the surgical phases and linked those to PROs and PRO measures.

At press time, staff had analyzed the calendar year 2018 Medicare Physician Fee Schedule (MPFS), and identified 17 issues in the MPFS that may affect surgeons. These provisions pertain to reimbursement for physicians’ practice expenses, scope system equipment and costs, liability premiums, telehealth, values of certain Current Procedural Terminology codes, evaluation and management guidelines, and MACRA patient relationship categories and codes. (Details will be published in the January 2018 issue of the Bulletin.)

In addition, the ACS has engaged in numerous efforts to address potential changes to payment for global surgery services. As CMS collects data on global codes, the ACS has analyzed CMS policies and methodologies for data collection and provided several rounds of feedback.

As CMS seeks to develop episode-based payment models and measures to assess cost, the ACS has provided feedback via comment letters and requests for information, has attended meetings where episode-based cost measures are being developed, and has analyzed and commented on patient relationship codes that may be used to attribute costs to physicians starting in 2018.

Graduate medical education (GME) continues to be another issue of concern to ACS members. In anticipation of congressional efforts to reform GME financing and governance, the DAHP worked with a task force of experts to formulate principles and draft a discussion paper that was published in January.

DAHP staff has worked with congressional champions to revise and reintroduce legislation to study shortages of general surgeons and potentially designate surgical shortage areas. The Ensuring Access to General Surgery Act (S. 1351/H.R. 2906) was introduced in June in both the House and Senate.

The ACS worked to develop policy positions and materials to educate and advocate for surgeons who are experiencing problems with third-party payors. The DAHP also created a questionnaire on the ACS website that physicians can complete to receive assistance directly from DAHP staff on specific problems with commercial insurers.

With respect to state issues, the DAHP worked with the Brooklyn/Long Island Chapter to encourage New York surgeons to contact the governor to oppose a package of bills that would increase the medical liability statute of limitations for cases involving alleged misdiagnosis of cancer. This move would lead to increased medical liability insurance premiums and additional lawsuits. More than 35 surgeons responded by visiting the Surgery State Legislative Action Center (SSLAC) to send their letters.

Maintenance of Certification (MOC) legislation, S.B. 1148, was introduced earlier this year in Texas. Numerous e-mails were sent to Texas Fellows, and the College sent letters of opposition to every state senator and representative, resulting in amendments to S.B. 1148 that preserved the ability of hospitals to set MOC requirements.

Twelve chapters received state lobby day grants in 2017. The basic grant is up to $5,000. One grant in 2017 was raised to $15,000 and went to the Georgia Society of Surgery, which used the funds to cosponsor, with the Georgia Trauma Foundation, the first annual Georgia Trauma Day. The centerpiece of this program was Stop the Bleed®. Legislators allocated $1 million to place Stop the Bleed kits in all Georgia public schools.

The ACS addressed a number of scope-of-practice issues through activation of the SSLAC. In Florida, Georgia, Maryland, and North Carolina, SSLAC letters were sent addressing legislation regarding optometry’s scope of practices.

In Georgia, an out-of-network bill was defeated, thanks in part to Georgia surgeons responding to ACS Action Alerts to contact their legislators. State Affairs worked with the New Jersey Chapter to oppose out-of-network legislation in the state. The College weighed in on proposed regulations in Massachusetts requiring cancer counseling on every possible treatment option regardless of its relevance to the particular case, and in...
Alaska, the College joined with the American Society of Anesthesiologists and the Alaska Chapter to oppose draft rules permitting certified registered nurse anesthetists to practice independently.

The Commission on Cancer (CoC) Advocacy Committee held its annual planning meeting in February, developing a robust legislative agenda for 2017, followed by a day on Capitol Hill. The CoC also participated in two Capitol Hill visits in March and in June through One Voice Against Cancer.

On September 8, the College convened its first Virtual Hill Day in conjunction with the Cancer Programs Conference in an effort to build support for cancer research funding, a resolution highlighting College cancer programs, palliative care for cancer patients, and access to colorectal screening.

Leaders of the ACS and Committee on Trauma (COT) hosted a congressional briefing February 28 to highlight the Hartford Consensus and the Stop the Bleed training program. Throughout the briefing, lawmakers and congressional staff participated in simulations of how to treat severe bleeding injuries as an immediate responder.

The College continues to support COT advocacy priorities, including funding for trauma systems and trauma systems research funding with a goal of creating a nationwide trauma system. The Mission Zero Act (H.R.880/S.1022), which the ACS strongly supports, would create a grant program to assist civilian trauma centers partnering with military trauma professionals to establish a pathway to provide patients with the highest quality of trauma care in times of peace and war. The act moved through the House Energy and Commerce Committee this summer, and the College is lobbying for House floor consideration this fall.

In a related matter, the DAHP worked with the Military Health System Strategic Partnership ACS (MHSSPACS) to persuade Congress to include in the National Defense Authorization Act both a Joint Trauma System within the Defense Health Agency to promote continuous improvement of trauma care provided to members of the Armed Forces, and a Joint Trauma Education and Training Directorate to ensure military traumatologists maintain surgical readiness.

Other ACS advocacy initiatives centered on the interoperability of the electronic health record and participation in the National Academy of Medicine’s Physician Wellness program, which is poised to issue a report and action plan on physician burnout.

More than 300 surgeons and residents participated in the ACS Leadership & Advocacy Summit this May in Washington, DC. Participants met with lawmakers and congressional staff to educate them about ACS legislative priorities.

### Education

The ACS has played a leadership role in the Society for Academic Continuing Medical Education (SACME), which aims to advance the field of Continuing Medical Education (CME) and interprofessional education. Areas of focus for SACME have included leadership, scholarship, innovation, member engagement, and operational excellence.

The Division of Education has appointed a Steering Committee for Retraining and Retooling of Practicing Surgeons. The committee comprises leaders from across the surgical specialties and representatives from academic institutions, hospital systems, and the insurance industry. The committee’s present focus is on defining standards and establishing a national infrastructure to achieve optimal outcomes. The ACS-Accredited Education Institutes (ACS-AEIs) would be at the core of this infrastructure.

Training the Next Generation of Surgeons: Making It Stick, Making It Real, Making It Together, took place in June at the WWAMI Institute for Simulation in Healthcare (WISH), University of Washington, Seattle. The symposium focused on cutting-edge models of simulation-based surgical training and helped to define standards to enhance the value of simulation.

The Division of Education has appointed a Committee on Coaching the Next Generation, which is charged
with engaging senior surgeons to share their expertise with the next generation of surgeons and participate in education and training programs. In addition, the Subcommittee on Simulation-based Teaching designed an Introduction to Simulation-based Teaching Course for senior surgeons, which was offered as a pilot program at the University of North Carolina at Chapel Hill.

The Future of General Surgery Training Committee builds on the work of the former Committee on Residency Training (“Fix the Five”). The new committee has identified 10 critical areas to improve general surgery training.

A total of 30 institutions have been approved to offer the ACS Program for Mastery in General Surgery, formerly known as the Transition to Practice (TTP) Program in General Surgery. A total of 16 TTP Associates were recruited for academic year 2017–2018. Experiences from the TTP Program have yielded invaluable information regarding individualized training in diverse locations with different mentors and strategies to provide sufficient autonomy to increase both competence and confidence.

The ACS remains a leader in the field of faculty development for surgeons. The Surgeons as Educators Course remains the flagship faculty development program. In the coming year, the Division of Education plans to create a comprehensive program for faculty development and support. This new program will address a spectrum of needs anchored to the four levels of professional development: teacher, master teacher, educator, and master educator.

The ACS Academy of Master Surgeon Educators launched at Clinical Congress. The goals of the academy are to recognize master surgeon educators, advance the science and practice of leading-edge surgical education and training, foster innovation and collaboration, support faculty development and recognition, and underscore the importance of surgical education and training.

Plans are under way to offer a Certificate Program for Surgeon Educators, which will involve workplace activities centered on translation of the science and practice of surgical education to real settings. An initial step in this process has involved a survey of graduates of the Surgeons as Educators Course to further identify gaps and opportunities.

The ACS Clinical Congress continues to offer a range of education and training opportunities to practicing surgeons, surgery residents, medical students, and members of surgical teams. The Clinical Congress 2017 program, which took place October 22–26 in San Diego, CA, included 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. (Details regarding Clinical Congress 2017 will be published in the January 2018 Bulletin.)

After more than 45 years, the Surgical Education and Self-Assessment Program (SESAP®) remains the premier self-assessment and cognitive skills education program for practicing surgeons. SESAP 16, released in October 2016, comprises 850 questions and critiques that can be used to earn up to 90 Category 1 CME Self-Assessment Credits.

Selected Readings in General Surgery (SRGS®) celebrated its 10th anniversary in January. SRGS continues to publish evidence-based reviews of the medical literature, and the cycle of topics is designed to cover the field of general surgery in 48 months. SRGS offers the opportunity to earn 80 Self-Assessment Credits per year. The SRGS package contains an overview of the literature, a concise review of 10 recently published articles accompanied by an expert commentary for each article, and an editorial on health care. A posttest of 20 multiple-choice questions is available.

This year, the ACS also launched ACS Case Reviews in Surgery, which is published six times per year. Each issue features 10 peer-reviewed case reports from an array of surgical specialties.

Evidence-Based Decisions in Surgery includes concise, focused modules derived from practice guidelines. A total of 60 modules are available. A new educational
model is being designed and will include discussions of key articles based on the review of evidence.

The Committee on Ethics released *Ethical Issues in Surgical Care* at Clinical Congress 2017. This book covers key topics and defines the field of ethics in surgery as it has evolved in the last 10 years. Topics address the broad areas of the surgeon-patient relationship, the surgeon and the surgical profession, and the surgeon and society.

Key activities of the Surgical Patient Education Program include development of Home Skills Kits; Education for Better Recovery; Informed Surgical Prep brochures and e-Learning materials; and a new Professional Training Program to ensure a well-trained patient education workforce. The Home Skills Kits are the centerpiece of this program, which focuses on supporting successful transitions to home care. Kits focus on colostomy/ileostomy, urostomy, feeding tubes, central lines, and surgical wounds; kits in development center on tracheostomy and anticoagulation therapy.

A new Patient Education Program on surgery and opioids and managing pain during surgery is in development. A Statement on the Opioid Abuse Epidemic was prepared by the DAHP in collaboration with the Patient Education Program of the Division of Education and was approved by the Board of Regents in June.

There are currently 95 ACS-AEIs, 14 of which are outside the U.S. Further refinement of the accreditation model has continued, and a new Maintenance of Accreditation model that involves assessment of outcomes and review of robust annual reports with longer accreditation cycles is being phased in. The 10th Annual ACS-AEI Consortium Meeting, now the Annual ACS Surgical Simulation Conference, took place March 17–18, attracting 237 attendees.

The number of ACS Members using the MyCME program to request transfer of their CME Credits to the American Board of Surgery (ABS) has steadily increased. In 2016, 3,974 individual members sent 5,885 records to the ABS.

Steps are being taken to support surgeons seeking to meet requirements for MOC and re-licensure and, more recently, to meet educational requirements of the ACS Clinical Accreditation and Verification Programs. The focus on Self-Assessment Credits for MOC continues to steer the design of many programs. A complete list of requirements by state has been compiled and is available online at facs.org/education/cme/state-mandates. Additional content is being developed to address regulatory mandates and those identified for CME Credit.

**Continuous Quality Improvement (CQI)**

The CQI programs within DROPC have continued to grow and respond to surgeons’ evolving needs. The ACS National Surgical Quality Improvement Program (ACS NSQIP®) has 805 participating hospitals, with 698 in ACS NSQIP Adult and 107 in ACS NSQIP Pediatric. Another 65 hospitals are in various stages of the onboarding process. A steady 10 percent of ACS NSQIP hospitals are international, although there is interest in expansion in Australia, Asia, the Middle East, and South America.

Enrollment in ACS NSQIP Pediatric has increased by 16 sites since October 2016. This interest from the pediatric community is likely attributable to the launch of the Children’s Surgery Verification (CSV) Quality Improvement program in January 2017.

ACS NSQIP collaboratives are a popular means of engagement, enabling sites to share outcomes and best practices and work on quality improvement (QI) in organized groups. More than 50 collaboratives have been established and more are in development. The Department of Defense has the largest collaborative, with 42 enrolled hospitals and four more in the onboarding process. In addition, the first international regional collaborative, the ACS NSQIP Middle East Collaborative, has been established, comprising hospitals from the United Arab Emirates, Jordan, Lebanon, and Saudi Arabia.

The new ACS Quality and Safety Conference, formerly the ACS NSQIP Annual Conference, took place in July in New York, NY. The conference boasted a
record-breaking attendance. For details about the conference, see the October Bulletin.

As ACS NSQIP prepares to move to a new data portal hosted by QuintilesIMS, some programmatic changes are being made to better meet hospital needs, including the introduction of the ACS NSQIP Participant Portal, which will help streamline hospital enrollment and participation. Interested hospitals will be able to learn about ACS NSQIP, apply to join ACS NSQIP, and track the application process. Existing ACS NSQIP sites will be able to update hospital information, hospital contacts and registry users, and ACS NSQIP sampling.

An updated ACS NSQIP Surgical Risk Calculator was released in July. This version adds predictions of several postoperative complications and uses a new recalibration process that improves accuracy.

Nearly 125 sites have shown interest in CSV Quality Improvement Program accreditation. The program officially launched in January, and five pilot centers have been verified as Level I children’s surgery centers. The first non-pilot site visits occurred this summer and 16 sites are going through the verification process.

A total of 847 centers participate in the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP), 762 of which are fully accredited. From October 2014 through August 2017, 867 site visits were completed. A total of 68 surgeon surveyors are expected to perform approximately 250 site visits in 2017.

MBSAQIP’s national enhanced recovery initiative, Employing New Enhanced Recovery Goals to Bariatric Surgery (ENERGY) has been fully deployed to 36 U.S. centers and is set to conclude in the fall 2018. The overarching goal of ENERGY is to enhance patient experience through improved pain management, fewer opioid side effects, decreased readmissions, and quicker return to normal activity.

The ACS Quality Data Platform Project is in the midst of a three-year implementation plan through a partnership with QuintilesIMS to migrate all existing ACS clinical databases into a single platform. The new platform will incorporate both financial data and PROs to give participating hospitals insights into the value of care they provide as well as the quality of that care as judged by patients. Patient-reported outcomes are being piloted within ACS NSQIP and the MBSAQIP.

The new SSR, which launched on the new QuintilesIMS platform in April, continues to evolve as a means for individual surgeons to log and track and meet regulatory requirements, such as MIPS and MOC Parts 3 and 4.

With the CMS reimbursement programs and policies becoming increasingly centered on individual provider measures data, the College has sought to provide its members with an array of options to participate in MIPS and other CMS payment programs. The following reporting options are available through the SSR for surgeons who participate in the 2017 MIPS reporting cycle:

- General Surgery Specialty Measures Set for general surgeons (MIPS-Qualified Registry)
- ACS Surgical Phases of Care Measures Set (MIPS-Qualified Clinical Data Registry)

Participation in either set of measures also allows for the inclusion of reporting Improvement Activities to CMS.

New Surgical Phases of Care Measures were developed to be inclusive of multiple subspecialties, thereby easing the burden of complying with the requirements for physicians. ACS Clinical Scholars used the College’s new quality manual, Optimal Resources for Surgical Quality and Safety, and other CQI programs, including the Coalition for Quality in Geriatric Surgery Project, to align the measures.

Strong for Surgery is a joint program of the ACS and the University of Washington, Seattle. The ACS administers and promotes this program as a quality initiative aimed at identifying and evaluating evidence-based practices to optimize the health of patients before surgery. Strong for Surgery provides hospitals with
checklists to screen patients for potential risk factors that can lead to surgical complications, and the program offers appropriate interventions to ensure better surgical outcomes. The checklists target four areas known to be highly influential determinants of surgical outcomes: nutrition, glycemic control, medication management, and smoking cessation.

The Coalition for Quality in Geriatric Surgery Project (CQGS), funded by the John A. Hartford Foundation, completed its second year in development. The four-year project aims to improve care of older patients through a standards and verification program. The CQGS published its first manuscript in the *Annals of Surgery*, “Hospital standards to promote optimal surgical care of the older adult.” This paper was the culmination of a two-year study performed as a modified RAND-University of California, Los Angeles, appropriateness methodology study.

The CQGS also conducted its second Patient and Family Advisory Council (PFAC) meeting at Oregon Health & Science University (OHSU), Portland, in March with older adults who underwent surgery or who had a family member undergo surgery at OHSU. The information and patient perspectives gleaned from the OHSU PFAC group informed the development of the beta standards, data registry measures, and structure of the quality program. Additionally, the CQGS published the model for building and disseminating the geriatric surgery program, “Improving quality in geriatric surgery: A blueprint from the American College of Surgeons,” in the December 2016 *Bulletin*.

The Agency for Healthcare Research and Quality (AHRQ) Safety Program for Improving Surgical Care and Recovery (ISCR) is a collaborative program between the ACS and Johns Hopkins Medicine Armstrong Institute for Patient Safety and Quality to enhance the recovery of the surgical patient. The ISCR is a five-year funded project that seeks to meaningfully improve clinical outcomes by supporting hospitals in the implementation of evidence-based enhanced recovery pathways that promote the delivery of evidence-based perioperative care and reduce variability. ISCR will comprise five anticipated cohorts, each lasting 12 months—colorectal, orthopaedic, gynecology, emergency general surgery, and bariatric—and is open to all hospitals in the U.S., Puerto Rico, and the District of Columbia.

The pilot Residents Leading Quality Course course took place preceding the official start of Clinical Congress 2016 in Washington, DC. The course introduced surgery residents and fellows to the basics of QI, including the identification of a problem, data review, QI models and techniques, and patient and provider engagement strategies.

The College released *Optimal Resources for Surgical Quality and Safety* at the ACS Quality and Safety Conference in July 2017. “The red book” is intended to be 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 for patient-centered care, to help health care institutions perform better evaluation and achievement of quality processes and outcomes at the facility/departmental level. Exploratory work is under way to evaluate the feasibility of developing adjunctive or integrated resources/standards within the manual, as well as a Surgical Quality Verification Program.

The Surgical Research Committee selected the recipient of the 2017 Jacobson Promising Investigator Award (JPIA) and sponsored the 2016 Health Services Research Methods (HSRM) Course, December 8–10, 2016. Previously the Outcomes Research Course, the HSRM course was redesigned in 2016 for clinical and health services researchers with varying degrees of experience in the field. In addition to didactic lectures and skills-based labs tailored to individual interests, participants had one-on-one consultations with leading experts focused on their specific research questions.

The ACS Clinical Scholars in Residence Program features four Clinical Scholars who are working on CQI activities, one with support from the CQGS, two with
support from the AHRQ ISCR, and one with a focus on PRO measures.

The ACS was awarded a three-year R01 from the National Institute on Minority Health and Health Disparities. L. D. Britt, MD, MPH, DSc(Hon), FACS, FCCM, FRCSEng(Hon), FRCSEd(Hon), FWACS(Hon), FRCSEd(Hon), FCS(SA)(Hon), FRCSSlag(Hon), will serve as the principal investigator on this award. The project period is September 1, 2017, through May 30, 2020, with overall funding expected to exceed $2.36 million. The four participating sub-award sites are Eastern Virginia Medical School, Norfolk; Brigham and Women’s Hospital, Boston, MA; University of California, Los Angeles; and the National Quality Forum. The overall aim of this project is to determine robust surgical disparities-sensitive metrics across the continuum of care that can be used to develop targeted interventions aimed at eradicating disparities.

Cancer Programs

A total of 1,486 programs have CoC accreditation, and 460 cancer programs were due for survey in 2017. In all, 42 new cancer programs applied for accreditation in 2017, whereas 35 programs have withdrawn or had their accreditation discontinued. A total of 42 cancer programs surveyed between January 1 and December 31, 2016, received the 2016 Outstanding Achievement Award. Results for the January–June 2017 survey period were announced in September. The annual accreditation fee is $9,000. In 2018, the CoC will introduce a tiered fee structure.

The CoC is evaluating future options for the Oncology Medical Home (OMH) accreditation program, and the National Accreditation Program for Rectal Cancer (NAPRC) manual is undergoing final revision. Launch will proceed when the manual is released.

Four workgroups are developing revised content for the CoC Cancer Program Standards: Ensuring Patient-Centered Care (2016 Edition), including cancer program goals, prevention and early detection activities, QI activities, and survivorship care plan requirements. The Accreditation Committee brought final changes to the CoC Executive Committee in October.

The National Cancer Database (NCDB) completed a successful call for data in the first quarter of 2017. More than 10.2 million cancer patient records were submitted to the NCDB in January, 1.43 million of which were for new cases diagnosed in 2015, representing approximately 70 percent of all newly diagnosed cases in the U.S. The NCDB released the 2017 NCDB Data Quality Tools this fall. The NCDB curates 35.2 million records from diagnosis years 1985–2015.

Rapid Quality Reporting System (RQRS) participation has grown to 1,342 programs—more than 90 percent of CoC-accredited facilities. As of 2017, participation is required for all CoC-accredited programs. February 2018 deliverables from the Quintiles project for the NCDB will include a new file uploader and submission reports, and a Rapid Cancer Reporting System. These enhancements will simplify the data submission process, decrease the time between diagnosis and NCDB receipt of an initial record of disease, and will integrate a QI platform for data-driven quality measures for 1,500 CoC hospitals.

Targeted efforts are under way to increase participation in ACS Clinical Research Program (ACS CRP) committees and dissemination of materials from the Operative Standards for Cancer Surgery. A total of 1,050 hard copies and 50 e-books of Operative Standards for Cancer Surgery Volume I have sold to date. In addition, Controversies in Surgical Oncology, a series of 10 articles based on Operative Standards for Cancer Surgery Volume I, has been published in Annals of Surgical Oncology. Operative Standards for Cancer Surgery Volume II is set for publication in July 2018.

The ACS CRP Cancer Care Delivery Research group is engaged in ongoing activities related to two projects centered on optimizing the effectiveness of routine posttreatment surveillance in prostate cancer and the comparison of operative to medical endocrine therapy for low-risk ductal carcinoma in situ. Activities related to three projects on posttreatment
surveillance for breast, colorectal, and lung cancer have been completed.

The Dissemination & Implementation Committee surveyed members of the ACS and National Accreditation Program for Breast Centers (NAPBC) to determine the following: how physicians enroll patients in clinical trials, the facets of implementation of standards, and preferences for dissemination. The CRP Education Committee are collaborating with the Society of Surgical Oncology (SSO) Research Committee to cosponsor a session, Clinical Trials for Surgeons: Hurdles and Opportunities, at the SSO annual meeting in March 2018.

Educational Cancer Programs include the 2017 ACS Cancer Programs Conference: Creating a Culture of Quality, which took place September 8–9. This program provided integrated education, including content from all areas of the Cancer Programs department.

More than 400 individuals across 18 expert panels and several disease-specific groups were involved in the development of content for the American Joint Committee on Cancer (AJCC) Cancer Staging Manual, Eighth Edition, published in October 2016. More than 21,000 copies of the book have been sold. The guidelines in the eighth edition go into effect January 1, 2018.

More than 600 U.S. centers are accredited by the NAPBC. Reaccreditation rates for 2017 remain at more than 95 percent, and there are three accredited international centers: Abu Dhabi, UAE; South Africa; and Toronto, ON. Centers in Lebanon, Venezuela, and Australia have applied for accreditation.

The NAPBC continues to work with the Cancer Programs leadership team to identify opportunities for increased collaboration between the CoC and NAPBC. NAPBC participated in the 2017 Cancer Quality Conference in September, and plans are under way to integrate NAPBC content into the DROPC Quality and Patient Safety Conference in July 2018.

Finally, Cancer Programs revised the weekly e-newsletter, The Brief, to include news, updates, and information that will be relevant to all areas within Cancer Programs. The newsletter was renamed The Cancer Programs Brief and is disseminated to more than 25,000 cancer center personnel.

Trauma Programs

The COT, a sponsor of a recent report from the National Academies on Science, Engineering, and Medicine (NASEM), strongly supports the findings and 11 recommendations in A National Trauma Care System: Integrating Military and Civilian Trauma Systems to Achieve Zero Preventable Deaths after Injury. In collaboration with military partners and the National Highway Traffic Safety Administration (NHTSA), the COT held a conference, attended by 170 trauma care professionals, in April to advance the NASEM recommendations.

Four core workgroups have formed in the areas of governance/framework for a national trauma care system; research funding and direction; data linkage, integration, and outcome measures; and military/civilian trauma workforce. Along with these four areas of focus, the COT is working to develop a coalition of stakeholders from other organizations and specialties with the shared goal of achieving zero preventable deaths. NHTSA has offered the COT additional funding to develop a policy statement on data linkage across the trauma care continuum in support of NASEM report recommendations.

The COT Injury Prevention and Control Committee (IPCC) is advocating for a public health/trauma system approach to firearm injury prevention; that is, implementing evidence-based firearm violence prevention programs through its network of trauma centers. These institutions are working toward a consensus approach to reduce firearm injuries and deaths. Following a survey of COT members and a Town Hall, the IPCC developed a paper outlining COT members’ views and opportunities to improve firearm injury prevention, which was accepted for publication in the Journal of Trauma and for presentation at an American Association for the Surgery of Trauma session. Additionally, the IPCC’s work on firearm injury prevention was featured in the October Bulletin.
The IPCC also developed a position statement on the significance of lithium battery injuries, promoting safety regarding manufacturing, safe storage, and reporting and tracking injuries. In addition, the committee prepared a position statement outlining the risk of motor vehicle crashes due to driving under the influence of opioids.

More than 700 centers participate in the Trauma Quality Improvement Program (TQIP®). This past year has seen the most growth in TQIP’s Level III program, and 15 state/regional/system TQIP collaboratives have been established.

The 2017 TQIP Scientific Meeting and Training took place November 11–13 in Chicago. The conference included tracks for all members of the trauma team and sessions tailored to Level III centers and TQIP collaboratives. There are 486 ACS-Verified Trauma Centers.

The verification program has embarked on a new process for the ongoing review and revision of trauma care standards detailed in Resources for Optimal Care of the Injured Patient. Workgroups have been established to review and provide recommendations for each chapter.

Performance improvement and patient safety efforts have focused on the development of best practice guidelines for patient imaging. The expert panel for this project includes pediatric and adult trauma surgeons as well as radiologists. The guidelines will cover imaging across injury types, for special populations, and will be a resource on performance improvement for imaging.

The 10th edition of the Advanced Trauma Life Support® (ATLS®) program is the most transformational iteration in the 40-year history of ATLS. Significant changes to the format and delivery of education are as follows:

• Traditional lectures have been replaced with interactive discussions to foster engagement.

• The skills stations are now taught through unfolding...
case scenarios that allow students to apply learned skills to real-life situations.

• Incorporation of a hybrid course option, mATLS, which allows students to complete interactive modules online before attending the in-person skills day.

• The addition of a faculty and coordinator online toolkit, which provides easy-to-use/downloadable tip sheets and instructional videos.

Member Services
The ACS has 81,244 members, 65,080 of whom are Fellows (57,590 U.S; 1,310 Canadian; 6,180 International). Of these Fellows, 8,727 are senior status and 18,658 are retired (both dues-exempt). The ACS has 2,703 Associate Fellows, 10,529 Resident Members, 2,424 Medical Student Members, and 518 Affiliate Members.

This year’s Initiate class totals 1,827, including 1,221 U.S., 24 Canadian, and 582 international new Fellows representing 68 countries. Among the Initiates, 448 are women, 1,379 are men. Class size has continued to rise for the last 16 years and is at its highest point since 2001. Almost 900 Initiates attended this year’s Convocation.

The ACS has engaged in the following recruitment and retention activities:

• Release of the Physician Well-Being Index—a validated screening tool that helps members better understand their overall well-being and identify areas of risk

• Outreach to Fellows who are in jeopardy of losing their Fellowship because their dues are in arrears

• Outreach to surgeons who became Fellows in 2012, 2013, and 2014 whose membership has lapsed

• Outreach to nonmember registrants of ACS meetings and courses and nonmember purchasers of ACS products

• Discount membership offers to participants in select ACS meetings

• Created contact lists of surgeon interest groups (SIGs) at medical schools, created and promoted a toolkit focused on the student membership for SIGs to use, established an online Community for Medical Student members, created a new web page of resources for medical students, and started a medical student newsletter

• Surveyed new Fellows to determine areas for improvement in the application process and customer service and to determine why they chose to become Fellows

• Developed a new online orientation program for new Fellows

• Surveyed all dues-paying Fellows and Associate Fellows

• Expanding the member engagement events at this year’s Clinical Congress to include the reunion class recognition effort and wellness activities, including yoga, a spin class, and running tours

The College continues to add chapters and expand the range of services available to them. Examples are as follows:

• The Bangladesh and Kuwait Chapters were chartered in June.

• The first Chapter Officer Leadership Program occurred in May 2017.

• Quarterly domestic and international chapter newsletters were launched in January.

Members of the Chapter Activities Domestic Workgroup continued to establish a process to capture the health of ACS chapters and revised the Chapter Guidebook and the Chapter Meeting Toolkit. These documents have been combined into one online resource.
The Chapter Activities International Workgroup continues to advocate for all ACS international chapters by assisting them in implementing and promoting ACS programs. Chapters in Lebanon, Jordan, Chile, and Greece successfully offered the General Surgery Review Course to surgeons in their respective regions. The workgroup is working to enable more international chapters to conduct similar courses and to present ATLS and other trauma courses.

The Advocacy and Health Policy Pillar of the Board of Governors (B/G) and its workgroups continue to focus on legislative and regulatory issues. The Health Policy and Advocacy Workgroup produced a white paper on out-of-network billing. The Grassroots Advocacy Engagement Workgroup focused on enhancing bidirectional communication between the ACS leadership and Fellows regarding important legislative and regulatory issues.

The Communications Pillar continues to focus on bidirectional communication between Fellows and the Regents. This mission is accomplished through the Newsletter and Survey Workgroups. The Newsletter Workgroup continues to produce The Cutting Edge e-newsletter, which will move to a biannual publication to be distributed before the Clinical Congress and the Leadership & Advocacy Summit.

The Survey Workgroup published the results of the 2016 Board of Governors Annual Survey in several College venues over the past year, including the Bulletin. The Workgroup has completed the 2017 Board of Governors Annual Survey. This year’s survey focused on the Stop the Bleed campaign, the opioid crisis, work-related injuries/surgical ergonomics, and advanced practice providers in surgery.

The Education Pillar and its three workgroups continue to collaborate with the Division of Education on several projects. The Patient Education Workgroup has developed a presentation for Governors to provide communication back to their chapters or societies and is working with the Young Fellows Association (YFA) and the Patient Education Committee to improve awareness of the College’s patient education resources. After seeking input from the Association of Program Directors in Surgery and the Association for Surgical Education, the members of the Surgical Training Workgroup finalized a standardized letter of recommendation for applicants to surgery training programs, which is available on the ACS website.

The Member Services Pillar continues to strengthen both domestic and international chapters by updating resources, creating a chapter performance metric, and surveying the chapters about their activities and needs.

The Surgical Volunteerism and Humanitarian Awards Workgroup received a historically high number of nominations—54 versus 44 in 2016. The workgroup selected five recipients, who were honored at the B/G dinner at Clinical Congress 2017. The workgroup will continue to collaborate with the military Governors and the MHSSPACS to better define the criteria for a military award and to reach out to the Excelsior Surgical Society for nominations.

The Quality Pillar has three workgroups. The Best Practices Workgroup continues to participate in the Evidence-Based Decisions in Surgery Program module review and is developing a standard template and timeline for annual guidelines development, as well as a new guideline on perioperative anticoagulation management. The Physician Competency and Health Workgroup has three subcommittees focused on ergonomics, disruptive surgeons, and wellness. The Surgical Care Delivery Workgroup updated ACS Statements on the Rationale for Emergency Surgical Call and the Development and Use of Proprietary Guidelines for Accountable Patient-Centered Care, which the Regents approved in June.

Since last October, seven Advisory Councils have issued newsletters. The Advisory Councils also have engaged in the following activities:

- Assisted with review of expert witness testimony for the Central Judiciary Committee
• Nominated members for boards and specialty review committees

• Developed an ACS Statement on The Use of General Anesthetics and Sedation Drugs in Children and Pregnant Women

• Recommended members to represent the ACS on specialty guidelines writing and review panels

• Asked specialty colleagues to encourage their residents and junior colleagues to join the ACS

• Communicated with non-ACS member specialty program directors to encourage enrollment

The YFA is launching a speakers’ bureau and paired 15 mentors/mentees for the YFA Annual Mentoring Program. The Resident and Associate Society (RAS-ACS) is collaborating with the YFA and the ABS to develop a podcast series for resident learning. The RAS-ACS also engaged in the following activities:

• Offered 18 webinars for Associate Fellows

• Established a subcommittee to identify resources and engagement opportunities for Associate Fellows

• Developed a survey on opioid education and prescribing methods by residents

• Contributed articles on the opioid epidemic to the August RAS issue of the Bulletin

Operation Giving Back (OGB) continues to encourage surgeon volunteerism in underserved domestic and international regions. A new OGB website launched in October 2016 with a unique feature that lists volunteer opportunities offered by partner organizations. To date, 31 opportunities have been posted, 51 partners have enrolled, 257 volunteers have signed up, and 68 volunteers have signed up for the disaster registry.

The MHSSPACS contract with the DoD has been extended through 2022. MHSSPACS and the COT are visiting the major military treatment facilities (MTFs) that are charged with achieving Level 1 or Level 2 trauma center status within their region. MHSSPACS has formed an ACS NSQIP Collaborative for MTFs. The MHSSPACS Quality co-chairs have created their own Quality Committee and have visited three MTFs to support their patient safety initiatives. Data from these centers already indicate that MTF QI initiatives have proven beneficial.

The Excelsior Surgical Society has been resurrected and is now a formal society within the ACS. The Society has elected officers, developed a charter, and convenes a full-day meeting at the ACS Clinical Congress.

Due to the efforts of the subcommittees of the International Relations Committee, a total of 21 international scholars and travelers were invited to Clinical Congress 2017, and two international scholars participated in the 2017 Quality & Safety Conference.

In spring 2017, the first ACS/American Society of Breast Surgeons (ASBrS) International Scholar attended the annual meeting of the ASBrS and the ACS NAPBC. A request for a new cosponsored scholarship program, the ACS/American Association for the Surgery of Trauma International Scholarship, was presented to the Board of Regents in October.

The Central Judiciary Committee (CJC) has addressed issues of unprofessional conduct in the care and treatment of patients, expert witness testimony that does not meet ACS standards and guidelines, impaired physicians, state medical licensure issues, negligence and incompetence, failure to maintain adequate and accurate medical records, and inappropriate use of social media.

The Women in Surgery Committee (WiSC) and its four subcommittees continue to generate resources for women members of the College. WiSC wrote the ACS Statement on Gender Salary Equity, which the Board of Regents approved in June, and selected the
recipient of the second Mary Edwards Walker Inspiring Women in Surgery Award. This is the fifth year of the Mentorship Program, and in 2017–2018 26 pairs of mentors and mentees will participate.

The Committee on Diversity Issues’ new web page will address why diversity is important and will include needs assessment tools and articles and resources to address cultural competency at work, implicit bias, and development of diverse surgical teams.

More than 450 surgeons and residents participated in the ACS Leadership Summit May 6–7. The Leadership portion of the Leadership & Advocacy Summit included a series of presentations that provided practical take-home tips on how to be a better leader. For details, see the August issue of the Bulletin. The 2018 Leadership & Advocacy Summit is scheduled for May 19–22, 2018, in Washington, DC.

Integrated Communications
The ACS website remains a vibrant source of information for members of the College, other members of the surgical team, and the general public, providing content on College programs, initiatives, and surgical news. Moreover, the functionality of the site undergoes continual improvements. Key enhancements in 2017 include:

- Search by Zip feature for Find a Surgeon is more precise (within 10 miles of a specified zip code)
- Usability updates to My Profile, including clearer indications for members’ mailing address preferences and security settings for each section of the surgeon’s profile, and easier editing features for a member’s subspecialties and conditions/procedures
- Enhanced Clinical Congress page
- Improved ability for users to share ACS news releases on social media

The web team in the Division of Integrated Communications collaborated with staff in several College divisions, including information technology, to bring other new dynamic content online for many of the programs described in this report, including the AHRQ Safety Program for ISCR, Strong for Surgery, Resources in Surgical Education articles, ACS Case Reviews in Surgery, surgeon well-being, and CSV. From August 1, 2016, through July 31, 2017, the ACS website had nearly 9.5 million page views.

The College’s bleedingcontrol.org website had 262,710 page views between August 1, 2016, and July 31, 2017. The Twitter site, @bleedingcontrol, has nearly 2,200 followers, and we have tweeted nearly 1,000 times since the site launched approximately one year ago.

ACS media relations outreach efforts are focused on highlighting original research studies promoting surgical advances and innovation. In Washington, DC, the focus is on building media awareness of our positions and opinions on health care policy issues at the federal and state levels. Noteworthy media mentions of the College and its activities included coverage by U.S. News & World Report, Reuters Health, New York Times, NBC News, USA Today, and National Public Radio.

The Bulletin successfully transitioned from a mostly print publication to an online publication in January 2017. At press time, the Bulletin team was gearing up to survey readers on their impressions of the transition as part of a strategic planning process to ensure that the Bulletin remains one of the College’s most widely read and trusted publications.

In November 2016, the Journal of the American College of Surgeons (JACS) successfully implemented a direct login process for ACS members to facilitate ease of access to full-text articles online. With implementation of this direct login process, JACS has begun the process of transitioning to an electronic-only journal.

The College’s social media presence continues to grow. The 115 ACS Communities continue to attract
a range of members. In three years, the communities have become home to more than 4,631 unique contributors who have posted more than 53,279 messages in approximately 8,996 discussion threads. Furthermore, the ACS continues to see upward trajectories on our Facebook, Twitter, and LinkedIn sites.

Over the last year, ACS partnered with Weber Shandwick on several campaigns and activities. For the third year, the Weber Shandwick team worked with the ACS Program Committee to develop the Clinical Congress Daily Highlights e-newsletter. In 2016, the newsletter was distributed twice daily to all ACS Fellows, including those off-site. The newsletter also received three newsletter and writing awards from the Public Relations Society of America.

In 2016, Weber Shandwick began working with the ACS COT to develop a messaging platform and campaign that would draw attention to the urgent need to fill the gaps in the nation’s trauma system and respond to the NASEM report. This work is expected to continue over the next year in support of the COT’s effort to develop a National Trauma Action Plan and support key legislation, including the Mission Zero Act. In addition, this spring, the team launched a trauma story series, Putting the Pieces Together: A National Effort to Complete the U.S. Trauma System, to draw attention to gaps in the system and proposed solutions.

**ACS Foundation**

The ACS Foundation experienced a 35 percent increase in total contributions over the previous year while maintaining its low cost-per-dollar-raised.

Under the leadership of a new Chair, Mary H. McGrath, MD, MPH, FACS, the ACS Foundation is offering new initiatives to broaden its outreach to Fellows. One example is National Doctors’ Day, which in its second year nearly tripled total contributions from donors giving in honor of their mentors. A generous donor also provided a Challenge Grant match opportunity at Clinical Congress 2016, raising $100,000 for the ACS Greatest Needs Fund. The Chair and Foundation staff are working with each ACS division to offer more defined giving opportunities to donors.

Philanthropic funding continues to sponsor ATLS training in underdeveloped countries; provide mentorship opportunities to trauma surgeons; bring new skills courses to Clinical Congress; make breakthrough research possible with scholarship and fellowship awards; and support advocacy efforts in patient safety.

**Closing remarks**

None of the efforts described in this report would be possible without the tremendous work carried out by the College’s Facilities and Finance, IT, Human Resources, Convention and Meetings, and Performance Improvement teams. These support areas provide the backbone of all College endeavors, along with all of the ACS volunteers and division staff. Because of their dedication and hard work, the College continues to lead the way in ensuring all surgical patients have access to high-quality care.

♦
The Centers for Medicare & Medicaid Services (CMS) released the Inpatient Prospective Payment System (IPPS) final rule August 2. The rule establishes fiscal year (FY) 2018 policies for Medicare payments to hospitals for inpatient stays occurring between October 1, 2017, and September 30, 2018. Under the final rule, the payment rate update for general acute care hospitals paid under the IPPS is 1.2 percent. The American College of Surgeons (ACS) submitted comments to CMS on the proposed IPPS rule released in April, which CMS took into consideration when drafting the final regulation.

How does the 2018 IPPS final rule affect surgeons?
The IPPS rule sets reimbursement rates and coverage criteria for Medicare Part A claims for services provided in the inpatient hospital setting. In addition, the IPPS rule contains modifications to hospital pay-for-reporting and pay-for-performance programs used to determine hospital payment adjustments. The IPPS rule does not directly update Medicare Part B physician payments; however, because a large proportion of surgical care is furnished in the acute care setting, changes to payment policies for inpatient facilities have an effect on surgeons who practice in hospitals. In the final rule, CMS made a number of changes to Medicare payment, coverage, and quality reporting policies for inpatient hospital services.

What changes were made to the VBP program relevant to surgical care?
Under the hospital Value-Based Purchasing (VBP) program, CMS calculates incentive payments made to hospitals based on their performance on specified measures. In the IPPS final rule, CMS made changes to the measures included in this program, some of which are relevant to the provision of surgical care. CMS finalized a proposal to remove the patient safety indicator (PSI)-90 composite safety measure from the VBP program, effective for FY 2019, and to adopt a modified version of this measure, the PSI-90 Patient Safety and Adverse Event Composite measure, for FY 2023 and subsequent years. The modified measure includes:

- PSI-03 Pressure ulcer rate
- PSI-06 Iatrogenic pneumothorax rate
- PSI-08 In-hospital fall with hip fracture rate
- PSI-09 Perioperative hemorrhage or hematoma rate
- PSI-10 Postoperative acute kidney injury rate
- PSI-11 Postoperative respiratory failure rate
- PSI-12 Perioperative pulmonary embolism or deep vein thrombosis rate
- PSI-13 Postoperative sepsis rate
- PSI-14 Postoperative wound dehiscence rate
- PSI-15 Unrecognized abdominopelvic accidental puncture/laceration rate

In addition to the name change, the number of indicators in the composite increased from eight to 10. PSIs 9, 10, and 11 were added to better capture the range of patient safety events, while PSI-7 (central line-related bloodstream infection rate) was removed. PSI-15 was re-specified to focus on the most serious intraoperative injuries due to an accidental puncture or laceration and only includes abdominal and pelvic surgery in the denominator. To reflect these changes, the name of the PSI changed from accidental puncture or laceration rate to unrecognized abdominopelvic accidental puncture/laceration rate. The numerator has also been updated to only include accidental punctures or lacerations that result in a patient returning to the hospital.
The new weighting methodology improves measure validity and reliability, and now accounts for both the frequency and severity of the harms associated with each patient safety event, in addition to volume weights.

operating room at least one day after the index procedure. The ACS supported these changes.

The PSI-90 measure also was changed to account for harm in how the components of the measure are weighted. The previous version of PSI-90 determined the weight of each PSI based on volume weights. The new weighting methodology improves measure validity and reliability, and now accounts for both the frequency and severity of the harms associated with each patient safety event, in addition to volume weights. PSI-15, for example, previously was weighted at 44 percent, but after incorporating harm is valued at <1 percent.

Have changes been made to the Hospital IQR program that will affect quality reporting for surgeons?
The Hospital Inpatient Quality Reporting (IQR) program is a pay-for-reporting program that requires hospitals to report specific quality measures to CMS. Successful participation is determined based on whether hospitals report the Hospital IQR measures; however, the payments made to hospitals under this program are not related to a hospital’s performance on those measures. The IQR program primarily functions to publicly report hospitals’ quality performance on Hospital Compare. It also provides an opportunity to further analyze and understand the usability and outcomes of new quality measures before they are incorporated into pay-for-performance programs, such as the hospital VBP program. Under the IQR program, hospitals must meet the requirements for reporting specific quality information to receive the full market basket update for that year.

In response to concerns raised by stakeholders about the opioid epidemic in the U.S., CMS finalized a series of changes to the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. The agency is replacing the three pain management questions included in the HCAHPS with three new communication about pain questions. Under the IPPS final rule, this change, applicable to surveys administered to patients when they are discharged beginning January 1, is a response to stakeholder concerns that the pain management questions could have the unintended consequence of incentivizing hospital staff to overprescribe opioids to optimize their HCAHPS score. The three new questions address the constructs: effective communication with patients about pain management issues, discussion of treatment options, and patient understanding of pain management options.

Were there any changes to the measures in the PCHQR program?
The Prospective Payment System (PPS)-exempt Cancer Hospital Quality Reporting (PCHQR) program began in 2014 as a pay-for-reporting program under which there are no penalties for the 11 PPS-exempt cancer hospitals (PCH) that fail to meet the reporting requirements. The initial program included five quality measures and subsequent rulemaking has modified the measure set. A total of 17 measures were adopted for implementation in 2019.

For 2018, CMS finalized the removal of three cancer-specific process measures:

• Adjuvant chemotherapy is considered or administered within 4 months (120 days) of diagnosis to patients under the age of 80 with AJCC III (lymph node-positive) colon cancer (PCH-01/NQF #0223)

• Combination chemotherapy is considered or administered within 4 months (120 days) of diagnosis for women under 70 with AJCC T1c, or stage II or III hormone receptor-negative breast cancer (PCH-02/NQF #0559)
• Adjuvant hormonal therapy (PCH-03/NQF #0220)

CMS’ rationale for removing these measures is that they are topped out, which means measure performance is high and unvarying and, therefore, no meaningful distinctions can be made from one provider to the next.

The ACS opposes the removal of these measures because measuring these high-value processes together can be more meaningful and tell a more complete story of patient care while allowing hospitals to continue to track disparities in cancer care. The ACS will continue to advocate for retention of these measures as part of a composite measure.

**Did the IPPS final rule include any modifications to the EHR Incentive Program for providers?**

The CMS Medicare Electronic Health Record (EHR) Incentive Program is divided into three stages, each intended to incentivize providers to demonstrate meaningful use of an EHR system through a progression of measures and objectives. Stage 1 established the foundation for the program by instituting requirements for the electronic capture of clinical data and by providing patients with electronic access to their health information. Stage 2 expands on Stage 1 by encouraging the use of health information technology for continuous quality improvement at the point of care and the exchange of information in a structured format. Stage 3 focuses on improving clinical outcomes. For clinicians, the EHR Incentive Program has transitioned to the Advancing Care Information component of the Merit-based Incentive Payment System.

The 21st Century Cures Act, enacted in December 2016, allows for the expansion of protections from payment adjustments under the EHR Incentive Program. Under this authority, CMS finalized its proposal to add a new exception for the 2018 payment adjustment for providers who have been unable to comply with reporting requirements because their certified EHR technology (CEHRT) has been decertified by the Office of the National Coordinator (ONC) for Health Information Technology. Providers eligible for this program may qualify for this exception if their CEHRT was decertified either in the 12-month period preceding the EHR reporting period for the 2018 payment adjustment year or during the EHR reporting period for the 2018 payment adjustment year, which is any continuous 90-day period in 2016 or 2017. When applying for this exception, providers must demonstrate that they intended to attest to meaningful use for a certain EHR reporting period and that they made a good-faith effort to adopt and implement another CEHRT in advance of that EHR reporting period. The ACS recommends that providers seeking to use this exception retain any evidence of efforts to obtain new CEHRT.

Also under the authority of the 21st Century Cures Act, CMS finalized an exemption for ambulatory surgical center (ASC)-based providers. ASC-based providers include those who deliver 75 percent or more of their covered professional services in an ASC (as identified by place of service code 24 listed on claims). Whether a provider qualifies for the ASC-based exemption for a payment adjustment year is based on the provider’s services furnished years prior to the payment adjustment year. The ACS supported this proposal to ensure that providers are not penalized for circumstances beyond their control, including those physicians who have little influence over EHR decisions in their practice.

CMS additionally finalized a policy to allow providers to use either 2014 edition or 2015 edition CEHRT, or a combination of the two, for an EHR reporting period in 2018. CMS took this step to provide more flexibility in reporting options for clinicians.
CMS will continue to seek stakeholder input on the most appropriate social factors to include in risk adjustment or for the stratification of performance scoring, how to account for these risk factors, and which data sources are best suited to identify social risk variables.

Do the measures in these programs account for social risk factors?
Measures across IPPS quality and value-based purchasing programs do not account for social risk factors. To identify the best path forward, CMS is assessing the appropriateness of accounting for social risk factors across its inpatient programs. The goal is to incentivize improvements in health outcomes for patients with low socioeconomic status (SES) while ensuring access to care for these patients. There have been some initial investments in research to identify how to account for social risk factors in value-based programs by the National Quality Forum, the U.S. Department of Health and Human Services (HHS) Assistant Secretary for Planning and Evaluation, and the National Academies of Sciences, Engineering, and Medicine.3-5 Many of the findings indicate the need for further research in the area. CMS will continue to seek stakeholder input on the most appropriate social factors to include in risk adjustment or for the stratification of performance scoring, how to account for these risk factors, and which data sources are best suited to identify social risk variables.

CMS indicated that much of the feedback received in the rulemaking process is conflicting. Some stakeholders recommended risk adjustment as the best approach to account for social risk factors, while others expressed concern that adjusting for social risk factors may mask disparities or minimize incentives to improve the outcomes of disadvantaged patients. The ACS has advocated for SES risk adjustment for measures used in accountability applications (such as public reporting and pay-for-performance) on a case-by-case basis, and when they demonstrate a conceptual and empirical basis for adjustment.3 Without the use of appropriate risk adjustment for certain measures, clinical outcomes will be less reliable due to SES confounding variables. The ACS also has noted the importance of stratified results because they can demonstrate to CMS where more resources are needed to overcome the challenges vulnerable populations face from their SES. The ACS recommended that the Secretary of the HHS encourage CMS to work with other agencies to prioritize research efforts in this area and to examine the broader social determinants of health.

How will CMS enforce the critical access hospital (CAH) 96-hour certification requirement in FY 2018?
For inpatient services furnished in CAHs to be payable under Medicare Part A, CMS requires that a physician certify that a patient admitted to a CAH may reasonably be expected to be discharged or transferred to another hospital within 96 hours of admission. The ACS has expressed to CMS that the 96-hour certification requirement imposes significant burdens on the surgical community and believes that strict enforcement of this policy may violate the Emergency Medical Treatment and Labor Act, under which hospitals and physicians must treat patients until their condition has been stabilized or resolved.

In the IPPS final rule, CMS indicated that the CAH 96-hour certification requirement will not be stringently enforced or reviewed. CMS directed its auditors, including quality improvement organizations (QIOs), Medicare administrative contractors (MACs), supplemental medical review contractors (SMRCs), and recovery audit contractors (RACs), to make the CAH 96-hour certification requirement a low priority for medical record reviews as of October 1. CAHs should not expect to receive medical record reviews. CMS will continue to seek stakeholder input on the most appropriate social factors to include in risk adjustment or for the stratification of performance scoring, how to account for these risk factors, and which data sources are best suited to identify social risk variables.
requests from QIOs, MACs, SMRCs, or RACs related to the 96-hour certification requirement in the absence of evidence of potential fraud, waste, or abuse.

The ACS supports CMS’ decision to make the 96-hour certification requirement a low priority for medical record reviews, as this change indicates that CMS is aware of the problems inherent in this payment policy. However, the ACS continues to advocate on behalf of physicians who provide essential surgical care to Medicare’s rural beneficiaries and urges CMS to provide a definitive remedy for the problems associated with the 96-hour certification requirement that goes beyond instructing audit entities to forgo reviews of this certification in medical records.

Have changes been made to national health care accrediting organization requirements?
Section 1865 of the Social Security Act allows health care facilities, providers, and suppliers to demonstrate compliance with Medicare conditions of participation, coverage, and certification through accreditation by a private national accrediting organization (AO). CMS has responsibility for overseeing and approving AO programs used for Medicare certification purposes and for ensuring that providers and suppliers accredited under a CMS-approved AO program meet Medicare’s quality and safety standards.

In the IPPS proposed rule, CMS proposed to require AOs to make all Medicare provider and supplier accreditation survey reports, which measure compliance with Medicare quality and safety standards, publicly available on their websites. The ACS opposed this proposal and encouraged CMS to instead improve collaboration with AOs to ensure that accreditation surveys are designed and implemented to best identify needed areas of improvement for health care facilities, providers, and suppliers. Citing public feedback on this issue, CMS withdrew its proposal in the IPPS final rule. CMS indicated that it will further review and refine methods to share health quality and safety information with consumers.

The FY 2018 IPPS final rule can be accessed on the CMS website at www.gpo.gov/fdsys/pkg/FR-2017-08-14/pdf/2017-16434.pdf. Background information and IPPS resources are available on the ACS website at facs.org/advocacy/regulatory/medicare-a-b#ipps. If you have questions regarding the IPPS, contact the ACS Division of Advocacy and Health Policy at qualityDC@facs.org.

REFERENCES
ACS Surgical Coding Workshops help improve profit margins

Each year, the American College of Surgeons (ACS) offers workshops to teach and reinforce accurate reporting of American Medical Association (AMA) Current Procedural Terminology (CPT)* codes with an emphasis on codes that general surgeons commonly use. These courses include information about annual changes to CPT codes and payor coverage and examples of coding clinical scenarios. For the first time, the 2018 lineup will include a course on trauma and critical care coding.

Benefits of attending
The workshops are beneficial for surgeons, practice administrators/managers/coders, and reimbursement staff seeking to improve their profit margins. Team attendance is encouraged to ensure accurate, consistent, and complete coding. If the physician is an ACS member, team members or practice employees may attend the workshop at the ACS member rate.

Attending an ACS Surgical Coding Workshop increases participants’ knowledge of coding principles and helps them to reduce coding errors and the risk of an audit. In addition, attendees have the opportunity to share their different coding and practice management ideas, knowledge, and experiences with the other attendees.

The agenda
The first day of the workshop will focus on the basics of correct coding. Topics for discussion include:

- Correctly selecting the category of code and level of service for evaluation and management (E/M) visits
- Recognizing medical and surgical services that are and are not included in the global payment for surgery
- Collecting from patients with high deductible health plans
- Identifying key performance indicators that improve productivity

The second day of the workshop centers on surgical case coding with a focus on general surgery, including:

- Correctly coding common general surgery procedures, including breast, hernia, endoscopy, colorectal, bariatric, gallbladder, liver, and endovenous operations
- Identifying areas for improvement in surgical documentation
- Accurately applying modifiers when they are required and understanding their effect on reimbursement
- Reporting and getting paid for unlisted procedures
- Integrating 2018 CPT coding and Healthcare Common Procedure Coding System changes and guidelines into practice

Three of the 2018 workshops will include a third day centered on trauma and critical care coding (see Table 1, page 65). This course will cover the following topics:

- The difference between co-surgery and assisted surgery in trauma
- The procedural and medical management of critical trauma patients
- The treatment and disposition of trauma patients
- An overview of the trauma patient journey

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by Sadhana Chalasani
These workshops offer a third day with a focus on trauma and critical care coding.

### General Surgery Coding (Thursday/Friday)

- **January 25–26**: Hilton Dallas Southlake Town Square Southlake, TX
  - Hotel contact: 800-445-8667
  - Room rate: $179
  - Room rate cut-off date: 1/3/2018

- **February 8–9**: Encore Wynn Resorts Las Vegas, NV
  - Hotel contact: 866-770-7555
  - Room rate: $239
  - Room rate cut-off date: 1/8/2018

- **February 22–23**: Wyndham Grand Orlando Orlando, FL
  - Hotel contact: 407-390-2300
  - Room rate: $189
  - Room rate cut-off date: 2/8/2018

- **April 12–13**: Hyatt Centric Chicago/ Woman’s Athletic Club of Chicago Chicago, IL
  - Hotel contact: 888-591-1234
  - Room rate: $199
  - Room rate cut-off date: 3/28/2018

- **May 17–18**: The Yale Club New York, NY
  - Private club—attendees find and book own hotel rooms

- **August 9–10**: Loews Vanderbilt Hotel Nashville, TN
  - Hotel contact: 800-336-3335
  - Room rate: $189
  - Room rate cut-off date: 7/16/2018

- **November 1–2**: Hyatt Centric Chicago Chicago, IL
  - Hotel contact: 888-591-1234
  - Room rate: $199
  - Room rate cut-off date: 10/13/2018

### Trauma Coding (Saturday)

- **February 10**: Encore Wynn Resorts Las Vegas, NV
  - Hotel contact: 866-770-7555
  - Room rate: $239
  - Room rate cut-off date: 1/8/2018

### Hotel Contact Information

- Hilton Dallas Southlake Town Square Southlake, TX: 800-445-8667
- Encore Wynn Resorts Las Vegas, NV: 866-770-7555
- Wyndham Grand Orlando Orlando, FL: 407-390-2300
- Hyatt Centric Chicago/ Woman’s Athletic Club of Chicago Chicago, IL: 888-591-1234
- The Yale Club New York, NY: Private club—attendees find and book own hotel rooms
- Loews Vanderbilt Hotel Nashville, TN: 800-336-3335
- Hyatt Centric Chicago Chicago, IL: 888-591-1234

### Room Rates

- $179: January 25–26
- $239: February 8–9
- $189: February 22–23
- $199: April 12–13
- $199: May 17–18
- $189: August 9–10
- $199: November 1–2

### Room Rate Cut-Off Dates

- January 3, 2018: January 25–26
- January 8, 2018: February 8–9
- February 8, 2018: February 22–23
- March 28, 2018: April 12–13
- January 18, 2018: May 17–18
- July 16, 2018: August 9–10
- October 13, 2018: November 1–2

### How surgical modifiers are used in trauma and how they affect payment

- Application of coding concepts to common and complex trauma operations
- Use of E/M and critical care services modifiers

The ACS recommends attending a workshop once a year because the AMA updates the CPT code set annually. Moreover, improvements in coding constructs, additions of new technology, and changes to coding and reimbursement rules and payment policies make it beneficial to attend regularly.

### Workshops qualify for CME credit

Physician workshop attendees are eligible for 6.5 CME credits for each day of attendance. In addition, nonphysician attendees who are members of the American Academy of Professional Coders are eligible for 6.5 continuing education units for each day of attendance.

### When and where will the 2018 ACS Surgical Coding Workshops take place?

Dates and locations are as follows:

- January 25–26: Dallas, TX
- February 8–10: Las Vegas, NV
- February 22–23: Orlando, FL
- April 12–13: Chicago, IL
- May 17–19: New York, NY
- August 9–10: Nashville, TN
- November 1–3: Chicago, IL

### How to register

Register for the workshops online at www.karenzupko.com/workshops2/gensurg-workshops/ or by phone at 312-642-8310. Although ACS membership is not a requirement to attend, the ACS offers a special rate for members and their coding staff. Fellows and their staff should enter their ACS member number for each individual registering.

For hotel reservations, contact the hotel that is hosting the workshop and indicate that you are attending the ACS Surgical Coding Workshop to receive special pricing (see Table 1). The College also offers airfare discounts on United Airlines. Contact an ACS travel counselor at 800-456-4147 or ACSTravel@facs.org, or contact United Airlines by phone at 800-521-4041 or online at united.com. When booking individual travel, be sure to indicate the name of the meeting and refer to the ACS file numbers provided for any applicable discounts. The ACS file numbers are Agreement Code 838205; ZCode ZE6B.

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†These workshops offer a third day with a focus on trauma and critical care coding.
A frail woman, about 70 years old, sat on the hard cot, wearing an oversized donated gray sweater and huddling beneath the thin white blanket and the glaring lights of the Baton Rouge, LA, stadium that had been converted into a flood shelter. Earlier, she had been gesturing wildly, but now she was sitting still, dejected and mute. The flood shelter volunteers thought she might have dementia or psychosis but couldn’t tell because she didn’t speak English. They asked me to assess if she had dementia, and to help triage if she needed to be transferred to the special needs medical shelter at the Louisiana State University amphitheater across town.

I had just entered the stadium, doing a walk-through to assess the infrastructure of the on-site medical team in my new role as the Chief Medical Officer (CMO) for Medicaid, Louisiana Department of Health. Just a few weeks earlier, I had finished my training at the Brandeis University Heller School of Management, Waltham, MA, Executive Leadership Program as the recipient of the ACS Health Policy Scholarship in General Surgery. Little did I know that the lessons learned about leadership, crisis management, and stakeholder engagement would be put to use so soon.

In the program, Stewart Altman, PhD, and Jon Chilingerian, PhD, described how Carlos Ghosn revolutionized the auto industry, shared stories about working in presidential administrations ranging from those of John F. Kennedy to Barack Obama, and described how they negotiated success in seemingly impossible situations. Now, I found myself thrust into the epicenter of Louisiana’s Great Flood of 2016. We worked around the clock to mobilize a systematic response to the flooding that wreaked $20 billion in damage to the state.

The woman stood up hopefully as I approached, but when she realized I didn’t speak her language, she dejectedly shook her head. Fortunately, I had a surgical colleague who spoke her language and helped from hundreds of miles away, translating by phone. She passed our rudimentary mini mental exam and did not appear to have dementia.

However, as it turned out, she didn’t know her address, had no belongings beyond the donated sweats she wore, had been separated from her son during the flooding, and did not know his phone number or whereabouts. She slumped her shoulders into the blanket as if to shrink herself into oblivion. I was of limited use, so I just held her. I barely clear five feet tall while wearing heels, but that day I towered over this frail, tiny woman. She felt so small and fragile in my arms, ready to shatter into dust if I held any tighter. I felt powerless, but she looked up, and it seemed as though something as simple as the human touch had bridged what words could not communicate.
I was reminded of what another tiny woman, Mother Teresa, once said: "Not all of us can do great things. But we can do small things with great love."

The impact of caring
If anything, I’m a testament to what people can do with great love. At one time, I had no home, lived in a shelter, and was clothed from a charity bin. It wasn’t a flood shelter in Louisiana, but a refugee camp on the other side of the world. It was 1980, and my family had just escaped from Cambodia. We sought shelter in the border camps. But two weeks later, an errant rocket-propelled grenade ripped through our tent, lacerating my scalp, tearing off the lower part of my left ear, and blasting a crater in my mom’s belly as she tried to shield me with her body. A volunteer Red Cross surgeon operated on both of us, saving our lives. I never learned his name, but he inspired me to become a surgeon. Since I was a small child, I’ve had an idealized image of this fearless superhuman hero who had saved my life. I’ve wondered how this nameless hero felt, knowing that he was making such an impact on so many lives.

The truth is, he probably didn’t know that. Since becoming a surgeon myself, I’ve crossed paths with several American physicians, a surgeon, an anesthesiologist, and an emergency medicine physician who had spent time working in those same Cambodian refugee camps in the late 1970s and early 1980s, treating survivors of the genocide known as the killing fields. I don’t know if they personally took care of me, among the hundreds of thousands of other refugees sheltered in the border camps; nonetheless, I’ve thanked them for their service to humanity. But what has always surprised me is that they thanked me.

As one of those volunteer physicians said, “I didn’t know if what I did even made any difference.” There was so much need and so little equipment. At times, it was a matter of triaging who among the injured would get surgery, who had a likely fatal injury, or which sick child would get the ventilator when so few ventilators were in the refugee camp. It was overwhelming, knowing that there were not enough providers to care for all of the wounded and sick. And even I’ve crossed paths with several American physicians... who had spent time working in those same Cambodian refugee camps in the late 1970s and early 1980s, treating survivors of the genocide known as the killing fields.... I’ve thanked them for their service to humanity. But what has always surprised me is that they thanked me. As one of those volunteer physicians said, “I didn’t know if what I did even made any difference.”
if they stopped the bleeding or sutured a laceration, they weren’t sure what substantial difference had been made when 2 million Cambodians had already died during the genocide, the infrastructure of the country had been razed to the ground, and hundreds of thousands of individuals were arriving in the refugee camps malnourished, diseased, and traumatized. One physician told me, “After I returned to the States, I wondered what happened to those children. What future did they have? I didn’t know if I’d even made any difference.” Then he smiled at me, and said, “Now I know. Thank you.”

Having lived in shelters and known the generosity of a stranger’s compassion, I’ve experienced both sides of the shelter cot, as a refugee and as a provider. And I often have felt that what we do is too small, too inconsequential, too futile. But the truth is, it does make a difference. We just might not get to see the results for years, if ever. But it matters.

**Rebuilding physical and mental health**

In Baton Rouge, the flood waters have receded and the streets are dry. But don’t be fooled. The need is tremendous. Months later, as I drove down the residential streets, both sides of the roads were lined with stacks of debris from gutted homes: flood-soaked mattresses, splintered wooden tables, ruined loveseats, tossed out like broken dreams. In the shelters that I visited, the need persisted as families tried to reconnect and rebuild, often without cars to drive or homes to return to.

Also great are the mental health needs. What we’ve learned from previous disasters, ranging from Katrina to Sandy, is that the mental health effects often occur late and linger.

In hard cents and dollars, the economic loss of the Louisiana Floods was staggering. It’s been estimated that Louisiana’s flood losses total $20.7 billion, with 110,000 homes damaged. Our challenge was tremendous as we surveyed the ravages of the flood, but we must never think that our efforts are futile.

The first time I went to the flood shelters, I met a young physician who had been working medical triage for three days straight. As we spoke, she started crying. She wasn’t crying because she was exhausted. She was crying as she described the circumstances of the flood victims. I heard this same heartfelt emotion from a tough Texas emergency medicine physician deployed to the Louisiana shelters, a large national guardsman patrolling the stadium, and a shy nursing student who had traveled across the state to volunteer at the shelter. The compassion in action came from all corners of the country, from all faiths and all shades of skin color. And they gave until it hurt. To paraphrase that tiny woman who knew the power of small acts, Mother Teresa, “This is the meaning of love, to give until it hurts.”

What the floods showed me is that this is a country with courage—where people from all races, faiths, and political
beliefs come to together when our country hurts. And, in my journey from a refugee camp to the flood shelters, I have seen that this is the heart of America. We come together to do something with great love, to give until it hurts.

Putting new skills to use
The ACS Health Policy Scholarship gave me the skills to start a new position as Louisiana Medicaid’s Chief Medical Officer (CMO), giving me strategies, techniques, and knowledge that I have used every single day, as well as a network of close friends and colleagues on whom I can call (including my surgeon translator, Quyen Chu, MD, FACS). As CMO for Louisiana Medicaid, I had the opportunity to tackle the opioid crisis, develop quality metrics to improve health care delivery and improve health information technology adoption among providers in the state.

Because of my work at Medicaid, I had the good fortune to be selected as a Presidential Leadership Scholar, where I had the opportunity to learn about leadership from Presidents George W. Bush and William J. Clinton.

The Presidential Leadership Scholars program enabled me to successfully implement opioid initiatives and policies, develop a naloxone standing order to enable the lay public to save lives during an overdose, and support the creation and passage of legislation limiting inappropriate opioid prescribing. At the commencement ceremony for the Presidential Leadership Scholars program, I had the opportunity to be the keynote speaker. I spoke about what a privilege it is to live in the U.S., and have the freedom to serve our communities. I am grateful to live in a country where everyone truly deserves a chance, and given that chance, we can take the risk and see what life yields.

Following my tenure as CMO at Medicaid, I now have the privilege of serving our country’s heroes as associate chief of staff at the Michael E. DeBakey VA Medical Center, the most complex VA hospital in the nation, which houses 5,000 staff and the busiest emergency department and operating rooms in the country.

My journey in health care policy began in a small classroom at Brandeis University. I cannot overstate how much this program has benefited me. I am truly indebted to the ACS for this life-changing experience, which enabled me to grow as a surgeon and as a leader. However, my journey as a healer began as the recipient of the compassion and kindness of one surgeon in a refugee camp. Whether that was a small act to him, among the thousands of lives that he likely saved, it was not small to me. There is great value in small acts. ♦
Present and future cancer staging with the eighth edition of the AJCC Cancer Staging Manual

by David J. Winchester, MD, FACS; Mahul B. Amin, MD, FCAP; Y. Nancy You, MD, MHSc, FACS; and Judy C. Boughey, MD, FACS

It has been more than one year since the American Joint Committee on Cancer (AJCC) published the eighth edition of the AJCC Cancer Staging Manual. The final pieces are in place for implementation of this edition on January 1, 2018.

During this prolonged window of transition from the seventh to the eighth edition, many logistical tasks have been accomplished, allowing clinicians, hospitals, software vendors, and tumor registrars additional time to prepare for a more complex manual than necessary for previous tumor/node/metastasis (TNM)-based manuals. This implementation period has also allowed time to correct errata and provide important updates to clinicians.

Updates in breast cancer staging
One of the most significant updates is in breast cancer staging. The eighth edition moves to “prognostic staging” for breast cancer with inclusion of tumor grade, estrogen receptor, progesterone receptor, and human epidermal growth factor receptor 2 status as key elements used to define stage. Prognostic staging was included in the 2016 publication, but with an additional year of clinical data and more than 340,000 breast cancer patients identified in the National Cancer Data Base, prognostic staging was separated into two schemata: clinical prognostic staging and pathological prognostic staging.

As therapy becomes more individualized, opportunities for neoadjuvant therapy have increased. The Alliance for Clinical Trials in Oncology ALTERNATE trial (ALTernate approaches for Clinical Stage II or III Estrogen Receptor positive breast cancer NeoAdjuvant TrEatment, Trial A011106) is an example of the expansion of neoadjuvant therapy to include endocrine therapy, with additional systemic treatment in select cases dictated by response. Clinical prognostic staging was added to provide an accurate staging option, assigned prior to treatment, for patients treated with neoadjuvant therapy. This methodology takes into consideration the anticipated impact of current and emerging neoadjuvant therapies.

Nonetheless, response to therapy remains an important criterion for survival and—due to the complexities of treatment and a logarithmic expansion of outcomes dictated by degree of response—a specific staging scheme incorporating response for breast cancer patients treated with neoadjuvant therapy remains regrettably absent. It is the hope and expectation of the AJCC that as additional data mature, a specific staging scheme for patients receiving neoadjuvant therapy will become a reality for patients and clinicians.

Moving beyond anatomic variables
As tumor subtypes, targeted therapy, and personalized medicine become more defined, staging will require more than anatomic variables. To maintain staging relevance, biomarkers and genomic assays need to be incorporated. Most importantly, tumor response to therapy and survival outcomes are critical to defining prognosis and stage.
As tumor subtypes, targeted therapy, and personalized medicine become more defined, staging will require more than anatomic variables.

underlining the importance of consistent, correct application of cancer staging for present and future applications. This new staging paradigm also heavily relies on the assumption that survival, and thus stage, are achieved not based on preclinical variables alone but through patient and clinician compliance with treatment guidelines. Without therapy for aggressive tumor phenotypes, stage becomes inaccurate.

Second printing planned
Other important updates to the print version of the eighth edition include clarification of histologic codes, which form an important foundation for data collection by the tumor registrars and for the AJCC to monitor longitudinal trends in cancer, efficacy of treatment, and quality of care. The formal position of the eighth edition editorial board was to promulgate the World Health Organization (WHO) histologic classification cancers.

Despite this conceptually accurate and contemporary approach, multiple exceptions in the registrar community precluded an opportunity to stage hundreds of thousands of cancer patients. Although accurate data collection is a paramount goal of the AJCC, inclusion of all cancer patients for staging is of equal importance. A comprehensive review of histology codes outside of the WHO classification was performed to include histologic categories of many patients with unstageable cancers.

In view of the aggregate magnitude of updates and clarifications and the ongoing demand for the printed staging manual, the AJCC, in partnership with Springer, will proceed with a second printing of the eighth edition, which will include, among several upgrades, corrected errata, breast cancer classification tables, updated histologic codes, and clarifications in staging definitions.

This new version also will be available in an electronic format. A mechanism will be in place for all individuals and practices that have already purchased the eighth edition to obtain updates without incurring additional expense. More information is available at the AJCC website, www.cancerstaging.org.

As January 1 approaches, accurate entry of stage and the collection of a new set of clinical data will be critical to developing future revisions and updates for cancer staging. It is incumbent upon all clinicians to stage the patient and define prognosis. Likewise, it is imperative that clinicians and tumor registrars monitor outcome and collect accurate and complete information for a diverse disease with an expanding array of treatment options. Staging with the eighth edition will more accurately determine the patient’s prognosis and will help to generate information for the next iteration as treatment and prognosticators continue to evolve. ♦
Are handoff communications a common problem for your OR team?

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

Does your hospital or medical center have tried-and-true processes for transferring patients to and from the operating room (OR)? If so, then there are no communication problems when the patient is handed off to your OR team—right? And, of course, there are no misunderstandings when your team hands the patient off to staff in recovery or the intensive care unit—correct?

These communications issues are bound to arise at most institutions. The latest Sentinel Event Alert, Issue 58, “Inadequate hand-off communication,” published by The Joint Commission, identifies actions providers can take to address handoff communication problems. It includes an infographic, “8 tips for high-quality hand-offs,” and provides advice to senders and receivers of handoff communication, including communication between caregivers within hospitals and other health care settings, and between hospital caregivers and non-hospital-based providers (see Figure 1, page 73).

Handoffs and patient safety

Handoffs—also known as handovers—are real-time processes of conveying patient-specific information from one caregiver to another or from one team of caregivers to another to ensure the continuity and safety of patient care. Handoffs are complex, and a common issue with these situations is that expectations may be out of balance between the sender of the information and the receiver.¹

Patient safety can be affected when the receiver gets information that is inaccurate, incomplete, not timely, misinterpreted, or irrelevant. Many factors contribute to handoff failure, such as the following:

- Health care provider training and expectations
- Language barriers
- Cultural or ethnic considerations
- Inadequate, incomplete, or nonexistent documentation

In 2006, The Joint Commission established a National Patient Safety Goal that addressed handoff communication. It became a standard in 2010. Provision of Care (PC) standard PC.02.02.01, element of performance 2, requires that: “The organization’s process for hand-off communication provides for the opportunity for discussion between the giver and receiver of patient information. Note: Such information may include the patient’s condition, care, treatment, medications, services, and any recent or anticipated changes to any of these.”²

Handoffs happen frequently in health care, particularly in hospitals. A typical teaching hospital may experience more than 4,000 handoffs each day.³ The Joint Commission’s sentinel event database includes reports of inadequate handoff communication contributing to adverse events, including:

- Wrong site surgery
- Delay in treatment
- Falls
- Medication errors

In addition, a 2016 study estimated communication failures...
in U.S. hospitals and medical practices were responsible for 30 percent of all medical liability claims, which resulted in 1,744 deaths and $1.7 billion in costs over a five-year period.4

Solutions to handoff miscommunication

The Joint Commission Center for Transforming Healthcare conducted a handoff communications study involving 10 hospitals that used robust process improvement to identify root causes of, and solutions to, inadequate handoffs. Receivers assessed that 37 percent of the handoffs were unsuccessful, and senders estimated that 21 percent of handoffs were unsuccessful. The Joint Commission’s Targeted Solutions Tool (TST) for Hand-off Communications—to which Joint Commission-accredited organizations have free access—can assist in managing this quality improvement process. A study in the March 2016 issue of The Joint Commission Journal on Quality and Patient Safety found that after implementing the TST and its processes for resolving a hospital’s identified root causes, the rate of defective handoffs decreased by 58.2 percent.3

The Sentinel Event Alert lists critical information that should be communicated to the receiver during a handoff, including the following:6

- Sender contact information
- Illness assessment, including severity
- Patient summary, including events leading up to illness or admission, hospital course, ongoing assessment, and plan of care
- To-do action list
- Contingency plans
- Allergy list
- Code status
Patient safety can be affected when the receiver gets information that is inaccurate, incomplete, not timely, misinterpreted, or irrelevant.

• Medication list
• Dated laboratory tests
• Dated vital signs

The Sentinel Event Alert also suggests that hospitals take the following actions to address handoff communication:

• Demonstrate leadership’s commitment to successful handoffs and other aspects of a safety culture.
• Standardize critical content to be communicated by the sender during a handoff—both verbally (preferably face-to-face) and in written form. Make sure to cover everything needed to safely care for the patient in a timely fashion. Standardize tools and methods (forms, templates, checklists, protocols, mnemonics, and so on) to communicate to receivers.
• Conduct face-to-face handoff communication and sign-outs between senders and receivers in locations free from interruptions, and include multidisciplinary team members and the patient and family, as appropriate.
• Standardize training on how to conduct a successful handoff—from both the standpoint of the sender and receiver.
• Use electronic health record capabilities and other technologies—such as apps, patient portals, and telehealth—to enhance handoffs between senders and receivers.
• Monitor the success of interventions to improve handoff communication, and use the lessons to drive improvement.
• Sustain and spread best practices in handoffs, and make high-quality handoffs a cultural priority.

The Sentinel Event Alert can be viewed at www.jointcommission.org/sentinel_event_alert_58_inadequate_handoff_communications.

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
Urethral injuries are commonly divided by anatomic location and mechanism. Anatomically, the male urethra is divided into the posterior urethra (prostatic and membranous portions) and the anterior urethra (bulbar and pendulous portions); both are susceptible to penetrating and, more commonly, blunt trauma. Female urethras, on the other hand, are both shorter and more mobile than their male counterparts, making them less susceptible to trauma. Female urethral injuries are typically seen in the setting of pelvic fractures and occur in less than 6 percent of these fractures.1

**Common causes of injuries**

In contrast, male posterior injuries almost always are associated with pelvic fractures with an incidence of more than 10 percent.2,3 Motor vehicle crashes and falls are the most common causes of pelvic fractures leading to urethral disruptions.3 Although the exact mechanism of injury is not fully elucidated, postmortem studies suggest that shearing forces avulse the membranous urethra (fixed to the pelvis by the urogenital diaphragm) from the bulbous urethra.4

Given its position, the anterior urethra is uniquely susceptible to straddle-type injuries, in which the anterior urethra is crushed between the pubic bone and some other object. Common causes of straddle injuries include motor vehicle collision, bicycle crashes, or a direct kick to the perineum. Unlike posterior urethral injuries, anterior urethral injuries are rarely associated with major concomitant organ trauma and thus may go unrecognized.3,5

Unless associated with major hemorrhage, urethral injuries are rarely life-threatening. However, sequelae including stricture may lead to significant long-term morbidity.

To examine the occurrence of urethral injuries in the National Trauma Data Bank® (NTDB®) research admission year 2015, medical records were searched using the International Classification of Diseases, 10th Revision Clinical Modification codes. Specifically searched were records that contained a code of S37.3 (injury of urethra), S37.30 (unspecified injury of urethra), S37.32 (contusion of urethra), S37.33 (laceration of urethra), or S37.39 (other injury of urethra). A total of 929 records were found, of which 893 records listed a primary type of trauma with 83 percent resulting in blunt injury.
A total of 836 records contained a discharge status, including 456 patients discharged to home, 232 to acute care/rehab, and 106 sent to skilled nursing facilities; 42 died (see Figure 1, this page). Of these patients, 92 percent were men, on average 39.3 years of age, had an average hospital length of stay of 12.3 days, an intensive care unit length of stay of 8.7 days, an average injury severity score of 19.4, and were on the ventilator for an average of 8.9 days. Of those tested for alcohol, more than one-quarter (143 of 519) tested positive.

Nonetheless, urethral injuries are relatively uncommon and were only found in one-tenth of 1 percent of records in this dataset. Pelvic fractures and hematuria can be clues to posterior urethral disruptions, whereas anterior urethral disruptions are typically associated with significant soft tissue bruising.4 To stay out of trouble, it is important to keep a high index of suspicion for urethral trauma, especially when the mechanism of injury involves blunt force to the pelvis.

Throughout the year, we will be highlighting NTDB data through brief reports in the Bulletin. The NTDB Annual Report 2016 is available on the ACS website as a PDF file at facs.org/quality-programs/trauma/ntdb. In addition, information about how to obtain NTDB data for more detailed study is available on our website. To submit your trauma center's data, contact Melanie L. Neal, Manager, NTDB, at mneal@facs.org.

Acknowledgement
Statistical support for this article was provided by Ryan Murphy, Data Analyst, NTDB.

REFERENCES
Ronald. V. Maier, MD, FACS, the Jane and Donald D. Trunkey Endowed Chair in Trauma Surgery, vice-chairman, department of surgery, and professor of surgery, University of Washington School of Medicine, Seattle, was elected President-Elect of the American College of Surgeons (ACS) at the October 25 Annual Business Meeting of Members at Clinical Congress 2017 in San Diego, CA. The First and Second Vice-Presidents-Elect also were elected.

President-Elect
Dr. Maier is highly esteemed for his contributions to trauma surgery, surgical research, and surgical education. In addition to his positions at the University of Washington, he is director, Northwest Regional Trauma Center; surgeon-in-chief; and co-director, surgical intensive care unit (SICU), Harborview Medical Center, Seattle. He also is associate medical staff, University of Washington Medical Center and Seattle Cancer Care Alliance.

Prior to his current positions at the University of Washington School of Medicine, he was assistant professor (1981–1984) and then associate professor of surgery (1984–1990). At Harborview Medical Center, he previously served as associate director, SICU (1981–1983); director, SICU (1983–2001); acting chief of trauma, Northwest Regional Trauma Center; and acting chief of surgery (1992–1994).

A Fellow of the College since 1984, Dr. Maier served as the First Vice-President of the ACS (2015–2016). He has played an active role on several key committees, most notably the Committee on Trauma (COT). He chaired the COT’s Ad Hoc Committee on Prevention (1992–2002) after serving as a member of the committee for three years (1989–1992). He also served on the COT Performance Improvement Committee (1994–2004), Trauma System Committee (1994–2004), Regional Committee Organization (1990–2000), and Publications Committee (1988–2004). He was State Chair (1987–1990) and Chair of Region X (1990–1996) for the COT. Dr. Maier has served on the Program Committee as a Consultant (2007–2017), Vice-Chair (2004–2005), and member (2001–2007). He has served on the Committee on Emerging Surgical Technology and Education (member, 2001; senior member, 2001–2003); the Committee for the Forum on Fundamental Surgical Problems (1991–1994); and the Member Services Liaison Committee (2015–2016). At present, Dr. Maier is a member of the Board of the ACS Professional Association political action committee (ACSPA-SurgeonsPAC).

In addition to the ACS, Dr. Maier has held leadership positions in a number of professional associations, serving as president of the Society of University Surgeons, Shock Society, American Association for the Surgery of Trauma, Surgical Infection Society, International Surgical Society, International Association of Trauma Surgery and Intensive Care, the Halsted Society, the North American Trauma Association, and currently the American Surgical Association. He is a past member of the board of directors (1996–2004) and past-chair (2003–2004) of the American Board of Surgery.

Among his many honors, Dr. Maier is a recipient of the Distinguished Alumnus Award, department of surgery, University of Washington; Lifetime Achievement Award in Trauma Resuscitation for outstanding contributions in trauma science, American Heart Association; Dr. Rodman E. Sheen and Thomas G. Sheen Award for outstanding contributions to the medical profession; Lifetime Service Award, International Association for Trauma Surgery and Intensive Care; the Scientific Achievement Award from the Shock Society; the Flance-Karl Award for seminal contributions in basic laboratory research with clinical surgery applications, American Surgical...
Association; the Parker J. Palmer Courage to Teach Award from the Accreditation Council for Graduate Medical Education; and the Surgeons’ Award for Service to Safety, National Safety Council. He delivered both the Fitts Oration in Trauma at the American Association for the Surgery of Trauma in 2017 and the Scudder Oration in Trauma at the ACS Clinical Congress in 2013. Dr. Maier is a member of the Gold Humanism Honor Society, and has been an elected Fellow of the American Association for the Advancement of Science since 1995 for his research on molecular signaling during proinflammatory innate immunity.

Dr. Maier serves on the editorial boards of several prestigious journals, including World Journal of Surgery; World Journal of Emergency Surgery; Injury; and European Journal of Trauma and Emergency Surgery. He is associate editor of SHOCK and the Journal of Trauma and Acute Care Surgery. Since 1995, Dr. Maier has been a visiting professor or named lecturer on 38 occasions, and has delivered more than 400 lectures on trauma, critical care medicine, and surgical immunology. Dr. Maier has been funded continuously by the National Institutes of Health (NIH) since 1981, totaling more than $20 million in grants, and has been a member and Chair of the NIH Surgery, Anesthesiology and Trauma Study Section.

He graduated magna cum laude with a Bachelor of Science degree from the University of Notre Dame, IN, in 1969. Dr. Maier earned his medical degree at Duke University, Durham, NC, in 1973, where he also completed a research assistantship. He did a clerkship in surgical and gross pathology at St. Bartholomew’s Medical College, University of London, U.K., and an externship in medicine and oncology at Fitzsimmons Army Hospital, Denver, CO. His internship in surgery was conducted at Parkland Memorial Hospital, Southwestern Medical School, University of Texas, Dallas.

Dr. Maier’s surgical residency was performed at the University of Washington, Seattle, and he was chief resident in general surgery at that institution (1977–1978). He did a research fellowship in immunopathology (1978–1980) and was a research associate in immunopathology (1980–1981) at Scripps Clinic and Research Foundation, La Jolla, CA.

**Vice-Presidents-Elect**

Mark C. Weissler, MD, FACS, Past-Chair of the ACS Board of Regents (2014–2015) has been elected First Vice-President-Elect. An otolaryngologist, Dr. Weissler is the Joseph P. Riddle Distinguished Professor, department of otolaryngology–head and neck surgery, and chief, division of head and neck surgery, University of North Carolina (UNC) School of Medicine, Chapel Hill.

An ACS Fellow since 1989, Dr. Weissler is a former ACS Regent (2006–2015), serving as Vice-Chair of the Board of Regents for two years (2012–2014) and Chair for one year (2014–2015). He has served on the ACS Board of Governors (2002–2007) and in other leadership capacities for the College, including: Committee on Ethics (Chair, 2011–2013; consultant, 2013–present; Member, 2009–2011); Chair, Central Judiciary Committee (2011–2012); member and Past-Chair, Advisory Council for Otolaryngology–Head and Neck Surgery (2002–present); and President, North Carolina Chapter of the ACS (2002–2003). He has been a member of the ACS Scholarships Committee (2007–2013); Comprehensive Communications Committee (2008–2017); the Health Information Technology Committee (2011–2017); the Program Committee (Liaison, 2011–2013); and the Health Policy and Advocacy Group (Ex Officio, 2014–2015).
In addition, Dr. Weissler is one of 15 directors of the American Board of Otolaryngology (2012–present), chair of the membership committee of the American Laryngological Association (2012–2014), and a member of numerous other medical and surgical associations.

Dr. Weissler’s practice at UNC focuses on the treatment of head and neck cancer, laser head and neck surgery, and laryngeal/tracheal stenosis. He is a co-investigator on the Carolina Head and Neck Cancer Epidemiology Study (CHANCE)—a population-based, case-control study of head and neck cancer in a 46-county region of North Carolina. The study evaluates the relationship between polymorphisms of diverse genes that, in combination with exposure to tobacco and alcohol, modify the risk of head and neck cancer. His recent work has focused on new treatment paradigms for human papillomavirus-associated oropharyngeal cancer.

Dr. Weissler is a member of the editorial board of ACS Surgery News (2007–present), was a case report associate editor for Otolaryngology–Head and Neck Surgery (2009–2012), and is a reviewer for Head & Neck (1998–present) and Archives of Otolaryngology/Head & Neck Surgery (1994–present).

A graduate of Boston University School of Medicine, MA, six-year medical program in 1980, Dr. Weissler completed two years of general surgery training at Massachusetts General Hospital, Harvard University, in 1982 and a residency in otolaryngology at Massachusetts Eye and Ear Infirmary, Harvard University, in 1985, followed by a fellowship in head and neck oncologic surgery at the University of Cincinnati, OH (1985–1986).

The Second Vice-President-Elect is Phillip R. Caropreso, MD, FACS, a general surgeon from Keokuk, IA. A committed rural surgeon, Dr. Caropreso has practiced in Mason City, IA; Keokuk (1998–2005); and Carthage, IL (2005–2013). Academic positions have included serving on the teaching faculty family practice residency, North Iowa Medical Center, Mason City; adjunct clinical professor of surgery, University of Iowa, Iowa City; and director, general surgery rotation, North Iowa Medical Center.

A Fellow of the ACS since 1979, Dr. Caropreso has been active at the local and national level. He was Chair, Iowa State COT (2002–2008); President of the Iowa Chapter (2004); and ACS Governor (2006–2012), serving on the Board of Governors Committee on Surgical Practices. He has served on the Advisory Council for Rural Surgery (Member, 2012–2014; Vice-Chair, 2014–2016); Advisory Council for General Surgery (Liaison, 2014–2016); and the Advisory Council Chairs (2014–2016). He has been a member of the Comprehensive Communications Committee (2011–2014), Coalition for Quality Geriatric Surgery, and the COT Trauma Systems Consultation and Disaster and Mass Casualty Management Committees. He has led numerous Advanced Trauma Life Support® and Advanced Trauma Operative Management® courses and served as an ACS COT Verification, Review, and Consultation Surveyor.

Among his honors, Dr. Caropreso received the ACS COT Millenium Commitment Award in 2000, the ACS Certificate of Recognition for his service as Web Portal Editor (2014), and the ACS Caropreso Rural Surgery Distinguished Service Award (2014).

Dr. Caropreso graduated cum laude from Seton Hall University, South Orange, NJ, and earned his medical degree at State University of New York, Health Science Center, Syracuse, in 1972. He completed his surgical training in 1976 at Polyclinic Hospital, Harrisburg, PA.
New Regents, Board of Governors Executive Committee members elected

The Board of Governors (B/G) of the American College of Surgeons (ACS) elected two new members of the Board of Regents at the Annual Business Meeting of Members, October 25, in San Diego, CA. In addition, new B/G Executive Committee Members were elected.

**Regents**

**Gary L. Timmerman, MD, FACS,** is a general surgeon from Sioux Falls, SD, where he is professor and chair, department of surgery, University of South Dakota (USD) Sanford School of Medicine, and active staff at Sanford USD Medical Center and Royal C. Johnson Veterans Affairs Hospital. He also serves on several committees at Sanford, including the medical management quality, multidisciplinary cancer center, physician-advisory, and surgery-ops committees.

A Fellow of the College since 1992, Dr. Timmerman has exhibited loyal service to the ACS, starting with his active role on the Committee on Young Surgeons (member, 1999–2005; and Chair, 2004–2005). Most recently, he was Chair, ACS B/G Executive Committee (2013–2014) after serving as Vice-Chair for two years (2011–2013). He was an ACS Governor (2008–2013) and served on the Nominating Committees for Fellows and Governors (2005–2010). He also has served on the Committee on Education (2003–2008). At present, Dr. Timmerman is a member of the Advisory Council for Rural Surgery, the Board of the ACS Professional Association political action committee (ACSPA-SurgeonsPAC), and the Health Policy and Advocacy Group. He is a Past-President of the South Dakota Chapter of the ACS (1997–1998).

**Douglas E. Wood, MD, FACS, FRCSEd,** is the Henry N. Harkins Professor and Chair, department of surgery, University of Washington. His clinical and academic interests are in thoracic oncology and tracheobronchial pathology and he has developed the University of Washington as a leading thoracic surgery center and training program in cardiothoracic surgery.

Dr. Wood has been a Fellow of the College since 1995. He has played an active role on the Advisory Council for Cardiothoracic Surgery (2007–2013) and the Commission on Cancer (CoC), including serving on the CoC Accreditation Committee (2010–2016). Dr. Wood has been involved in the leadership of cardiothoracic surgery professional organizations, previously serving as president of the Society of Thoracic Surgeons and president.
of the Western Thoracic Surgical Association. He has served as director of the American Board of Thoracic Surgery and chair of the Accreditation Council for Graduate Medical Education Residency Review Committee for Thoracic Surgery. Dr. Wood is president of the Thoracic Surgery Foundation, president of the Cardiopulmonary Surgery Network (CTSNet), and vice-chair of the American Cancer Society National Lung Cancer Roundtable.

In addition, the following individuals have been reappointed to three-year terms on the Board of Regents:

• **James K. Elsey, MD, FACS**, a general and vascular surgeon in private practice and visiting professor of surgery, Emory University School of Medicine, Atlanta, GA

• **Gerald M. Fried, MD, FACS, FRCSC**, Edward W. Archibald Professor and Chairman, department of surgery, McGill University and surgeon-in-chief, McGill University Health Centre Hospitals, Montreal, QC

• **B. J. Hancock, MD, FACS, FRCSC**, associate professor, departments of surgery and pediatrics and child health, University of Manitoba; and pediatric surgeon and pediatric intensivist, Children’s Hospital of Winnipeg, MB

• **Lenworth M. Jacobs, Jr., MD, MPH, FACS**, professor of surgery, University of Connecticut; and director, Trauma Institute, Hartford Hospital, CT

**B/G Executive Committee**

The B/G reelected **Diana L. Farmer, MD, FACS, FRCS**, to serve as the Chair of the Executive Committee. Dr. Farmer is the Pearl Stamps Stewart Professor of Surgery and chair, department of surgery, University of California Davis Health System, Sacramento.

**Steven C. Stain, MD, FACS**, has been reelected to serve as Vice-Chair of the Executive Committee. He is the Henry and Sally Shaffer Chair and Professor, department of surgery, Albany Medical Center, NY.

The newly elected Secretary of the B/G Executive Committee is **Daniel L. Dent, MD, FACS**, Distinguished Teaching Professor, general surgery residency program director, and professor of surgery, University of Texas Health School of Medicine, San Antonio.

Two surgeons have been elected to serve one-year terms on the B/G Executive Committee: **David A. Spain, MD, FACS**, The David L. Gregg, MD, Professor and Chief of Acute Care Surgery, Stanford Health Care, CA; and **Therese M. Duane, MD, MBA, CPE, FACS, FCCM**, professor of surgery, University of North Texas, and chief of surgery and surgical specialties, the John Peter Smith Health Network Fort Worth, TX.

Two surgeons also join the Executive Committee for two-year terms: **David J. Welsh, MD, FACS**, a general surgeon in private practice in Batesville, IN; and **Terry L. Buchmiller, MD, FACS**, a pediatric surgeon at Boston Children’s Hospital, and associate professor of surgery, Harvard Medical School, Boston, MA.

**Dr. Dent**  **Dr. Spain**  **Dr. Duane**  **B. J. Hancock**  **Dr. Farmer**  **Lenworth M. Jacobs, Jr.**  **Steven C. Stain**  **Dr. farmer**  **B. J. Hancock**  **Dr. Farmer**  **Lenworth M. Jacobs, Jr.**  **Dr. Spain**  **Dr. Wood**  **Gerald M. Fried**  **Dr. Farmer**  **B. J. Hancock**  **Dr. Farmer**  **Lenworth M. Jacobs, Jr.**  **Dr. Spain**
Feel the power of volunteerism and make a difference in the world.

The tribal leaders of a Mundari cattle camp in Terekeka, South Sudan, stand proudly with Barclay T. Stewart, MD, MPH, PhD (center). The program Dr. Stewart ran was responsible for assessing the burden of neglected tropical diseases and delivering drug treatment to millions of people across the war-torn country.

Making a difference in the world starts with one step forward. One personal challenge. One decision to give back.

facs.org/ogb
The American College of Surgeons (ACS), in association with Pfizer, Inc., will begin accepting nominations December 4, 2017, for the 2018 Surgical Volunteerism Award(s) and Surgical Humanitarian Award. All nominations must be received by February 28, 2018.

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

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

Humanitarian Award
The ACS/Pfizer Surgical Humanitarian Award recognizes an ACS Fellow whose career has been dedicated to ensuring the provision of surgical care to underserved populations without expectation of commensurate reimbursement. This award is intended for surgeons who have dedicated a significant portion of their surgical careers to full-time or near full-time humanitarian efforts, rather than routine surgical practice. Examples include a career dedicated to missionary surgery, the founding and ongoing operations of a charitable organization dedicated to providing surgical care to the underserved, or a retirement characterized by surgical volunteer outreach.

Having received compensation for this work does not preclude a nominee from consideration and, in fact, may be expected based on the extent of the professional obligation.

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

Nominations
The following conditions apply to the nominations process:

• Self-nominations are permissible but require at least one outside letter of support
• Renomination of previous nominees is acceptable but requires completion of a new application

Plan to spend a minimum of 30 minutes completing the application form. For the nominee to have a fair review, detailed information is required, including the following:

• Demographic information about the nominee and nominator.
• Details about the nominator’s relationship to the nominee, along
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100+ years
The American College of Surgeons Professional Association (ACSPA) and its political action committee (ACSPA-SurgeonsPAC) raised more than $460,000 from more than 1,100 individual members and College staff January 1–November 6. The SurgeonsPAC also disbursed more than $327,000 to more than 80 congressional candidates, leadership PACs, and political campaign committees. Distributions were made in line with congressional party ratios: 59 percent to Republicans and 41 percent to Democrats.

In addition to raising funds to elect and reelect congressional candidates who support a pro-surgeon, pro-patient agenda, ACSPA-SurgeonsPAC supported 12 physician members of Congress, and supporters and staff attended more than 160 fundraisers, candidate meetings, and health care industry events and organized several physician community events for key members of Congress and political campaign committees.

In addition to hosting events at the ACS Leadership and Advocacy Summit and annual Clinical Congress, the ACSPA-SurgeonsPAC conducted targeted fundraising campaigns and used other tools, including health professional PAC benchmarking, an annual dues insert, and peer-to-peer outreach to maintain and grow its contributor base. SurgeonsPAC supporters and staff also participated in the physician and dentist candidate workshop and in-district PAC check deliveries.

To learn more about SurgeonsPAC fundraising or disbursements, visit SurgeonsPAC.org (login required using facs.org username and password) or contact Katie Oehmen, Manager, ACSPA-SurgeonsPAC and Grassroots, at 202-672-1503 or koehmen@facs.org. For more information about the College’s legislative priorities, visit SurgeonsVoice.org.

**Note**

Contributions to ACSPA-SurgeonsPAC are not deductible as charitable contributions for federal income tax purposes. Contributions are voluntary, and all members of the ACSPA have the right to refuse to contribute without reprisal. Federal law prohibits ACSPA-SurgeonsPAC from accepting contributions from foreign nations. By law, if your contributions are made using a personal check or credit card, ACSPA-SurgeonsPAC may only use your contribution to support candidates in federal elections. All corporate contributions to ACSPA-SurgeonsPAC will be used for educational and administrative fees of ACSPA and other activities permissible under federal law. Federal law requires ACSPA-SurgeonsPAC to use its best efforts to collect and report the name, mailing address, occupation, and the name of the employer of individuals whose contributions exceed $200 in a calendar year. ACSPA-SurgeonsPAC is a program of the ACSPA, which is exempt from federal income tax under section 501c(6) of the Internal Revenue Code.
Physicians, nonphysician practitioners, and other Medicare Part B suppliers must enroll in the Medicare program to be paid for covered services furnished to Medicare beneficiaries. Providers must make their 2018 Medicare participation determination by December 31. As this deadline approaches, many providers are considering their options with respect to Medicare participation and the implications of their decision. The American College of Surgeons provides guidance to assist Fellows in navigating their contractual relationships with Medicare.

**Medicare participation options for surgeons**

Three options are available to surgeons who participate in Medicare Part B:

- **Sign a participation (PAR) agreement.** Providers who choose to participate in the Medicare program agree to always accept Medicare claims assignment for all covered services furnished to Medicare beneficiaries.

- **Elect nonparticipation (non-PAR).** Providers who select the non-PAR option may choose to either accept or not accept Medicare assignment of claims on a case-by-case basis. Providers who do not accept Medicare assignment may bill patients for more than the Medicare-allowed amount for a particular service.

- **Become a private contracting physician (opt out).** Providers who opt out of Medicare participation must bill their patients directly and forego any Medicare reimbursement.

Participating providers are contractually obligated to accept the Medicare-approved amount as payment in full for all covered services rendered to Medicare patients. Participating providers may collect only the Medicare deductible and copayment from any beneficiary.

To finalize enrollment as a Medicare participant, providers must submit the Medicare Participating Physician or Supplier Agreement (Form CMS-460, available at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS460.pdf) to the appropriate Medicare Administrative Contractor (MAC). Providers have 90 days from when the CMS-460 form is submitted to decide whether to maintain their participation status or revoke their enrollment. Once a provider becomes a Medicare participant, he or she must remain a participant until the following annual enrollment period.

MACs conduct an annual open participation enrollment period in order to offer providers an opportunity to make their calendar year Medicare participation decision. During open enrollment, which typically occurs from mid-November through December 31 each year, providers can choose to enroll in the Medicare program, maintain their participation status, or terminate their participation. Participation agreements will be in effect from January 1 to December 31, 2018, and cannot be changed once open enrollment has ended.

**Steps to participation**

The steps for achieving Medicare participation are as follows:

1. Obtain a national provider identifier (NPI). Providers must be assigned an NPI before enrolling in the Medicare program. Visit the National Plan and Provider Enumeration System website (nppes.cms.hhs.gov/#/) to apply for an NPI.

2. Complete the proper Medicare enrollment application. Once an NPI is obtained, providers can submit either a paper enrollment...
Providers must make their 2018 Medicare participation determination by **December 31**. As this deadline approaches, many providers are considering their options with respect to Medicare participation and the implications of their decision.

3. Await application processing. MACs screen and verify all provider information on the enrollment application. Once the applicable MAC approves an application, providers will receive an approval letter and will be designated as “approved” on PECOS.

4. Keep enrollment information up to date. Providers must revalidate their Medicare enrollment record information every three to five years using PECOS or the appropriate paper application (Application CMS-855I, as above). Providers who are actively enrolled in Medicare may check the Medicare Revalidation Lookup Tool (https://data.cms.gov/revalidation) to find their revalidation due date. In the event that a provider experiences a change of information (such as change of practice address or ownership) after their revalidation due date, they should update their record in PECOS within 30 days of the reportable event.

For more information about Medicare participation; ways to apply for, revalidate, or make changes to Medicare enrollment; and more, visit the ACS website at facs.org/advocacy/regulatory/medicare-enrollment or contact the ACS Division of Advocacy and Health Policy at regulatory@facs.org.

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

100+ years
Making quality stick:  
*Optimal Resources for Surgical Quality and Safety*

The SQSC and credentialing and privileging processes ensure sustainability of standards

**Editor’s note:** In July, the American College of Surgeons (ACS) released *Optimal Resources for Surgical Quality and Safety*—a new manual that is intended to serve as a trusted resource for surgical leaders seeking to improve patient care in their institutions and make quality stick. Each month, the *Bulletin* will highlight some of the salient points made throughout “the red book.”

To ensure that they have the right infrastructure in place and competent health care professionals on staff, hospitals should have a Surgical Quality and Safety Committee (SQSC) and standardized credentialing and privileging processes in place. The SQSC should be chaired or co-chaired by the Surgical Quality Officer described in the November issue of the *Bulletin*. This committee oversees myriad activities depending on local characteristics and factors. Specific SQSC responsibilities listed in the quality manual include the following:

- Monitor surgical mortality and adverse event rates
- Address clinical practice variations
- Establish quality and safety standards, guidelines, and surgery-related policies
- Monitor primary data and data reports to identify consistent, cross-cutting surgical issues
- Use other sources of information, including direct observation, to evaluate quality, safety, and reliability
- Develop, align, and implement corrective action plans
- Monitor compliance with regulations
- Foster, lead, and implement culture improvement activities

While the SQSC focuses on the institutional infrastructure, the credentialing and privileging processes ensure that the surgeons who practice in health care institutions are trained and competent to provide safe, reliable care. The credentialing process uses objective criteria, such as board certification, to determine whether a health care professional has the education, experience, and skills needed to practice in the institution. Through the privileging process, institutions designate the specific surgical procedures that a surgeon may perform. The manual outlines the criteria that should be evaluated in the credentialing and privileging processes and the intervals at which a surgeon’s privileges should be evaluated. It also defines which individuals and committees should lead the credentialing and privileging processes.

Be sure to read next month’s overview of the quality manual, which will focus on creating a culture of safety and high reliability and describe the infrastructure needed to create and sustain this environment. *Optimal Resources for Surgical Quality and Safety* is available for $44.95 per copy for orders of nine copies or fewer and $39.95 for orders of 10 or more copies at web4.facs.org/eBusiness/ProductCatalog/product.aspx?ID=853.
Call for nominations for the ACS Board of Regents and ACS Officers-Elect

The American College of Surgeons (ACS) 2018 Nominating Committee of the Fellows (NCF) and the Nominating Committee of the Board of Governors (NCBG) will be selecting nominees for leadership positions in the College as follows.

**Call for nominations for Officers-Elect**
The 2018 NCF will select nominees for the three Officer-Elect positions of the ACS: President-Elect, First Vice-President-Elect, and Second Vice-President-Elect. The deadline for submitting nominations is **February 23, 2018**.

**Criteria for consideration**
The NCF will use the following guidelines when considering potential candidates:

- Nominees must be loyal members of the College who have demonstrated outstanding integrity and an unquestioned devotion to the highest principles of surgical practice.
- Nominees must have demonstrated leadership qualities, such as service and active participation on ACS committees or in other components of the College.
- The ACS encourages consideration of women and underrepresented minorities for all leadership positions.

All nominations must include the following:

- A letter/letters of nomination
- A personal statement from the candidate detailing his or her ACS service and interest in the position (for President-Elect position only)
- A current curriculum vitae (CV)
- The name of one individual who can serve as a reference

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

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

Nominations must be submitted to officerandbrnominations@facs.org. If you have any questions, contact Emily Kalata at 312-202-5360 or ekalata@facs.org.

**Call for Nominations for Board of Regents**
The 2018 NCBG will select nominees for pending vacancies on the Board of Regents to be filled at Clinical Congress 2018. The deadline for submitting nominations is **February 23, 2018**.

**Criteria**
The NCBG will use the following guidelines when considering potential candidates:

- Nominees must be loyal members of the College who have demonstrated outstanding integrity along with an unquestioned devotion to the highest principles of surgical practice.
- Nominees must have demonstrated leadership qualities, such as service and active participation on ACS committees or in other components of the College.
- The ACS encourages consideration of women and underrepresented minorities for all leadership positions.
- The NCBG recognizes the importance of the Board of Regents representing all who practice surgery in both academic and community practice, regardless of practice location or configuration.
Nominations are open to surgeons of all specialties, but particular consideration will be given this nomination cycle to those in the following specialties:

- Burn and critical care surgery
- Gastrointestinal surgery
- General surgery
- Surgical oncology
- Transplantation
- Trauma
- Vascular surgery

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

All nominations must include the following:

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

Further details
Entities such as surgical specialty societies, ACS Advisory Councils, ACS Committees, and ACS chapters that would like to provide a letter of nomination must provide at least two nominees and a description of their selection process along with the total list of applicants reviewed.

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

Nominations may be submitted to officerandbrnominations@facs.org. If you have any questions, contact Emily Kalata at 312-202-5360 or ekalata@facs.org.

For information only, the current members of the Board of Regents who will be considered for re-election are (all MD, FACS): John L. D. Atkinson, James C. Denneny III, Timothy J. Eberlein, Henri R. Ford, Enrique Hernandez, L. Scott Levin, Linda Phillips, Anton A. Sidawy, Beth H. Sutton, and Steven D. Wexner.

Carter C. Lebares, MD; Ekaterina V. Guvva; Nancy L. Ascher, MD, PhD, FACS; et al found that high levels of burnout, severe stress, and distress symptoms are experienced in general surgery training. In this national cohort, higher dispositional mindfulness was associated with lower risk of burnout, severe stress, and distress symptoms, supporting the potential of mindfulness training to promote resilience during surgery residency.

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Nevada Chapter meeting covers a range of hot topics in surgery

The Nevada Chapter of the American College of Surgeons (ACS) hosted its first all-day statewide meeting October 7 in Las Vegas. The day started and ended with Stop the Bleed® training sessions. Deborah Kuhls, MD, FACS, FCCM, President of the Nevada Chapter, emphasized the importance of continuing annual statewide meetings. She also praised surgeons for their comradery and care of those injured in the October 1 shooting in Las Vegas and highlighted the College’s initiatives in firearm injury prevention and advocacy. James Dylan Curry, MD, FACS, Chapter President-Elect; Jennifer Baynosa, MD, FACS, Chapter Secretary-Treasurer; and Christopher McNicoll, MD, Resident and Associate Society Representative, led several sessions.

The program included an opioid panel composed of Ross Goldberg, MD, FACS, chief of surgery, University of Arizona College of Medicine, Phoenix; Dr. McNicoll; and Jessica Johnson, Southern Nevada Health District, as well as representatives from the office of Gov. Brian Sandoval (R)—John DiMuro, DO, Medical Officer for the State of Nevada, and Elyse Monroy, Health and Human Services Policy Analyst. Wydell Williams, Jr., MD, FACS, a general surgeon from Las Vegas, spoke on unconscious bias among surgeons and patients.

Other program highlights included a panel discussion on gallbladder disease and surgical complications moderated by Charles R. St. Hill, MD, FACS, assistant professor of surgery, division of surgical oncology, department of surgery, University of Nevada, School of Medicine; Surgical Jeopardy; and research presentations. Research paper competition winners in the medical student category were Jonathan Habashy, first-place winner, and Ashley Tarchione, second-place winner, both from the University of Nevada Reno School of Medicine. Research paper winners in the general surgery category were Marlo Asis, MD, postgraduate year (PGY)-3, University of Nevada Las Vegas School of Medicine, in first place and Hossein Solimany, MD, PGY-2, Mountain View Hospital, in second place.

The Nevada Committee on Trauma Resident Paper Competition winners were Allison McNickle, MD, PGY-7, University of Nevada Las Vegas School of Medicine, in first place and Hossein Solimany, MD, PGY-2, Mountain View Hospital, in second place.

The Nevada Committee on Trauma Resident Paper Competition winners were Allison McNickle, MD, PGY-7, University of Nevada Las Vegas School of Medicine, first-place winner, and Dr. McNicoll
Massachusetts Chapter holds surgical advocacy summit at the Massachusetts State House

The Massachusetts Chapter of the American College of Surgeons (MCACS) held its fifth Advocacy Day October 16 in the Great Hall of Flags of the Massachusetts State House. More than 80 medical personnel, government officials, law enforcement officials, and legislators and their staffs attended. The program was titled The Massachusetts Opioid Epidemic: The Surgeons’ Response to a Public Health Crisis. Peter T. Masiakos, MD, FACS, director, pediatric trauma services, Massachusetts General Hospital, Boston, moderated a panel of speakers, including Sarah E. Wakeman, MD, medical director, Substance Use Disorders Initiative, Massachusetts General Hospital; Haytham M. Kaafarani, MD, MPH, director of patient safety and quality, trauma, and emergency surgery, Massachusetts General Hospital; Michael Reinhorn, MD, FACS, general surgeon, Newton Wellesley Hospital; and Edward M. Kwasnik, MD, FACS, vascular surgeon, Brigham and Women's Surgical Associates at South Shore, Weymouth.

Boston Police Commissioner William Evans spoke on the effect of the opioid crisis on the local population. Allison F. Bauer, JD, LICSW, Director, Bureau of Substance Addiction Services, Department of Public Health, spoke on the role of the surgeons on the front line of the epidemic. Anne C. Larkin, MD, FACS, UMass Memorial Medical Center, Worcester, MCACS President, presented the fifth John Collins Warren Award to Massachusetts Lt. Gov. Karyn Polito, who accepted the award on behalf of Gov. Charlie Baker. Christopher Johnson, State Affairs Associate, ACS Division of Advocacy and Health Policy, concluded the morning by preparing attendees for afternoon visits with their legislators.

Bangladesh Chapter hosts program for surgical trainees

The newly chartered Bangladesh Chapter of the American College of Surgeons hosted an event for postgraduate surgical trainees September 17 in Dhaka. The meeting was well attended by approximately 150 faculty and participants. Prof. Mohammed Shadruul Alam, MB, BS, MS, FACS, FCPS, professor of pediatric surgery, Shaheed Suhrawardy Medical College and Hospital, Dhaka, was the master of ceremonies for the event. The program centered on Updates in Surgical Disciplines and covered several topics, including abdominal wound closure, oculoplasty, aesthetic surgery, ventral hernia, stem cell revascularization, obstructive uropathy in children, joint replacement, and pediatric vascular anomalies. Participants encouraged the leaders of the Bangladesh Chapter to conduct similar events in the future.

Dr. Townsend participates in China-Hong Kong Chapter ATLS program

Courtney M. Townsend, Jr., MD, FACS, then-President of the ACS, participated in the China-Hong Kong Chapter’s presentation of the Advanced Trauma Life Support (ATLS®) Provider Course September 22.
at the University of Hong Kong Li Ka Shing Faculty of Medicine. In addition to attending the course, Dr. Townsend met with the faculty. This year marked the 20th anniversary of ATLS in Hong Kong. The inaugural ATLS Course in Hong Kong took place in January 1997 under the auspices of the ACS Committee on Trauma. As of September 2017, a total of 143 Provider Courses have taken place in Hong Kong and more than 2,200 physicians from various specialties and hospitals have been trained. The China-Hong Kong Chapter promulgated ATLS in mainland China in 2016 in response to the great demand for trauma training.

The chapter hosted a reception at the Hong Kong Club in honor of Dr. Townsend during his visit.

### Uruguay Chapter hosts annual chapter meeting

The Uruguay Chapter of the ACS hosted a chapter meeting September 23, which 67 local surgeons and residents attended. Invited international guests included Alberto R. Ferreres, MD, PhD, FACS(Hon), FASA(Hon), professor of surgery, University of Buenos Aires, Governor, Argentina Chapter, and Chair, ACS International Chapter Region XIV; and Owen Korn, MD, FACS, professor of surgery, Universidad de Chile, and Past-President, Chile Chapter.

The Chapter Board, led by President Roberto Taruselli, MD, FACS, organized the event, which began with a welcome and opening speech by Prof. Gonzalo Estapé, MD, FACS, past-Governor of the Uruguay Chapter, briefly summarizing the history of the chapter and highlighting its formation in 2003.

Following the welcoming address, Dr. Ferreres provided lectures on Error in Surgery, Medico-Legal Implications of Surgical Practice, and Informed Consent in Surgical Practice. The second lecturer of the event was Dr. Korn, who gave a well-received talk on The Complicated Patient. The final lecture of the event was titled Surgical Aids and Error in Surgery.

The event concluded with a panel session, which provided an opportunity for participants to engage in a discussion with the invited international guests.
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Boston, MA
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New Jersey Chapter
December 2
Iselin, NJ
Contact: Andrea Donelan, njsurgeons@aol.com, www.nj-acs.org

Brooklyn-Long Island Chapter
December 6
Uniondale, NY
Contact: Teresa Barzyz, Acsteresa@aol.com, www.bliacs.org

Trinidad and Tobago Chapter
December 10
Port of Spain, Trinidad and Tobago
Contact: Dr. Dilip Dan, dilipdan5@gmail.com

Northern California Chapter
April 6–7
Berkeley, CA
Contact: Christina McDevitt, nccacs@att.net, www.nccacs.org

Ohio Chapter
April 6–7
Cincinnati, OH
Contact: Emily Maurer, emaurer@facs.org, www.ohiofacs.org

South Texas Chapter
February 22–24
Houston, TX
Contact: Janna Pecquet, janna@southtexasacs.org, www.southtexasacs.org

Puerto Rico Chapter
February 22–24
San Juan, PR
Contact: Aixa Velez-Silva, acspuertoricochapter@gmail.com, www.acspuertoricochapter.org

South Texas Chapter
February 22–24
Houston, TX
Contact: Janna Pecquet, janna@southtexasacs.org, www.southtexasacs.org

Montana-Wyoming and Idaho Chapters
January 26–28
Big Sky, MT
Contact: Gyan Sportsman, csportsman21@outlook.com, Montana and Wyoming: acschapter.wixsite.com/mtwyacs
Idaho: acschapter.wixsite.com/idacs

Peru Chapter
March 14–16
Lima, Peru
Contact: Dr. Herrera-Matta, scgperu@gmail.com

APRIL

Japan Chapter
April 5–7
Tokyo, Japan
Contact: Dr. Yoshida Kazuhiko, kaz-yoshida@jikei.ac.jp

MARCH

Peru Chapter
March 14–16
Lima, Peru
Contact: Dr. Herrera-Matta, scgperu@gmail.com

FEBRUARY

Puerto Rico Chapter
February 22–24
San Juan, PR
Contact: Aixa Velez-Silva, acspuertoricochapter@gmail.com, www.acspuertoricochapter.org

South Texas Chapter
February 22–24
Houston, TX
Contact: Janna Pecquet, janna@southtexasacs.org, www.southtexasacs.org

FUTURE CLINICAL CONGRESSES

2018
October 21–25
Boston, MA

2019
October 27–31
San Francisco, CA

2020
October 4–8
Chicago, IL

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