



Governors' Committee on Surgical Practice in Hospitals and Ambulatory Settings:

An update

by R. Phillip Burns, MD, FACS

The Board of Governors' Committee on Surgical Practice in Hospitals and Ambulatory Settings remains active in its evaluation of multiple issues influencing surgical practice. A few of the prominent issues discussed and evaluated by the committee include the following: continued evaluation and promotion of patient safety efforts, continued diligence in analysis of surgical workforce needs nationwide, support for enhanced surgical quality evaluation in hospitals, and changes in surgical practice structure.

Patient safety

The committee has worked diligently over the last two years to develop an enhanced, and more detailed, ACS Statement on Surgical Patient Safety. The finalized proposal was approved by the ACS Board of Governors in October 2008 and subsequently approved by the Board of Regents.¹ Many individuals on the committee contributed to the work that led to the final document, and we were provided additional assistance by some past

members of the committee who have extensive experience and expertise in this area.

The approved statement expands efforts to improve patient safety in several ways. It continues to emphasize the significance of accurate surgical site selection during the preoperative, time-out, and operative phases of the procedure in an effort to further reduce the incidence of this surgical complication. Additionally, the updated statement goes further than the previous version and emphasizes the need for improvement in communication between all members of the operative team in the preoperative, intraoperative, and immediate postoperative stages.

The new statement offers some flexibility for individual institutional variation in regard to adopted standards for implementation of this improved communication scenario. For example, a previously tested communication outline by the World Health Organization has functioned well in other institutions and could be used as a starting point in most operating rooms.² Recent research

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has indicated significant improvement in patient safety as well as operating room effectiveness and efficiency when these steps are incorporated as a standard operating room algorithm of care.³ The ACS statement provides the added suggestion that defined points, or stages, of some operative procedures should be designated as “no hand-off time”—when certain members of the team will not be rotated—to further enhance efficient and effective teamwork and therefore improve results. The statement also incorporates previous recommendations by both the ACS and The Joint Commission regarding safety issues such as

double gloving, blunt-tip suture needles, neutral zones, and protective sharp device use.⁴

Surgical workforce

For three years, this committee has discussed and expressed their concern about current, and future, surgical workforce availability. This concern has been shared with, and championed by, the Executive Committee of the Board of Governors, the Board of Regents, and the ACS leadership. It is encouraging to the committee that the ACS leadership has intensified efforts to gain more accurate information regarding surgical workforce demographics with initiatives such as the ACS Health Policy Research Institute. It is well known that the surgical workforce shortfall is having a strong impact on adequate health care in rural areas, but many urban centers are now suffering from the lack of availability of surgeons willing to take emergency call. This problem cannot be easily corrected—and the fact that the ACS leadership is making this issue a priority is encouraging. Our committee will continue to contribute to the discussion and study of this problem.

Surgical practice structure

Members of the committee continue to report significant change in the surgical practice structure's business model across the country. The number of surgeons who currently work in an employment model appears to be growing rapidly as many are converting from time-honored mod-
continued on page 47

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COMMITTEE ON SURGICAL PRACTICE..., from page 23

els of private practice to a variety of institutional/hospital employee models. This rapid shift in the business model for a growing number of College members has been acknowledged by the Board of Governors' Executive Committee. Some members are concerned that such shifts may ultimately become a threat to the structure and, possibly, the long-term viability of the ACS. Hopefully, further discussion, study, and ACS program presentations will highlight and elucidate the magnitude and potential influence of such change. It is important to generate ongoing suggestions for dialogue topics between the Board of Governors and the Board of Regents to continue further collaborative evaluation of this issue.

Quality/NSQIP

The committee continues to address issues of transparency in evaluation of surgical care outcomes through peer-reviewed, surgeon-driven evaluation models such as the National Surgical Quality Improvement Program (NSQIP). The

public image of the surgical community will be significantly enhanced by championing efforts to assess surgical quality, with the anticipation that those measures can be used to improve surgical care and outcomes. The public—and especially our patients—deserve to know that, both as a group and as individuals, surgeons are responding to transparency issues with programs that analyze shortcomings and provide a road map for improved surgical care. [Ω](#)

References

1. Statement on surgical patient safety. *Bull Am Coll Surg.* 2009;94(1):46-47.
2. World Alliance for Patient Safety. *WHO Guidelines for Safe Surgery.* Geneva, Switzerland: World Health Organization; 2008.
3. Haynes AB, Weiser TG, Berry WR, et al. A surgical safety checklist to reduce morbidity and mortality in a global population. *N Engl J Med.* 2009;360:491.
4. Statement on sharps safety. *Bull Am Coll Surg.* 2007;92(10):34-37.