

# ACS/Bulletin

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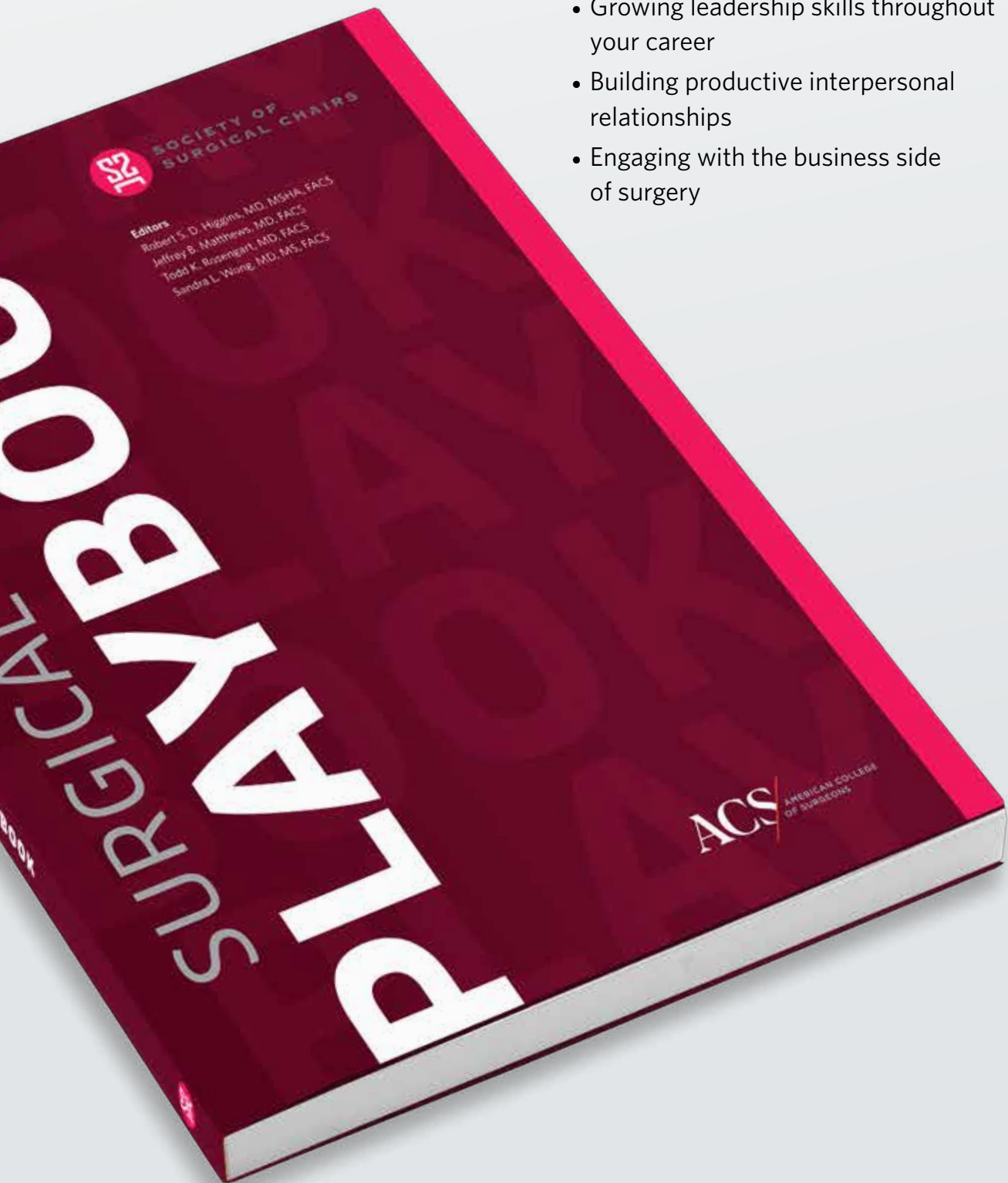
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# The Power of Unity: Collaborating across Specialties within the House of Surgery

Patricia L. Turner, MD, MBA, FACS

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BEFORE ASSUMING STAFF LEADERSHIP roles in the ACS, I was in academic surgical practice, focusing on minimally invasive surgery, teaching residents, and conducting outcomes research. The ACS has been one of my key professional societies since I was a member of the Resident and Associate Society.

As I shifted to a staff position in ACS leadership, I have maintained a faculty appointment and devoted more of my time to topics affecting all surgeons in all specialties, acknowledging that our 87,000 members need different things from the ACS and may need different things over the course of their careers. Those topics can be as diverse as innovation in a particular specialty, career development, practice management, humanitarian work, policy development, reimbursement, quality improvement, surgeon well-being, collaboration, and more. In other words, my focus has broadened

to supporting colleagues and their patients across the entire House of Surgery.

Striving to provide the highest-quality healthcare in every practice setting requires mobilizing the largest coalitions of our profession. Indeed, the ACS cannot Heal All with Skill and Trust, as our motto states, unless we include every kind of surgeon in the work of the College. Regardless of specialty or subspecialty, we all can maximize our impact on our profession by collaborating to advance initiatives that enhance the practices of all surgeons and every patient.

This past month, I was pleased to join many of our members at the Leadership & Advocacy Summit in Washington, DC. There, surgeons from a variety of specialties, locations, and practice configurations discussed issues affecting the surgical workforce, including proposed legislation banning noncompete agreements, reducing student loan debt, and eliminating cuts to the Medicare physician payment program.

The summit also included talks focused on leadership, resiliency, and performance-based teaching. The 3-day event ended with more than 260 surgeons meeting with elected officials and their staff members on Capitol Hill to discuss the surgical issues affecting their practices and their patients. As these surgeons' efforts demonstrate, assembling coalitions does enhance our ability to drive the healthcare conversation nationally. See the summit recap on pages 56–63.

The College's advocacy work also extends to the Surgical Care Coalition, a group of multispecialty professional associations that collectively represents 150,000 surgeons and anesthesiologists in the US. The ACS helped formally found the Coalition



in 2020, after years of informal discussions to advocate for public policy that will improve the quality of care for all patients.

The value of working across specialties extends well beyond advocacy. When members of the Board of Regents were recently asked about their experiences with collaboration across specialties, many pointed out that working together is an essential way to advance our goals as surgeons.

ACS Past-President and vascular surgeon Julie A. Freischlag, MD, FACS, DFSVS, said, “Working on the Board of Regents collaborating with those in other surgical specialties has identified many opportunities to work together on similar issues and concerns, as well as outlined unique needs and future strategies in each field.”

General surgeon Annesley W. Copeland, MD, FACS, pointed out that clinical care is a prime example of the essential nature of cross-specialty collaboration. “As a former Army surgeon who works at the Walter Reed National Military Medical Center (now as a civilian), I have extensive experience in collaborating across the surgical subspecialties in the care of our wounded warriors. ENT, ophthalmology, and plastic surgery are frequently consulted in their care, in addition to the ‘workhorse’ specialties of orthopaedics and general surgery. Every subspecialty brings a unique and valuable perspective, and the care of these patients is enormously rewarding.”

Regent Fabrizio Michelassi, MD, FACS, who is the Clinical Congress Program Chair, highlighted Clinical Congress as a great example of collaboration across specialties. “Care of complex patients may require input from different specialties, and this approach is stressed in the multidisciplinary panels at the annual Clinical Congress. As evidence of their value and pertinence to our surgeons and Fellows, these panels are always well attended.”

Within the College, more than half of our 87,000 members represent a specialty other than general surgery. As surgeons, we are leaders in our own right and the engine that drives most hospitals. Together, specialists and subspecialists have far greater impact than each specialty might have alone. We know that we are stronger in coalitions with all specialties represented.

As Regent and urological surgeon Anthony Atala, MD, FACS, explained, “As our surgery ecosystem

continues to evolve and we face new challenges, the role of the College as the nexus for all specialties becomes even more relevant—we can accomplish more working together.”

## Quality and Safety Conference

The ACS’s Quality Improvement (QI) Programs are also key offerings that can benefit surgeons, surgical teams, and patients. All 18 ACS Quality Programs will be featured at the Quality and Safety Conference, July 10–13, in Minneapolis, Minnesota. Join us to learn more about improving QI for the benefit of all surgeons and every patient we treat.

Sessions will address engaging key community stakeholders, centering patient experience, helping residents serve as patient advocates, and handling the fundamentals of QI. We will also offer courses and sessions on QI basics, our quality verification programs, and implementation of QI in a wide range of settings and specialties. Learn more and register at [facs.org/qsc2023](https://facs.org/qsc2023). I look forward to seeing you there.

## Clinical Congress

As I write this, registration for Clinical Congress 2023 is opening. This year, we look forward to welcoming colleagues to Boston, Massachusetts, balancing last year’s San Diego, California, conference with a location on the East Coast. Last year, we had the first-ever hybrid Clinical Congress, which meant that, after 3 long pandemic years of online meetings, we were assembled in person once more. By all accounts, the meeting was terrific. Clinical Congress 2023 will be hybrid again, with selected livestreamed and on-demand content available to virtual attendees. That said, the benefit of camaraderie and the engagement of seeing colleagues in person cannot be overstated.

We will continue to unite surgeons of all specialties across the House of Surgery, so please register here: [facs.org/clincon2023](https://facs.org/clincon2023) and encourage your colleagues to come. **B**

**Dr. Patricia L. Turner** is the Executive Director & CEO of the American College of Surgeons. Contact her at [executivedirector@facs.org](mailto:executivedirector@facs.org).

# Surgeons Address Adolescent Obesity with **BARIATRIC SURG**

Matthew Fox, MSHC

The global obesity epidemic, along with its significant patient comorbidities and cost to health systems, continues to grow.

ERY

IN THE US, MORE THAN 40% OF ADULTS are classified as obese, with nearly 10% classified as severely obese.<sup>1</sup> As prevention and treatment paradigms evolve, metabolic and bariatric surgery has become known as a safe and effective option to induce significant, durable weight loss in adults with severe obesity.<sup>2</sup>

Modern acceptance regarding the utility and safety of bariatric surgery in adults has been hard won, taking decades of research and documentation of positive long-term outcomes. Over the past 2 decades, however, a debate has emerged on the use of bariatric surgery in an even more vulnerable population—adolescents with severe forms of obesity.

Despite data and statistics on obesity often being framed in terms of adults, this chronic condition does not discriminate by age. The epidemic is moving through children and adolescents ages 2 years to 19 years, with nearly 20% of minors in the US classified as obese or severely obese.<sup>3</sup>

Although metabolic and bariatric surgery has been an option for adolescents meeting specific criteria, the treatment has not, historically, been widely recommended by primary care physicians.

The corpus of research showing positive outcomes for this younger age group has been growing, and leading health authorities for children and adolescents have created guidelines that suggest bariatric surgery is a viable, effective treatment option for select patients. Among the data and recommendations is the reality that adolescents have unique challenges when it comes to addressing obesity.

This article reviews recent developments in outcomes studies on bariatric surgery in adolescents, a clinical practice guideline for managing obesity in this vulnerable population, and how surgeons and care teams must meet adolescent patients' needs outside of the operating room.

### **State of the Science**

As a treatment for a chronic condition, some of the most important data to determine the effectiveness and safety of metabolic and bariatric surgery is in investigating long-term outcomes. Statistics are widely available for adult patients, but there has



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been a relative paucity of comparable findings for adolescents.

Within that context, a 2022 study featured in the *Journal of the American College of Surgeons (JACS)*, “Long-Term Outcomes after Adolescent Bariatric Surgery,” provides valuable data, particularly because the outcomes were measured many years after surgery.<sup>4</sup>

Nestor F. De la Cruz-Muñoz Jr., MD, chief of bariatric surgery at the University of Miami Miller School of Medicine in Florida and lead author in the *JACS* study, said there haven’t been many studies that look at outcomes up to 10 years after bariatric surgery, which is partially because it can be difficult to track patients—especially adolescents—for follow-up.

To fill this research gap, Dr. De la Cruz-Muñoz and his team tracked down 96 patients of the 130 on whom he had operated between 2002 and 2010. “We ended up finding that the majority were still doing incredibly well,” he said.

Most patients received Roux-en-Y gastric bypass, he said, and at 2 years postsurgery, weight loss was at about 44% of total body weight—and notably, at almost 15 years postsurgery, weight loss remained high at 32%.

“One way to define success in bariatric surgery is by looking at the percentage of patients who have greater than 20% total body weight loss at 5 years or greater, and we found that 80% of our bypasses met that criterion,” Dr. De la Cruz-Muñoz said. “And we didn’t just have 5 years postoperative data—we had up to 15, and they reported significant reduction in comorbid conditions.”

Importantly, there were low rates of long-term complications, as well as high rates of satisfaction. The patients had largely found success in their lives, with most having received college or postgraduate degrees, gotten married, and had children.

“More than 90% of the patients we spoke with were happy with their outcomes and would do bariatric surgery again. Even a patient who had regained much of their weight told me that the weight loss during that period was instrumental in their development into a well-functioning adult,” Dr. De la Cruz-Muñoz said.

The *JACS* study offers a compelling argument that bariatric surgery can not only be effective, but also safe for adolescents over a long timescale. It is an important addition to a growing body of research and experiences showing similar positive results.

### Expanding Outcomes Research

The ongoing Teen-LABS (Longitudinal Assessment of Bariatric Surgery) study, a National Institutes of Health-sponsored prospective, observational study initiated in 2007, follows nearly 250 adolescents who have undergone bariatric surgery and found clear improvements in weight, reductions in type 2 diabetes and blood pressure, and few long-term complications.

Together with studies like Dr. De la Cruz-Muñoz’s, clear takeaways are emerging.

“First and foremost is that these operations are safe,” said Marc P. Michalsky, MD, MBA, FACS, FAAP, FASMBS, a pediatric bariatric surgeon and surgical director of the Center for Healthy Weight and Nutrition at Nationwide Children’s Hospital in Columbus, Ohio—the first freestanding adolescent bariatric surgery center in the US to be accredited by the ACS Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program.

“And they are effective, leading to the types of clinical outcomes that are very similar to what we see in the adult world,” he said.

The loss of total body weight and resolution or reduction of certain comorbidities has important implications for health outcomes that extend through adulthood, Dr. Michalsky suggested. In addition, there is compelling evidence that there may be advantages to operating on patients in this earlier age group—performed in adolescents decades before it typically is in adults.

“What we’ve seen is that certain comorbidities, like hypertension and type 2 diabetes, appear more likely to resolve when comparing clinical outcomes among participants from the Teen-LABS study to a matched cohort of adult patients from the larger LABS (Longitudinal Assessment of Bariatric Surgery) study.”

“More than 90% of the patients we spoke with were happy with their outcomes and would do bariatric surgery again. Even a patient who had regained much of their weight told me that the weight loss during that period was instrumental in their development into a well-functioning adult.”

Dr. De la Cruz-Muñoz

well-functioning  
development

**CARE**

“Try all you can first. But if you aren’t seeing results, don’t give up—refer them out.”

Dr. De la Cruz-Muñoz

He goes on to say that “this type of evidence supports the hypothesis that the degree of comorbid disease resolution may actually be more robust in children.”<sup>5</sup>

Taken together with numerous reports that demonstrate significant long-term negative health implications related to untreated severe obesity, these data help to make a powerful counter-argument against the commonly held suggestion that pediatric healthcare professionals should take a “wait and see” approach with children and adolescents affected from the most severe forms of obesity.

“In other words, these studies show that watchful waiting is not appropriate,” Dr. Michalsky said. “If you have an 11-year-old or a 12-year-old defined as having severe obesity, there is no evidence to suggest that waiting to see what happens is a sound medical paradigm.”

### **AAP Clinical Practice Guidelines**

As obesity rates continue to rise and treatment options including metabolic and bariatric surgery continue to be researched, a leading pediatric health authority has taken a significant step to formalize clinical guidance for obesity in younger demographics.

In January 2023, the American Academy of Pediatrics (AAP) released its first “Clinical Practice Guideline for the Evaluation and Treatment of Children and Adolescents with Obesity,” which promotes a comprehensive, whole-child approach to obesity.<sup>6</sup>

The guideline outlines the importance of supportive communication and provides recommendations for various treatment options, starting with intensive health behavior and lifestyle treatment—as well as medication and bariatric surgery, if indicated.

This evidence-based guideline is the result of an extensive literature review, combined with previously released guidance.

“We got to a point where there was critical mass in the literature regarding the management of obesity,” according to Christopher F. Bolling, MD, FAAP, a recently retired general pediatrician and a contributor to the AAP guideline.

An option for managing obesity in adolescents, as the science has continued to indicate, is bariatric surgery. In 2019, the AAP released a policy statement focused on evidence, barriers, and best practices for pediatric bariatric surgery, which serves as a key repository of evidence featured in the 2023 guideline.<sup>7</sup>

However, despite the strength of the evidence, the AAP’s clinical practice guideline has received pushback—mostly from laypersons and the media, but also from some healthcare practitioners. Because obesity can be an emotional issue, particularly in relation to adolescents, Dr. Bolling suggests that there may be some misinterpretation of the guideline.

“We see some statements suggesting that because the guideline asserts that every patient should be given the *option* to start medications, people are interpreting that as every patient above the 95th percentile for weight *should* be given a prescription for medication and/or a referral to a bariatric surgery program,” he said.

The controversy, such as it is, did not go unanticipated by the contributors to the clinical practice guideline.

“A degree of skepticism is naturally anticipated and, in some ways, understandable—because the pediatric population is, by definition, vulnerable and the continued formation of more concrete and evidence-based recommendations regarding care for the pediatric population takes time to be incorporated into generally accepted practice,” said Dr. Michalsky, who contributed to both the 2019 and the 2023 AAP releases.

“It would have been surprising and unrealistic to assume that all of the responses would be positive, and that there would be no avenue for disagreement,” he said, noting that disagreement on a topic of such clinical and health significance can be important, as it allows individuals on both sides of the issue a chance to better understand one another.

At the very least, “it’s safe to assume that even where there is discourse, everyone’s heart is in the right place and everybody wants to see safe, effective, and thoughtful care administered to children,” he said, which presents an opportunity to persuade skeptics.

## **Bridging Divides**

One of the ways that the guideline is intended to work through modern sensitivities regarding the issue of weight, by both the lay public and medical professionals, is by furthering the understanding that obesity is a medical issue that can have, among other options, a medical solution.

“That’s one of the things we’re trying to impart—that obesity is a chronic disease,” Dr. Bolling said. He added that a comparison to a less emotionally charged chronic condition like asthma might be able to help guide a conversation.

“There are some people with asthma who can manage it with avoidance of allergens and cigarettes, or good cardiovascular conditioning,” he said. “But there are other people who require medications, and other people who require medications with side effects, or people who require tonsillectomy or adenoidectomy to assist with airway issues. There are all sorts of corollaries with other chronic disease.”

According to Dr. De la Cruz-Muñoz, who was not involved with the AAP clinical practice guideline but supports its collective message, it is important to communicate to potential detractors that bariatric surgery is not the first and only solution. But for the patient in whom alternative, less invasive approaches—behavior modification, dietary changes, therapy, and so on—have not achieved results, “think about surgery as an option when nothing else has worked.”

“We’re not telling you not to try less-invasive approaches,” Dr. De la Cruz-Muñoz said. “But if other methods do not work with some patients, do not give up on them when there’s an efficacious treatment that you can offer.”

All evidence suggests that severely obese adolescents are predisposed to becoming severely obese adults, and that incidence of heart disease, major cardiac events, and other comorbidities is higher than people with lower weight. As noted, there may be danger in doing nothing.

“Try all you can first. But if you aren’t seeing results, don’t give up—refer them out,” Dr. De la Cruz-Muñoz said.

## **Addressing Adolescents’ Social, Communication Needs**

Underlying the modest rate of research into metabolic and bariatric surgery and the charged response to the AAP clinical practice guideline is a recognition that adolescents are, as previously identified, a vulnerable population in their development and their social environment.

Recent research suggests that the media often stigmatize and sensationalize obesity in adolescents, as well as patients who elect to pursue bariatric surgery,<sup>8</sup> which exacerbates the skeptical response to clinical guidance and may worsen patient sensitivities to discussing their weight.

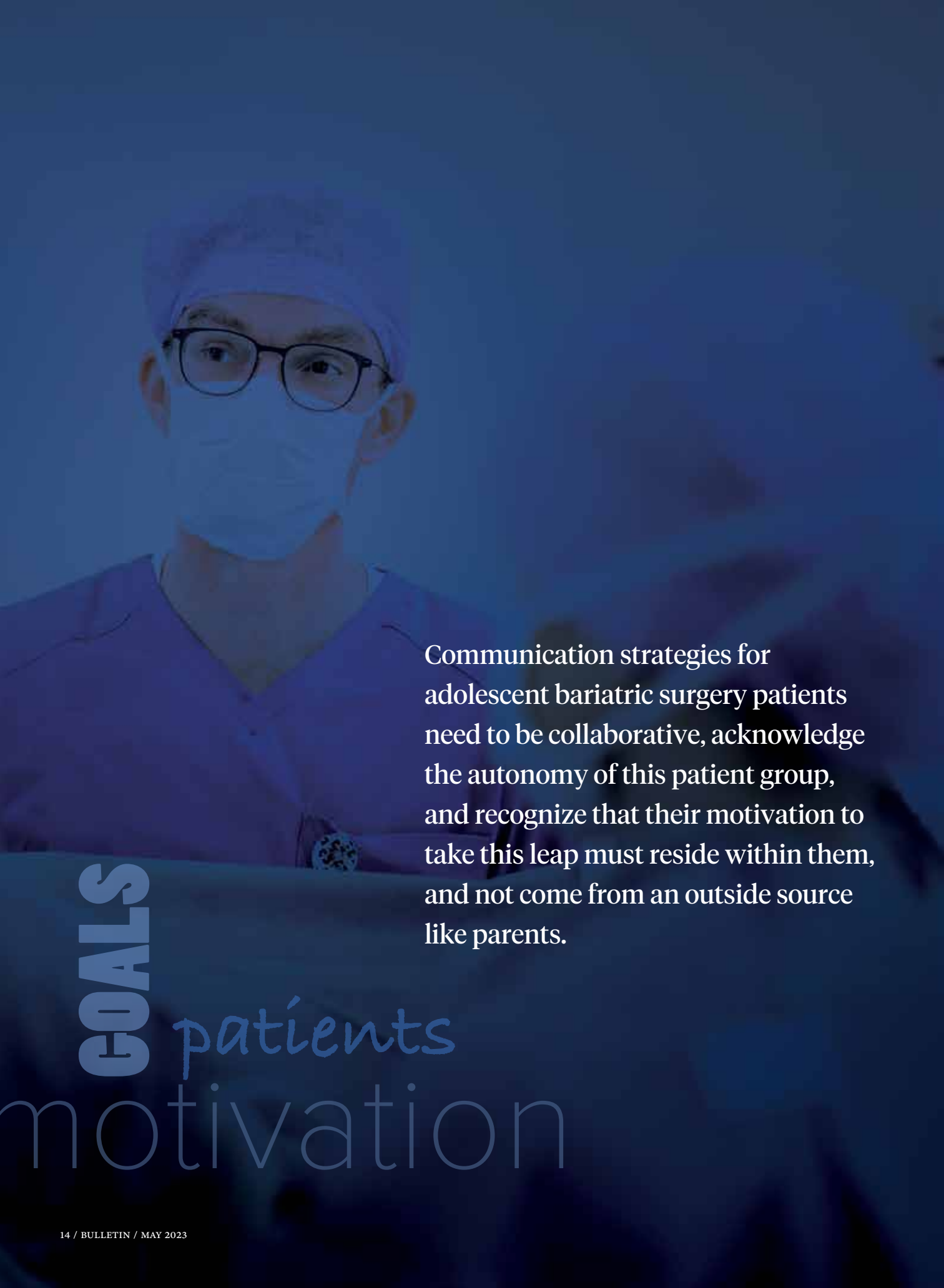
In this sometimes unfriendly climate, pediatric clinicians, bariatric surgeons, and weight management professionals are working to provide patient-centered environments and communication styles.

“Within their social universe, there are distinct differences when comparing pediatric and adolescent patients with adults,” Dr. Michalsky said. “As an example, a certain proportion of our patients are home schooled. The decision to participate in home schooling is a very individualized matter and may be the result of patients feeling stigmatized within their own social peer group. Centers that offer metabolic and bariatric surgery to the pediatric population attempt to create a safe space that fosters therapeutic relationships between the clinical team, patients, and their families, which are founded on mutual respect.”

Because there is not a guarantee of an environment conducive to open and effective communication for adolescents in a standard adult treatment institution, it is important for patients and families to seek out pediatric-focused centers.

“With adults, the common thinking is you should have your bariatric surgery done in a center of excellence that does so many surgeries, but that doesn’t necessarily work as well with adolescent bariatric surgery,” Dr. Bolling said.

“I don’t think it’s the volume of procedures that you do that makes it a better procedure, in this case—I think it’s having the procedure done in a pediatric facility with pediatric psychology support,



Communication strategies for adolescent bariatric surgery patients need to be collaborative, acknowledge the autonomy of this patient group, and recognize that their motivation to take this leap must reside within them, and not come from an outside source like parents.

**GOALS**

patients

motivation



pediatric nutritional services, and so on,” he said, adding that bariatric surgery and its preoperative and postoperative support is something that needs to be done at a place that is entirely designed around catering to adolescents’ needs.

Communication strategies for adolescent bariatric surgery patients need to be collaborative, acknowledge the autonomy of this patient group, and recognize that their motivation to take this leap must reside within them, and not come from an outside source like parents, Dr. Bolling suggested—although it is critical that the patient have a support structure that can help them accomplish their long-term goals.

The teenage patient must be able to reflect on their wants and needs, and what they hope to achieve through surgery, with their care team and surgeon. This requires a direct, one-on-one conversation, according to Dr. De la Cruz-Muñoz.

“I start my conversation with all the adolescents directly, ignoring the parent for a while, because I want to make sure that they’re mature enough to be able to carry on a conversation with me. If they’re not, then it’s a non-starter,” he said. “We don’t move on from there because they need to be able to explain themselves and their issues and be mature enough to follow a treatment plan. So, we start with just that conversation.”

Just as they have been in the vanguard of building technique and outcomes data and contributing to key clinical practice guidelines for evaluating and managing obesity, surgeons play a vital role in presenting bariatric surgery as a viable, safe, and effective treatment that will pay lifelong dividends. But their work cannot be done alone.

“The surgical profession by itself is limited in terms of providing access to patients that would benefit from bariatric surgical care,” Dr. Michalsky said. “Trying to build bridges to our nonsurgical colleagues has really been an important tool to raise professional awareness about what these operations do, the level of safety that they provide, and, ultimately, their long-term benefits.” **B**

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**Robotic  
Surgery**

**Is Here to Stay**

**and So Are  
Surgeons**

Jim McCartney

# Robotic surgery once was thought to be a futuristic idea whose time may never come. Today, robotic surgery is used in many types of operations, including cardiothoracic, colorectal, general, gynecology, and head-and-neck surgery.

Overleaf:  
Cardiothoracic surgeon Dr. T. Sloane Guy says robotic surgery offers patients benefits such as quicker recovery, decreased pain, and shorter length of stay.

THE OVERALL USE OF ROBOTIC SURGERY HAS GROWN significantly over the past 25 years.

Intuitive Surgical, once “the only game in town” and the current market leader in robotic surgery systems, reports that more than 12 million robotic surgery procedures have been performed and more than 60,000 surgeons around the world have been trained on its da Vinci Systems.<sup>1,2</sup>

Researchers in Michigan have noted an increase in robotic surgical procedures entered into the Michigan Surgical Quality Collaborative registry. From 2012 to 2018, the use of robotic surgery increased from 1.8% to 15.1%. Some specific procedures saw an even greater increase over that same time period. For example, use of robotic surgery for inguinal hernia repair grew 41-fold, from 0.7% to 28.8%.<sup>3</sup>

Growing acceptance of robotic surgery may be due largely to its apparent benefits to patients, surgeons, and hospital systems. Robotic surgery enables some procedures to be converted from open to laparoscopic, which often means less discomfort, less bleeding, less time in the hospital, and faster recovery periods for patients.

For surgeons, robotic surgery may help enhance performance and provide ergonomic benefits, such as

enabling the surgeon to sit rather than stand during a long procedure. For hospital systems, robotic surgery can reduce costs through shorter hospital stays and fewer complications, and it may help offset the strains of the hospital workforce shortage.

An indicator of growth in this industry could be the number of companies now offering robotic surgery systems. Among Intuitive’s competitors are several large medical device manufacturers in the US, including Medtronic, Johnson & Johnson, and US Surgical, as well as overseas manufacturers such as CMR Surgical in England, SS Innovations in India, and Medcaroid Corp. in Japan.

“There is a quiet tsunami of robotic surgery headed our way,” said T. Sloane Guy, MD, MBA, FACS, FACC, director of minimally invasive and robotic cardiac surgery at the Georgia Heart Institute with the Northeast Georgia Physician Group in Gainesville.

Increased competition is expected to reduce prices and increase innovation. Advances are underway that make robotic surgery instruments smaller and more flexible, enabling them to navigate through blood vessels or natural orifices. In addition, artificial intelligence (AI) and automation will allow surgical robots to guide and



An indicator of growth in this industry could be the number of companies now offering robotic surgery systems.

assess surgeons and even perform various surgical tasks such as placing sutures.

### Evolution of Robotic Surgery

The idea of robotic surgery took off as part of the US military's quest to create a "telepresence surgery system" that would enable surgeons to perform operations from a long distance.<sup>4</sup>

To provide immediate, expert surgical care to wounded servicemembers, the military collaborated with the Defense Advanced Research Projects Agency (DARPA) to find a way to virtually transport a surgeon to the front lines. When the Stanford Research Institute (SRI) developed a prototype of a surgeon-controlled robotic telepresence workstation and a remote surgical unit, DARPA and Stanford formed a research partnership to further develop the new tool.

Although the early robotics systems were developed for open surgery, it quickly became apparent that the robotic approach was particularly suitable for laparoscopy by helping surgeons operate in tight spaces. By seizing this idea, laparoscopic instrumentation pioneer Frederic Moll, MD, would become what Dr. Guy calls "the Steve Jobs of robotic surgery."

"Dr. Moll thought robotic surgery would offer more degrees of freedom to open, close, or rotate the instrument than a straight, shafted laparoscopic instrument would," Dr. Guy said.

In 1995, Dr. Moll and two partners formed Intuitive Surgical and negotiated to acquire SRI's relevant intellectual property.<sup>5</sup> Two years later, the first robotic-assisted operation—a cholecystectomy—was performed on a living patient using the Mona surgical robot.

In the early days, Intuitive competed with Computer Motion, which had funding from the National Aeronautics and Space Administration's Jet Propulsion Laboratory (JPL). The JPL was interested in developing remote-controlled robots for astronaut training and remote operations. Computer Motion developed Zeus, a robotic system that combined a camera holder with laparoscopic instrumentation. In 2001, a transatlantic cholecystectomy was performed using Zeus.<sup>6</sup>

The two companies competed in the marketplace and battled in the courtroom for several years until Intuitive acquired Computer Motion in 2003.

"At this point, Intuitive essentially gained a monopoly on the robotic surgery industry that has lasted for years," Dr. Guy explained.

Using a robot, Dr. T. Sloane Guy is able to perform heart surgery with incisions no bigger than the diameter of a pen.



This page: Hadley Freeman, MD, a general surgeon and chief resident at The University of Kansas in Wichita, performs a robotic surgery, with Dr. Kyle Vincent supervising.

Opposite: In 2022, Dr. Kyle Vincent performed more than 300 robotic surgery procedures.

## Robotic Surgery Gains Acceptance among Surgeons

As with many new technologies, there was initial resistance to robotic surgery. In addition to the natural struggle with change, some surgeons wanted more control over the operating field than what was offered by robotic surgery. Initially, the robotic approach to complex surgeries seemed more like a novelty than a new standard of care.

For example, cardiac cases were among the first to use robotic surgery based on the assumption that it would be easier to sew bypass grafts. But heart surgery often must contend with a heart-lung machine and a beating heart.

“A lot of surgeons tried robotic cardiac surgery and abandoned it early on,” Dr. Guy explained.

In addition, the goal of developing a remotely operated robotic system was stymied by latency time, which is the connectivity delay between sending and receiving information.

Another obstacle for remote robotic surgery is that many surgeons like to personally inspect and prepare the patient and operating field before going to the robot, said Stephanie G. Worrell, MD, FACS, section chief of thoracic surgery at the University of Arizona in Tucson.

Given these challenges and others, “it looked like robotic surgery might go away,” Dr. Guy reflected.

But robotic surgery began to build credibility when urologists and general surgeons regularly used it in a

variety of procedures. For example, the robotic radical prostatectomy was the first procedure to gain wide acceptance in the US. Research began to show that compared to open procedures, the robotic-assisted approach decreased hospital stay and blood loss among prostatectomy patients.<sup>6</sup>

“The prostate saved robotics,” Dr. Guy said.

Robotic surgery became popular in procedures involving tight, cramped, and sometimes inaccessible areas because of the system’s 3-D camera and wristed instruments.

Now robotic surgery is used in many surgical specialties, including general surgery, especially for repairing abdominal wall hernias because this technology enables the surgeon to take a minimally invasive approach.<sup>6</sup>

As a general thoracic surgeon, Dr. Worrell finds that the robot makes some procedures easier to perform. For example, when operating on a mediastinal mass that sits on top of the heart, the surgeon has to operate “kind of upside down,” she said.

“Doing it traditionally is very difficult, but the robot, with its wristed instruments, makes it much, much easier,” Dr. Worrell added. She also uses the robot to perform all of her esophagectomies and lobectomies.

## Training and Experience Lead to Improved Outcomes

More surgical training and experience also have led to greater acceptance of robotic surgery.

Early on, some surgeons would take a 1- or 2-day robotic surgery workshop, do a case, get a bad outcome, and get sued for malpractice, Dr. Guy said. The subsequent bad publicity deterred some surgeons from continuing to use the robotic approach. Today, most general surgery students receive robotics training, and there are fellowships available for additional robotics training, according to Dr. Worrell.

“Most hospitals require you to be proctored for a few cases,” she said. “So, there’s some good oversight in robotic surgery that is making it safer.”

**By seizing this idea, laparoscopic instrumentation pioneer Frederic Moll, MD, would become what Dr. Guy calls “the Steve Jobs of robotic surgery.”**

Kyle B. Vincent, MD, FACS, the associate director for the residency program at The University of Kansas in Wichita, trains seven residents a year in open, laparoscopic, and robotic surgery.

“The next generation of surgeons are much more competent on the robot than they are laparoscopically for some of the more advanced procedures,” noted Dr. Vincent.

Surgeons also are gaining more experience in robotic surgery through wider access to robotic systems. Early on in her career, Dr. Worrell had access to the robotics system only about two or three times a month. Now, she performs approximately 100 robotic procedures per year out of a total of 250 cases.

More rural surgeons also have access to robotics systems. In 2021, the 60 critical access hospitals in the US that have robotic surgery systems each averaged about 106 robotic procedures, according to a presentation on “Robots in Rural Operating Rooms” at the 2022 ACS Clinical Congress.

A decade ago, Dr. Vincent performed approximately 30 to 40 robotic surgery procedures per year; last year, he completed 315 robotic surgery procedures.

Although access is much better overall, it remains an issue, Dr. Worrell said.

“I think a lot of us would do even more robotic surgery if we had a robot available every day of the week,” she shared.

### **Patient Benefits Boost Use of Robotics**

Surgeons today often choose the robotic approach if it appears to have benefits for the patient compared to the conventional approach.

Robotic surgery can help make an operation less invasive, and overall, the less invasive the operation is, the more quickly the patient recovers. As a cardiac surgeon, Dr. Guy performs a lot of mitral valve surgery with robots because he’s able to make smaller incisions.





Like many surgeons, Dr. Stephanie Worrell takes off her shoes during robotic procedures to allow for better control while operating the pedals of the system.

“I discharge a fairly significant number of patients on day 1 after open heart surgery, which is really unheard of,” Dr. Guy said.

Cardiac surgery data show robotic surgery leads to faster recovery and return to work for patients, as well as decreases in length of stay, intensive care unit time, time on the ventilator, and blood transfusion and pain, according to Dr. Guy.

Patient benefits from the less-invasive robotic approach also are evident in other types of procedures, especially if the alternative is open surgery.

“For me, converting an open procedure is the biggest benefit,” said Dr. Vincent. “If I can keep people in the hospital for less time, they have a quicker recovery, or they require less pain medication, then that’s the way to do it.”

Dr. Vincent typically uses the robotic approach to perform hernia repairs, colon surgery, and upper gastrointestinal procedures. But there also are procedures for which the robotic approach does not offer much benefit, he said.

For example, a gallbladder procedure takes about 30 minutes with a robot—the same as it takes with a conventional laparoscopic approach. And in either procedure, the patients usually go home the same day.

However, the costs associated with a robotic laparoscopy are higher than the conventional laparoscopy because it must be done at the hospital as opposed to a surgery center, he said.

“It’s hard to make a laparoscopic gallbladder procedure much better,” noted Dr. Vincent.

Dr. Worrell shared that studies using data from The Society of Thoracic Surgeons National Database found that robotic thoracic surgery patients lose less blood

and have shorter hospital stays than those who have open surgery.

“But the results are mixed for laparoscopic versus robotic,” she said. “There are some studies that show robotic is better, while others show it’s equivalent.”

## Ergonomic Benefits for Surgeons

The robotic approach offers an opportunity for surgeons to sit in a chair rather than standing, bending, and twisting during a long conventional procedure, which can lead to orthopaedic injuries, according to Dr. Guy.

“It’s nice to be able to sit down in a chair, relaxed, to do an operation rather than stand up all day, hunched over,” he said.

For Dr. Worrell, long conventional surgeries can result in bursitis in her right shoulder and, when she was pregnant, edema in her legs.

“I think robotic surgery improves the longevity of surgeons because you have fewer joint issues, especially in your shoulders and back,” she said, adding that there are no studies to prove that robotic surgery extends the careers of surgeons because it is less physically demanding.

Even so, robotic surgery can be physically demanding. Some surgeons report back pain in different areas in addition to eye strain.

Dr. Vincent points out that he is often “just as sore” after a robotic procedure, though he agrees that there are “probably, over the long haul, ergonomic benefits to it.”

## Cost and Marketing Advantages

As noted earlier, compared to an open procedure, the robotic approach reduces costs for hospitals.

“In theory, hospitals save money on the back end with shorter lengths of stay and better outcomes,” said Dr. Worrell, who pointed out that some case-specific research shows robotics help hospitals lower costs. In addition, fewer complications—especially if they lead to readmissions—can reduce costs.

In fact, hospitals that offer robotic surgery services may find it easier to attract new patients.

Although a significant obstacle for the widespread use of robotic surgery is the cost of equipment and training, growing competition is expected to drive down costs. At the same time, robotics training is becoming a more significant part of resident training.



The burden of acquiring new robotics systems also is being eased by creative financed leasing programs. For example, Intuitive has a program in which hospitals pay for robotics systems by how much they use them rather than spending millions of dollars upfront to buy a new system.

“As we increase our volume, the number of robots increases with it,” Dr. Guy said. “If a new robotics system comes out, we get it without having to finance it.”

As a result, even smaller, less financially viable hospitals have the opportunity to acquire robotics systems.

## Future of Robotic Surgery

Greater competition will drive innovation, such as new instruments and new functions enhanced by advances in AI. These advances could include:

- **Flexible, snaky arms.** Among the new technologies in the works are robotic arms that are flexible and snake-like. This maneuverability will allow these devices to go, like a catheter, through the patient’s blood vessels or natural orifices instead of the skin. These new arms will be able to help perform procedures such as bronchoscopies and colonoscopies.
- **Digital enhancements.** Augmented reality, digital analysis of performance and feedback, and real-time suggestions will become part of robotic surgery platforms, according to Dr. Guy. They will reduce or eliminate the effect of tremors from a surgeon’s shaky hands, while also providing surgeons with a map of the surgical field. “If there’s a structure over to my right, and I shouldn’t be messing with it, the robot may be set to not allow me to do that,” he said.
- **Automated tasks.** Robotic systems should soon be able to execute small maneuvers such as a suture. Given that anatomy is relatively consistent and identifiable, it’s not hard to imagine a time when the robotic system could do a variety of relatively minor surgical tasks, Dr. Worrell said.
- **AI.** The prospect of driverless cars makes it seem quite possible that we will one day see surgeon-less surgery, Dr. Worrell said. Presumably, AI could review thousands of videos showing surgeons doing the same operation, put those videos into an algorithm, and figure out how to make the steps replicable by a machine.

## Will the Robot Replace the Surgeon?

Resistance to robotic surgery may fade as some surgeons retire and the technology becomes more readily available, Dr. Guy said.

Meanwhile, robotics will thrive and continue to grow because it can make surgery easier and safer, he added.

Dr. Vincent predicts a “meteoric rise” in the number of robotic cases that are being done.

However, there are disagreements about the ultimate question: Will the robot ever be able to replace the surgeon?

“I think we’re a long way off from the robots being fully automated, but I believe we will get to that point,” Dr. Guy said.

Dr. Vincent doesn’t think there “will be a complete replacement ever,” as robotics systems are intended to augment human abilities and improve postoperative results.<sup>7</sup>

“Certain things can be automated, but I think a surgeon will always need to be involved,” Dr. Worrell agreed.

In any case, one thing is clear, Dr. Guy said. “Robotics are here to stay.” **B**

*Jim McCartney is a freelance writer.*

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# ACS Award Helps Surgeon-Scientist Reverse Hearing Loss

Tony Peregrin



# Ask Rick F. Nelson, MD, PhD, FACS, what attracted him to the field of neurotology and he will tell you, in an almost hushed and reverent tone, that it's the "finesse required when operating in the head, neck, and ear."

Overleaf: The "finesse required when operating in the head, neck, and ear" is what attracted Dr. Nelson to the field of neurotology.

Opposite: Dr. Nelson examines a patient.

"WHEN WE DO A reconstruction of hearing bones, we measure an ossicular prosthesis in fractions of a millimeter, which can make all of the difference between good hearing and not-so-good hearing," said Dr. Nelson, a surgeon-scientist developing new treatments for congenital and adult-onset hearing loss. "It's a technical challenge every time."

Based on his innovative research in this area, Dr. Nelson received the ACS/Triological Society Clinical Scientist Development Award in 2017, which is intended to facilitate the research career development of otolaryngologists—head and neck surgeons, with the expectation that the awardee will have sufficient pilot data to submit a competitive R01 proposal. The grant provides financial support of \$80,000 per year for up to 5 years to supplement a K08/K23 award.<sup>1,2</sup>

The intricate anatomy associated with otologic surgery may have initially sparked Dr. Nelson's interest, but it's the experience of helping patients regain their hearing that provides him with a deeper sense of purpose.

One case that he found particularly inspiring involved a fellow healthcare provider who was struggling to communicate with her patients due to her own hearing loss. Dr. Nelson

performed a hybrid cochlear implant in both ears to save her low-frequency hearing, and she went from understanding 10% of words correctly to more than 95%.

"She's an outstanding performer," Dr. Nelson said. "She has minimal issues communicating with her patients now, and she's very happy. Obviously, you can imagine that this is why we do what we do. It makes us smile, and it's what gets us up in the morning."

According to the World Health Organization, 430 million people (more than 5% of the world's population) suffer from hearing loss.<sup>3</sup> By 2050, more than 700 million people (1 in every 10) will have some form of disabling hearing loss. Unaddressed hearing loss could potentially impose an annual global cost of \$980 billion, including healthcare and educational support costs, as well as losses associated with decreases in productivity.<sup>3</sup>

## Nelson Lab Driven by Innovation

In 2014, Dr. Nelson joined the faculty at Indiana University (IU) School of Medicine in Indianapolis.<sup>4</sup> Soon thereafter, he received supplemental support from the Department of Otolaryngology to start his lab, which focuses on understanding the mechanisms of sensory cell

degeneration in the cochlea and is the principle cause of sensorineural hearing loss.<sup>5</sup>

Receiving the ACS/Triological award was a turning point in Dr. Nelson's career, supporting his work in the Nelson Lab.

"The ACS/Triological award was a capstone on the National Institutes of Health K08 award, which is a mentored grant for junior clinician scientists that I received. While the K award supports a little bit of our salary and laboratory, it's not as much funding as typical R01 research grants—so the supplemental funding from the ACS and The Triological Society provided extra support to increase the number of people in my laboratory and allowed me additional time outside of clinic to write papers and grants."

Dr. Nelson and colleagues are currently studying a gene (TMPRSS3) that is one of the more common genetic causes for both congenital and childhood-onset hearing loss. TMPRSS3 is essential for the survival of hair cells in the cochlea, and more than 50 deafness-causing variants have been reported that are associated with this gene. It has been more than 20 years since the first variants in the TMPRSS3 gene were linked to hearing loss, yet the biological function of TMPRSS3 in the inner ear remains elusive.

“We have preliminary data that show how TMPRSS3 is working in the ear, although we have more work to do. Our lab will be the first to discover this mechanism of the gene, something that’s been an enigma for the last 2 decades,” Dr. Nelson said.

In early 2023, Dr. Nelson’s lab secured an R01 grant for a project that is designed to understand the mechanism of how the protein encoded by TMPRSS3—the “human deafness gene”—leads to ear hair cell death and hearing loss.

“This R01 grant is a direct result of the seed funding and support from the ACS and The Triological Society,” said Dr. Nelson.

A primary aim of this research is to eventually develop therapeutic approaches for deafness and balance disorders.

According to Dr. Nelson, one major obstacle with treating hearing loss is related to the fact that when the sensory cells (hair cells) die, they do not regenerate either in mouse models or adult humans.

The challenge involves placing the TMPRSS3 gene into the inner ear to prevent hair cell degeneration early, although the inner ear is surrounded by the strongest bone in the human body (the otic capsule), making this procedure difficult to say the least.

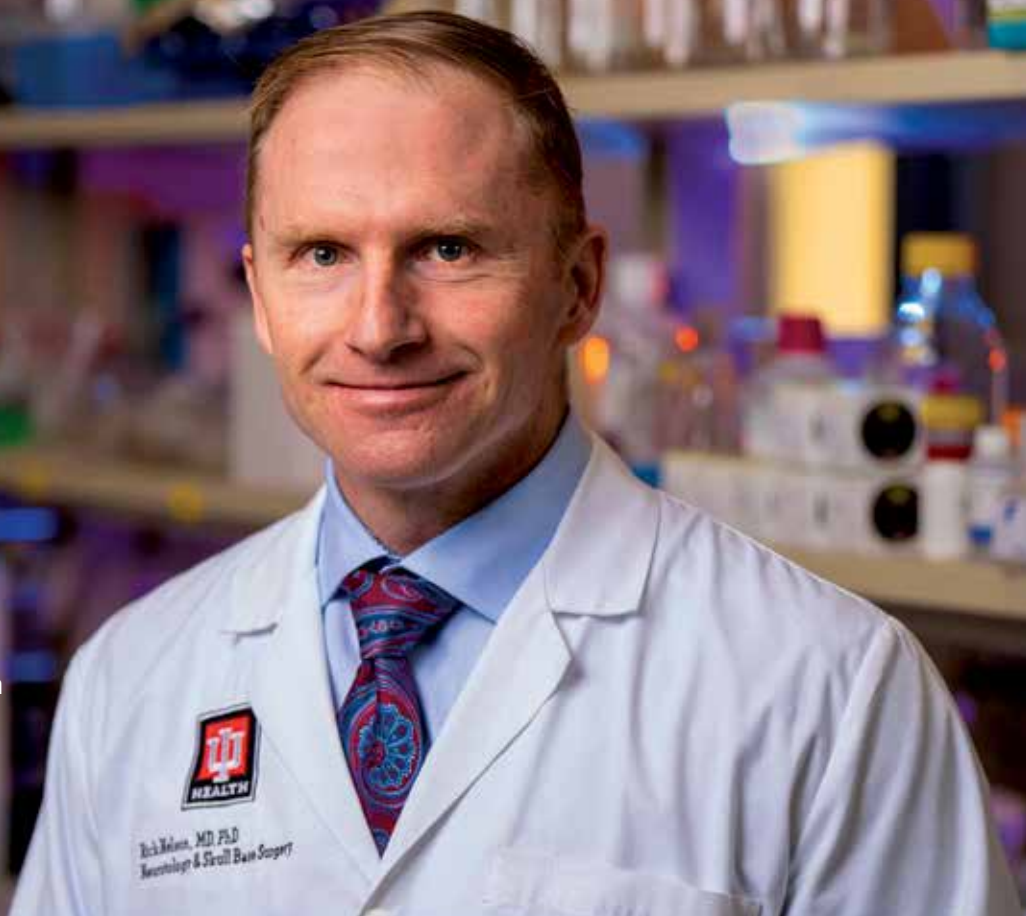
“How do we get the gene into the ear, and then how do we transduce those cells effectively so that all

**By 2050, more than 700 million people (1 in every 10) will have some form of disabling hearing loss.**



“Our lab will be the first to discover this mechanism of the gene, something that’s been an enigma for the last 2 decades.”

—Dr. Rick Nelson



the cells can be preserved? It’s a continuous challenge that we, as scientists, face,” he said. “I’m optimistic, but we have more research to do so we can improve our access to the ear, transduction efficiency, and timing.”

### **Collaboration and Mentorship Lead to Success**

Dr. Nelson, an associate professor of otolaryngology—head and neck surgery at the IU School of Medicine, credits a network of mentors and partners who study inner ear disorders as a primary driver in his work to advance the field.

“I have a wonderful team of collaborators, including Eri Hashino, PhD, professor of otolaryngology at Indiana, and Alan Cheng, MD, FACS, professor of otolaryngology and surgeon-scientist at Stanford University in Palo Alto,

California. These collaborations create a heightened intellectual environment that’s not just my lab, but several labs that provide not only me, but also my postdocs, technicians, and research assistants the opportunity to think outside the box and come up with new ideas.”

In fact, mentorship played a notable role in Dr. Nelson’s early career trajectory while he was pursuing a PhD in neuroscience at the University of Iowa in Iowa City.

While working in the laboratory with Henry Paulson, MD, PhD, professor of neurology and clinician-scientist at the University of Michigan in Ann Arbor, Dr. Nelson started investigating a mouse model with a genetic disorder that he hypothesized was going to result in a neurologic phenotype since the gene was expressed in the brain.

Employing a learning task in which mice are placed into a cage

where a tone is presented followed by a foot shock, it was assumed that the mice would learn the tone was going to be followed by the shock. The following day, the mice were placed back in the cage and the tone was presented, after which the investigators measured the freeze response of the mice in anticipation of the foot shock.

In fact, the gene-mutant mice learned that the cage was “bad,” but they failed to pick up the significance of the tone—because they were deaf. This discovery led Dr. Nelson into the field of auditory neuroscience where he started collaborating with Richard Smith, MD, a surgeon-scientist and professor of otolaryngology at the University of Iowa.

“The phenotype was actually in the inner ear, and that led

## Surgeon-scientists sometimes struggle to balance taking care of patients with conducting scientific research, even though both are complementary: Doing one can make you better at the other.

me into auditory neuroscience, genetic causes of hearing loss, and auditory pathways—and then I became really interested in ENT and otolaryngology,” he said. Eventually, Dr. Nelson completed his neurotology surgical fellowships at the University of Iowa Hospitals.

“Throughout my career I have been fortunate to be mentored by highly successful clinician-scientists who are passionate about patient care and scientific discovery.”

### Dual Role of Academic Clinician and Researcher

In an era marked by limited time and financial resources, surgeon-scientists sometimes struggle to balance taking care of patients with conducting scientific research, even though both are complementary: Doing one can make you better at the other.


“There’s always the potential for ‘clinical creep’ into your academic pursuits. You know patients need to be seen in a certain timeframe and that periodically takes precedence over your academic work. But I think you can take on this dual role with a very focused clinical practice,” said Dr. Nelson, while also urging academic departmental leadership to ensure there are enough providers to support patient care, and then ultimately, academic research.

Surgeon-scientists also must navigate diminishing sources of funding along with meeting clinical hour requirements to generate revenue.

“We’re competing against scientists who exclusively do research—individuals who are PhD scientists and research is all they focus on,” he said. “We are all in the same pool of applicants for grants. So, your science has to be just as good, yet we are spending less time on research, potentially, because we have a clinical aspect to our practices.”

Nevertheless, this dual role has its advantages such as access to clinical patients, and perhaps, human tissue samples.

“Being a clinician-scientist is not easy,” said Dr. Nelson. “But I have a self-driven passion for discovery and to advance our field forward. If that is your passion, then you can make it happen.”

Many scholarships and programs administered by the College are supported by funding from the ACS Foundation. To learn more about the ACS Foundation, the programs it supports, and how to contribute, go to [facs.org/acsfoundation](https://facs.org/acsfoundation). For more information about ACS scholarships and awards go to [facs.org/for-medical-professionals/professional-growth-and-wellness/scholarships-fellowships-and-awards/research](https://facs.org/for-medical-professionals/professional-growth-and-wellness/scholarships-fellowships-and-awards/research). 

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# ACS Training Hubs Help Build Surgical Capacity in Africa

M. Sophia Newman, MPH

**In sub-Saharan Africa, ACS Operation Giving Back (OGB) is transforming how ACS members—in collaboration with their African colleagues—provide services to populations with limited access to surgical care.**







Surgeons collaborate in a simulation laboratory during a training session at the Hawassa Surgical Training Hub. (Photo credit: Dr. Chris Dodgion)



Motorcyclists in Rwanda are subject to fastidious traffic safety efforts. (Photo credit: Dr. Eileen Bulger)

CHRISTOPHER M. DODGION, MD, MSPH, MBA, a trauma surgeon and assistant professor of surgery in the Division of Trauma/Critical Care at the Medical College of Wisconsin in Milwaukee, is one of many surgeons working in Africa via OGB, the College's volunteerism initiative.

What he does on his visits to Hawassa University Hospital in Ethiopia, though, is not what surgeons have traditionally done in volunteer work. "Most of the time, when I go to Hawassa, I am not providing clinical care," Dr. Dodgion said.

Instead, his work contributes to a larger-scale, sustainable shift in the way African surgeons gain skills, manage resource constraints, and improve patient care.

Worldwide, the need for more surgery is vast. Roughly one-third of the global disease burden can be addressed by surgical means. But per *Global Surgery 2030*, a report by *The Lancet* Commission on Global Surgery, 5 billion people worldwide lack access to safe, affordable surgical and anesthesia care.

Overall, the poorest one-third of the world population receives just 3.5% of all surgical procedures,\* and fully meeting the need in low- and middle-income countries would require an additional 143 million procedures per year.† In many parts of Africa and Asia, the absence of access to surgery is nearly total.‡

Originally established to connect willing surgeons to volunteer opportunities in the US and abroad, OGB is part of a long tradition of volunteerism in surgery.

"Previously, Operation Giving Back tried to find opportunities for our Fellows to provide clinical service or teaching by identifying nongovernmental organizations that work in low-resource settings," said OGB Medical Director, Girma Tefera, MD, FACS, letting interested surgeons initiate the volunteer work on their own.

Many of these opportunities involved long-standing models of surgical volunteerism, including surgeons traveling to address surging needs caused by disaster or war, or making short visits to underserved communities to complete as many procedures as possible.

Those approaches may seem intuitive, given the intensity of need in sub-Saharan Africa. But while such work remains helpful, Dr. Tefera explained that around 2017, "We started thinking: why can't we create the programs and develop partnerships that allow our Fellows to provide, in a meaningful manner, whatever contribution they want, instead of seeking these one-off opportunities? And if we do that, we could come up with a much more solid and sustainable, longitudinal program."

Six years later, that effort has resulted in emerging surgical training hubs designed to link US institutions with hospitals in Ethiopia, Rwanda, and Zambia, and provide US and African surgeons opportunities to collaborate on mutually beneficial education, workforce development, and quality improvement programs. Through these hubs, OGB is focused on building surgical capacity and improving patient care.

## Hawassa, Ethiopia

The insufficiency of access to surgery is a reality that Belay Mellese, MD, knows well. He is a general surgeon and assistant professor of surgery at Hawassa University Hospital, the first surgical teaching hub established by OGB. An OGB committee selected the hospital as the site of the first hub after it applied to OGB via an open call in 2017.

Surgery accounts for more than 200 of the tertiary facility's 500 beds. According to Dr. Belay, the hospital serves a catchment area of more than 20 million people, and the surgical team carries out more than 10,000 operations annually in six operating rooms.

In this environment, it would be understandable if local physicians wanted someone to simply tackle some of the caseload. Yet when Dr. Belay brings up Dr. Dodgion—the volunteer surgeon whose four trips to Hawassa have included little clinical work—he smiles broadly. “He has an extremely important role,” Dr. Belay said.

Dr. Dodgion was part of providing recent Advanced Trauma Life Support (ATLS™) training, which Dr. Belay and his colleague, emergency physician Emnet Tesfaye, MD, ECCP, said is the first ATLS

The ATLS training is just one of many things the hub has been able to accomplish since its start in Hawassa 3 years ago. During the COVID-19 pandemic, when travel was infeasible, the consortium virtually connected Hawassa surgeons to journal clubs, grand rounds, and a Trauma Evaluation and Management (TEAM™) course.

In addition, Dr. Dodgion and others led a course in research methods, which he said yielded 10 institutional review board-ready protocols, numerous case reports published in *East and Central African Journal of Surgery* (a journal affiliated with the College of Surgeons of East, Central, and Southern Africa—an ACS collaborator), and personalized support for the Ethiopian surgeons.

Hawassa University Hospital's chief executive director Anteneh Gadisa Belachew, MD, FCS-ECSA, FACS, who is a colorectal surgeon, summarized the impact of these educational opportunities. “The training hub has been instrumental in standardizing our service, our education, and bringing culture change in the department. In a sense, the faculty were not

“The hub helped to generate appetite, provide the training, and provide mentorship.”

—Dr. Anteneh Gadisa Belachew

course ever presented in Ethiopia. The training included teaching the Hawassa surgeons how to train others, so that additional Ethiopian physicians can receive ATLS training.

“They never had a clear and systematic way to care for the injured patient,” Dr. Tefera explained. “There was no overarching, structured approach. Now, it's become the place where others will go and get trained on how to care for trauma patients.”

According to Dr. Emnet, Hawassa physicians also may travel to Addis Ababa next year to lead ATLS courses there. “We want to expand. There is obviously demand all over the country,” Dr. Belay added.

interested and had no opportunity to do research, conduct quality improvement programs, or update skills in certain areas. The hub helped to generate appetite, provide the training, and provide mentorship in doing those things.”

All 13 US institutions remain committed to collaboration with the hub, including about a month of in-person work per institution per year. This means the project is poised to expand training into additional surgical and quality improvement initiatives.

“The ACS collaboration with our university has been beneficial in so many ways,” Dr. Emnet said.



## Lusaka, Zambia

While initiating the surgical training hub in Hawassa, OGB also has worked to create a second hub in Lusaka, Zambia. Situated between the Democratic Republic of Congo and Zimbabwe, Zambia, like Ethiopia and Rwanda, has insufficient healthcare infrastructure. Although as distant from Hawassa as Cincinnati is from San Francisco, this hub is nonetheless quite like the pilot site.

“The work that is being done has similarities,” said Dr. Tefera. “Both are focused right now on what we would call general surgery.”

To that end, the hub is in the middle of a post-pandemic scale-up in on-the-ground interactions between US and Zambian physicians, with a strong focus on “specific tasks that are geared toward transferring skills,” including a recent course on research methods, noted Dr. Tefera.

As with Hawassa, the collaboration began with a 2017 application from the University Teaching Hospital in Lusaka to become an OGB hub site. Following its acceptance, a consortium of 11 academic departments of surgery in the US was formed, all of which have multiyear commitments to the program, including at least 2 weeks of work in Zambia per year. In Lusaka, the consortium is working to establish a simulation laboratory, a nascent educational approach in sub-Saharan Africa. In addition, in the past 6 months, multiple groups have traveled to Lusaka to deliver workshops on research methodology, laparoscopic surgery, and pediatric surgery.

Dr. Tefera notes that the shift from laparotomy to laparoscopy is likely to reduce pressure on crowded surgical wards. “Imagine what that means for people who always have open gallbladder surgery,” said Dr. Tefera. “They stay in the hospital 5 days to 1 week. This way, they go home the next day.”

The hub is poised to build on previous successes. “From the pilot phase in Hawassa, we learned a lot of things. So, the Lusaka piece can be run a little bit smoother,” Dr. Tefera commented.

## Kigali, Rwanda

While the Lusaka and Hawassa surgical training hubs focus on general surgery, OGB’s collaborations in Rwanda are focused on cardiothoracic, vascular, and plastic surgery subspecialties and trauma system development.

In March 2023, trauma surgeons Jeffrey D. Kerby, MD, PhD, FACS, ACS Committee on Trauma (COT) Chair, Eileen M. Bulger, MD, FACS, Medical Director of the COT, and Barclay T. Stewart, MD, PhD, MPH, a COT Future Trauma Leader, visited Rwanda with OGB, on a trip also attended by Patricia L. Turner, MD, MBA, FACS, Executive Director and CEO of the ACS.

The primary purpose of the visit was to generate a report and action plan for building the nation’s capacity for trauma care. “We do a lot of trauma system development work in the US,” Dr. Bulger said about the COT. “But we haven’t done that as routinely in the global space, and there’s such a need for systems development.”

Indeed, 77% of preventable deaths from unmet surgical need worldwide arise from injuries\*—and at present, Rwanda has insufficient access to trauma surgery. “They don’t have any trauma or surgical critical care-trained surgeons in the country,” Dr. Kerby noted.

Trauma educational sessions will be among the initial steps to aid Rwanda. “I think there’s an opportunity for us to at least do a demonstration course and then try to promulgate ATLS,” Dr. Kerby stated, building off the OGB experience training surgeons in ATLS in Hawassa. The course can offer a meaningful starting point for further work.

“What ATLS brings is a common language that everyone learns. Everyone has the same priorities and is talking the same language because they’ve all taken ATLS, and the priorities are very clearly outlined,” he said.

The longer-term plan is full-scale systematic change in the way Rwanda serves the trauma patient. “When we talk about trauma systems,

Opposite:  
A simulation laboratory in Hawassa, Ethiopia, offers an educational opportunity rarely found in sub-Saharan Africa. (Photo credit: Dr. Chris Dodgion)



The Rwandan Minister of Health (center) joins Dr. Patricia Turner (fourth from left), OGB Director Dr. Girma Tefera (fourth from right), and OGB Program Manager Miranda Melone (right).

we're talking about everything from the point of entry to rehabilitation," Dr. Bulger said.

To that end, the group visited the three largest hospitals in Kigali, toured four of five levels of care in facilities outside the capital, and met with Rwandan Ministry of Health officials and local surgical champions, capping a year of online meetings. "You obviously need to have buy-in at a high level for systematic change, and this trip helped cement those relationships," Dr. Bulger explained.

In many ways, Rwandan health officials need no convincing. Unlike the surgical training hubs in Ethiopia and Zambia, which began via an open call for applications, OGB's work in Rwanda started with the Rwandan Human Resources for Health (HRH) Program reaching out directly to OGB to request specific help. "Before our visit, surgical champions in the country who we met with had already done a fair amount of legwork toward building standards for trauma centers and working on prehospital care coordination," said Dr. Kerby.

In addition, the visiting surgeons were enthusiastic about the country's fastidious traffic safety initiatives. "Helmets are mandated across the country for all motorcycle riders, and it's well enforced, with the uptake approaching 100%," explained Dr. Stewart, in describing the laws that apply to motorcycles, the dominant vehicles on many roadways in Kigali.

"There are hundreds of automated speed enforcement cameras that really limit people's inclination to overspeed. The cameras are connected to a system that distributes traffic tickets

via people's cell phones. The tickets are US\$25 and increase to US\$35 if they are not promptly paid; that's a lot of money for a lot of people, which further limits the inclination to speed," he said, adding that vehicles also are required to have speed governors, cell phones are locked in boxes installed on motorcycles while moving, and pedestrians respect crosswalks due to the strategic placement of walkways, curbs, and vegetation.

In addition to training and education, the COT will support a trauma task force centered in the Rwandan Ministry of Health. After noting that eliminating death and disability from trauma across the globe is part of the COT's vision statement, Dr. Bulger stated, "We expect it to be a long-standing relationship."

Trauma alone is not the extent of OGB's collaborations within the country. Rwandan HRH Program's initial request also aligned with OGB's interest in engaging specific kinds of subspecialist surgeon volunteers. "What we are doing in Rwanda is more subspecialty-focused, so it is cardiac surgery, thoracic surgery, plastic surgery, and vascular surgery," said Dr. Tefera, who is a vascular surgeon at the University of Wisconsin-Madison.

Toward that end, OGB has collaborated closely with King Faisal Hospital in Kigali on a plan to enhance supply chains, protocols, and workforce development plans in cardiothoracic surgery. OGB has also worked to engage US plastic surgeons to develop and conduct several workshops in plastic surgery for Rwandan resident physicians.


Dr. Tefera said the impact of this work is emerging. “Because of our presence, some changes are also happening with local general surgeons wanting to be subspecialists. For example, the very first vascular surgeon is finishing up now to go back and work in Hawassa. A cancer surgeon who was inspired by some of our volunteers has also completed his subspecialty training.”

### A Clear Perspective

In the end, OGB’s perspective is clear: The best way to improve global surgery is not just to do it but to teach it.

Dr. Tefera noted that ACS member surgeons do operate in Africa, and “inspiring others by actually being elbow to elbow in the operating room with them” is part of what the US surgeons can offer their African colleagues.

But, he added, “We don’t want the US surgeons going because they want to do tons of cases. We want them to go because they want to teach. The teaching happens in the classroom, the teaching happens in the simulation lab, and the teaching happens in the operating room as well.”

Many of the surgeons working with OGB also note that the surgical training hubs emphasize respect and mutual learning. Echoing remarks from Drs. Belay and Emnet on the presence in Africa of highly experienced surgeons with skills in rare disease management, laparotomic techniques, and creative workarounds for resource constraints, Dr. Tefera noted, “We learn from them as well.” 

### Note

Don’t miss the article in the June issue of the *Bulletin* about the ATLS promulgation in Ethiopia.

**M. Sophia Newman** is the Medical Writer and Speechwriter in the ACS Division of Integrated Communications in Chicago, IL.

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## ACS Resources for Physicians Interested in Global Surgery

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Discover how ACS members are engaging in domestic and international volunteerism through the Surgical Volunteerism group in ACS Communities at [acscommunities.facs.org](https://acscommunities.facs.org).

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Learn more about ACS OGB at [facs.org/ogb](https://facs.org/ogb).

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If you’re interested in connecting with OGB, email [ogb@facs.org](mailto:ogb@facs.org).

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Attend the ACS Clinical Congress Postgraduate Didactic Course, Global Health Competencies for Surgeons: Cognitive and System Skills, on Saturday, October 21, 2023 (8:30 am–4:00 pm).

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Participate in six global health-related Panel Sessions at Clinical Congress, starting with Global Engagement, a session moderated by OGB Medical Director Girma Tefera, MD, FACS, and Sherry M. Wren, MD, FACS, ACS Secretary, on Monday, October 24, 2023 (11:30 am–1:00 pm).

# California Advocacy Produces Six Lessons for Surgeons across America

John Maa, MD, FACS

Amy E. Liepert, MD, FACS

Jay J. Doucet, MD, FACS, FRCSC

Pascal Fuchshuber, MD, PHD, FACS

**Surgeon-led healthcare advocacy in California has a long and accomplished history and has paved the way for new trends across the nation.**







EFFORTS IN THE LATE 1960S were driven by the ACS Committee on Trauma's vision to establish a unified and coordinated approach to trauma care in California, and into the early 2000s, served as the foundation of ongoing advocacy by ACS California leaders, including David B. Hoyt, MD, FACS, Immediate Past ACS Executive Director.

Today, with the advent of surgical acute care programs, payment reforms, regulations (e.g., surprise medical billing), and the consolidation of surgical practices, surgical advocacy is more important than ever. In recent decades, there

have been increasing recognition and efforts from the ACS Division of Advocacy and Health Policy (DAHP) at the federal level.

However, sustained state-level advocacy efforts remain a challenge. This article summarizes the advocacy-related successes and challenges of the ACS California chapters since 2011 that have helped define expectations for future statewide goals and objectives that may inspire and help other state chapters.

### Three ACS California Chapters

California is the most populous state in the US, spanning a geographically large and diverse region with large academic institutions and private healthcare provider systems that operate large and small healthcare facilities in all chapters. California is one of six states in America with multiple chapters (see Figure 1, this page).

California has three chapters: Northern California (3,044 members), Southern California (3,864 members), and San Diego-Imperial (821 members), accounting for approximately 10% of ACS members in the US.

The state capital of Sacramento is within the Northern Chapter jurisdiction, with the University of California, Davis being the closest academic institution. The Southern Chapter includes the surrounding urban environments of Los Angeles, while the San Diego-Imperial Chapter is the farthest from Sacramento and represents the third largest city in California.

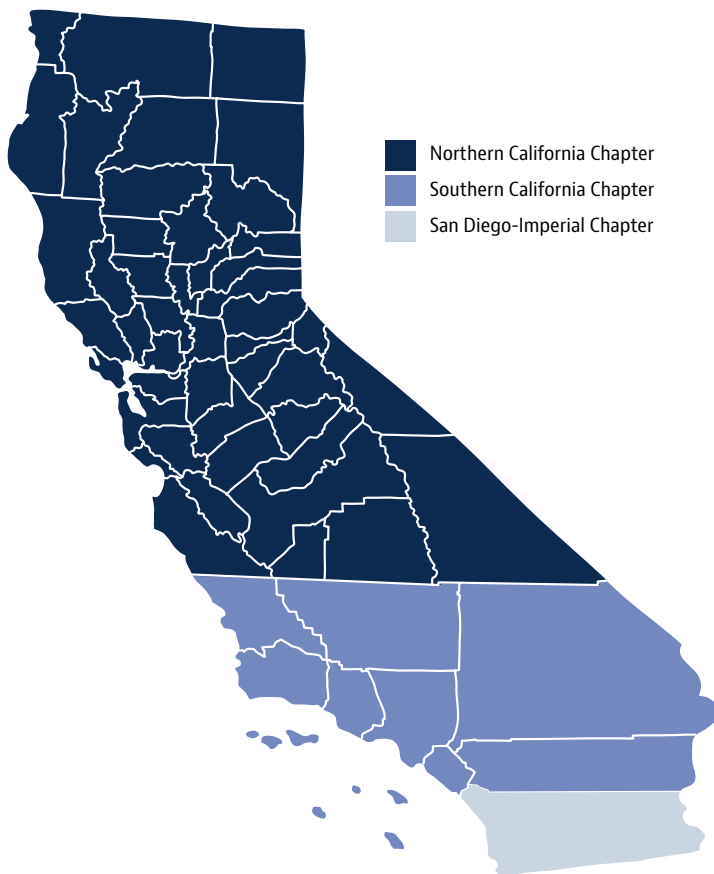
### Uniting Chapter Efforts through ACS Grant Funding

In a large state with three chapters, building a strong and coordinated advocacy effort at the state level requires improved communication, an understanding of differing priorities, and respect for each chapter's independent operations.

After the inception of the ACS Chapter State Advocacy Grant Program in 2011, the California chapters were awarded 12 consecutive advocacy grants.

For the first 3 years, the Northern California Chapter applied alone; in 2014, the Southern

**Figure 1. California State Chapters**



California Chapter joined for the first time.

Cross-communication was strengthened by the creation of the Joint Advocacy Committee (now called the Joint Advocacy Committee of the ACS California Chapters) with representation from each chapter in Washington, DC, at the 2016 Leadership & Advocacy Summit. Later that year, the three chapters united for the first time to apply for a joint statewide legislative grant.

Another key step forward to unify surgical health policy advocacy was the invitation of Southern California Chapter President Craig J. Collins, MD, FACS, to speak at the 2019 Northern California Chapter meeting to reach consensus on future advocacy priorities.

As reported in previous ACS *Bulletin* articles, advocacy efforts regarding surgical health policy in California achieved significant successes through coordinated action. The topics covered included several ACS state-level priorities:<sup>1-6</sup>

- Limiting the scope of practice expansion by optometrists and nonphysician health practitioners
- Improving emergency and trauma care access
- Supporting the Uniform Emergency Volunteer Health Practitioners Act (UEVHPA)
- Promoting firearm safety
- Preserving medical liability protections
- Strengthening insurance in-network coverage and access to care
- Enhancing colorectal cancer screening

The Joint Advocacy Committee continued to work virtually when in-person meetings with legislators and fellow surgeons were canceled or replaced by video conferencing, and many political issues were pushed aside in the maelstrom of pandemic-related priorities.

While the annual state advocacy day in Sacramento was canceled in 2020 and 2021, a virtual day allowed surgeons to meet, collaborate, and develop relationships with legislators.<sup>7</sup> In 2022, the three chapters emerged from social distancing restrictions to continue advocacy efforts that led to major statewide success with ACS STOP THE BLEED®.

## Six Lessons Learned through Advocacy

**1 Wins in passing sponsored legislation are harder than defeating bills that you oppose. Playing defense is easier than introducing and supporting new bills.**

It took a decade to repeat our initial success with passing a sponsored bill. In 2012, the Northern California Chapter championed a prostate cancer screening bill with Assemblymember Linda Halderman, MD, FACS (R), who was the first and only general surgeon elected to the California State Legislature in its 173-year history.<sup>2</sup>

Ten years later, the chapters jointly sponsored the STOP THE BLEED Assembly Bill (AB) 2260 with Assemblymember Freddie Rodriguez (D). The legislation, Emergency Response: Trauma Kits, was the first statewide law of its kind to make bleeding control kits widely accessible.

Throughout the next decade, the chapters had many advocacy-related successes, principally by defeating the undesirable bills sponsored by others. We also opposed unfavorable bills that still passed, such as surprise medical billing, and championed acts like UEVHPA that research revealed could be implemented without new legislation.

Resist becoming discouraged by setbacks when trying to pass your own legislation, and instead gain experience and visibility by defeating or supporting the legislation of others. This way, you may become a powerful advocacy presence and, by cultivating relationships with elected officials and their staff, you may create opportunities to speak at state capitol hearings, press conferences and debates, and with the media.

**2 Beware of forces beyond your control.**

Focus on the policy issues that endure, rather than individuals who may not. Advocacy-related victories are not always the result of one's own actions because opponents sometimes make unforced errors.

In 2014, the chapters' focus was on Senate Bill (SB) 47, which sought to eliminate the bullet-button



modification of semiautomatic weapons to convert them into assault weapons.<sup>4</sup> As the bill neared the governor's desk, the legislative author was forced to leave office, and all efforts in support of the bill were abandoned. Events beyond your control can derail a promising legislative agenda.

In 2014, the defeats of Proposition 45 and Proposition 46 at the ballot box by overwhelming voter majorities proved to be significant victories for surgeons.<sup>5,6</sup> These twin propositions had been sponsored by the trial attorneys to raise medical liability caps, require mandatory drug testing of physicians, and allow intervenors to file court challenges to health insurance rates.

One of the keys to victory was an “off the cuff” comment by one of the proponents that drug testing of physicians had been added as the “ultimate sweetener” to secure passage of the proposition, as drug testing had polled favorably with voters. His comment proved to be an unforced error that backfired, as some voters rebelled against the perception that they could be manipulated.

### 3 Be persistent.

While the intent of your advocacy-related efforts may not succeed in the first year, they may be fulfilled in the future. Don't underestimate the power of the ballot box.

In 2013, the Northern California Chapter endorsed SB 374, which sought to limit high-capacity magazines for semiautomatic weapons, but was vetoed by Governor Jerry Brown (D).<sup>4</sup>

The next year, SB 47 failed when the Senate author was forced out of office. In 2016, the three chapters were asked to support a comprehensive package of firearm legislation (Proposition 63) championed by then Lieutenant Governor Gavin Newsom (D). A lack of consensus among ACS members on firearm safety resulted in none of the California chapters endorsing Proposition 63, which passed by an overwhelming margin at the ballot box.

The silver lining is that the entire slate of unsuccessful firearm safety bills supported by the Northern California Chapter in earlier years (e.g., SB 374, SB 47) were part of the package in

Proposition 63 and, eventually, all became California laws in a single action by the voters. In 2018, the Northern California Chapter also endorsed SB 1100, which raised the firearms purchase age to 21 and was signed into law by Governor Newsom.

In 2017, the three California chapters first championed bleeding control kit legislation to require public trauma kits in public buildings and schools. With the help of Jay J. Doucet, MD, FACS, FRCS, a STOP THE BLEED training session with state legislators and staff was arranged for the same day as testimony at an Assembly committee hearing where the bill advanced.

Unfortunately, the bill did not pass the Appropriations Committee as it was assigned a high fiscal price tag. Repeat efforts over the next several years were unsuccessful, mainly due to the inability to pass the Appropriations Committee.

A revamping of the bill better aligned with STOP THE BLEED, and introduction in the Senate drove this effort forward with a new strategy. Finally, in 2022, the revised STOP THE BLEED AB 2260 passed with broad support and was signed into law.<sup>8</sup>

Be aware of cost estimates by legislative analysts, which proved to be the pitfall for both the colorectal cancer screening and initial versions of the STOP THE BLEED bill. If your bill is scored with a high fiscal price tag, try every measure to reduce the cost estimate by using volunteers, through charitable contributions, and by strategically addressing materials and scope, which led to passage of AB 2260 and other bills.

### 4 Partner with your state medical association, the ACS team in Washington, DC, and the SurgeonsVoice advocacy network.

Over the years, the primary ACS advocacy meeting in Sacramento was held concurrently with the California Medical Association (CMA) Legislative Advocacy Day, and partnering with the CMA and the ACS state affairs team have been keys to success.

In 2018, in the aftermath of AB 72 (surprise medical billing), another major threat to the practice of medicine was introduced—AB 3087, which sought to create a commission that would cap rates for healthcare services in all California clinics, hospitals, and physician practices.

Opposite, top: The California Delegation attends the ACS Leadership & Advocacy Summit in 2018.

Bottom: Alexandra Johns, MD, Thomas K. Duncan DO, FACS, Assemblymember Freddie Rodriguez (D-CA), and Sigrid K. Burruss, MD, FACS, join Drs. Jay Doucet, Amy Liepert, and John Maa for a STOP THE BLEED training session in the California State Capitol “swing space.”



The CMA focused the entire Legislative Advocacy Day in opposition to AB 3087. A letter from Dr. Hoyt was distributed to every elected official in the Capitol on that day. AB 3087 died shortly afterward in the Assembly Appropriations Committee.

In recent years, STOP THE BLEED training sessions were held at the CMA Legislative Advocacy Day, and the ACS delegation met in the CMA offices to prepare for the day.

Using the SurgeonsVoice advocacy network to email legislative updates and activate the grassroots network of ACS members was helpful to defeat Proposition 46 in 2014 and secure passage of the STOP THE BLEED bill in 2022.<sup>6</sup>

## 5 Partner with a strong coalition and master media training, while also being willing to participate in statewide television commercials on important topics.

In 2018, the three chapters united to oppose Proposition 8 that would have required dialysis centers to have a physician onsite and likely would have forced many dialysis centers to close. The chapters joined a broad statewide coalition to defeat the ballot initiative.

The ballot measure reappeared in 2020, and a new ACS logo designed for the three chapters was featured in the statewide television commercials to defeat the measure a second time. The initiative returned for a third time in 2022 (Proposition 29), and the California chapters united to defeat it once again.

Chapter members appeared in television interviews, spoke at press conferences and in radio debates, were featured in the newsprint media, and on statewide mailers to oppose Proposition 46. It is essential, however, to understand the importance of media training, and clear and concise communication. A Proposition 46 supporter mistakenly spoke to a *Los Angeles Times* reporter in what he thought was an off-the-record conversation and inadvertently disclosed information that defeated his own effort.

A 2014 *Bulletin* article highlighting the importance of protecting medical liability caps in California helped educate ACS members and was available for them to share with their patients.<sup>6</sup> The ACS team in Washington, DC, also sent materials to every California ACS member, requesting their engagement in defeating Propositions 45 and 46.

Success in our advocacy over the decade also came from multiple letters to the editor published in the *Sacramento Bee* and other state newspapers, live debates on radio and television programs, and speaking at press conferences and rallies.

## 6 Recognize the power of and need for the surgeon perspective in the legislature.

Be certain to work with the minority party. Our major victories in sponsoring new legislation came through partnerships with Republicans Dr. Halderman and then-Assemblymember Marc Steinorth.<sup>2</sup>

Defeating the most powerful California labor union over a surgical technologist bill revealed an intriguing insight. A Sacramento lobbyist reviewed the California chapters' opposition to a bill claiming that using surgical technologists would reduce wound infections. The lobbyist also noted that California surgeons were standing alone in opposition to a labor union that outnumbered the ACS in membership by nearly 500 to 1.

Our concerns as surgeons about the flawed science behind the bill were heard, and the bill was vetoed by the governor, citing the specific concerns we raised. The lesson is to stand up for what you believe in, have the data to be convincing, and be persistent. You can have a great impact outside of the operating room.

Building a statewide joint coordinating advocacy committee is critical to success in large states with several chapters. The three California chapters have not always agreed on topics like tobacco control and firearm safety, resulting in a chapter sometimes having to act alone on a bill. After the passage of AB 2260, it became clear that advocacy committee bylaws would help guide the future coordinated

decision-making and statewide priorities for the Joint Advocacy Committee.

This decision led to the creation of a memorandum of understanding (MOU) outlining leadership succession, membership structure, and voting procedures, in addition to the mission and goals of the committee.

The MOU represents the inaugural establishment of a joint advocacy committee between different ACS chapters within a state and may serve as a blueprint for other states to use. The new details in the MOU were designed to help unite a much larger constituency and enhance the ability to find coalition partners.

Finally, carefully note key legislative deadlines and calendars for bills to move through committees and the house of origin. Success in advocacy requires planning and anticipation, just like the operating room. The California State Legislature begins in January, recesses for the month of July, and returns for a short session in August before adjourning for the rest of the year, with few exceptions.

The time for action on potential bills is focused on the first half of the calendar year. In California, new bills must be submitted by February, well before the annual state Lobby Day. One strategy is to introduce several “spot bills” as placeholders early in the year or to “gut and amend” an existing bill if deadlines are missed. Your advocacy priorities may evolve, so try to be nimble in anticipating change and be willing to pivot rapidly to harness new legislative opportunities.

As the legislative session winds down in September each year, preparation of new advocacy topics for the following January is essential to meet the tight deadline of drafting a new bill and finding sponsors. Use the time when the legislature is not in session to meet with your elected member in the district.

As a surgeon-advocate and credible member of your community, you can complement the work of registered lobbyists and share your expertise to craft new solutions in health policy. **B**

**Dr. John Maa** is the immediate past-chief of general and acute care surgery at Marin Health Medical Center in Greenbrae, CA, and was the 2013 President of the ACS Northern California Chapter.



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In 2016, then-Lieutenant Gov. Gavin Newsom recognized Dr. John Maa and others for their advocacy against gun violence.



Dr. Medhat Fanous

# Skeletonize or Modernize: Which Approach Will Define the Future of Rural Surgery?

Medhat Fanous, MBBCH, FACS

Overhauling rural surgery is a challenging task. Multiple solutions have been entertained, and they boil down to two strategies that hinge on whether to transfer the patient to surgical care at larger hospitals or make the care available locally.



THE FIRST STRATEGY—transferring the surgical patient to a larger hospital—is centered on reducing surgical services in rural hospitals or skeletonizing, thus eliminating the costs of necessary infrastructure as well as the ongoing costs associated with less frequently performed inpatient operations. This approach suggests that smaller hospitals should perform only minor, straightforward surgeries.

When care is not urgent or emergent, the patient transfer approach could result in long waiting lists, and rural patients would be required to travel several times for the initial visit, workup, surgery, and follow-up. It also is important to note that there is extremely limited public transportation in many smaller communities, and rural patients sometimes cannot afford to fill their car gas tanks.

With some patients, including geriatric patients, the financial burden is even greater as the families need to pay for accommodations while losing days of work.

In emergency situations, transportation is not always reliable. The delay can result in the progression of the surgical disease, which has the potential of increasing morbidity and necessitating a long list of

consultations, interventions, possible protracted hospital stay, and increased cost.

When transferring the patient is not possible due to the lack of surgical beds at the larger facility or transportation is unavailable, rural patients with surgical emergencies such as viscus perforation or ischemic bowel could die.

The second strategy—modernizing—focuses on the provision of surgical care within the patient’s local community through a variety of modalities, such as telehealth, minimizing travel to larger hospitals.

This approach promotes performing advanced or cutting-edge surgeries locally by well-trained rural surgeons who act as one-person teams that do not rely on consults, thus saving a substantial amount of money.

Another important benefit is that patients can receive visits from family without traveling long distances—this aspect of care and its impact on healing should not be underestimated.

### **Experiences of Aspirus Iron River Hospital**

The data from the 2020 US census showed a reduction of rural populations from 2010 to 2020; however, these numbers predate the COVID-19 pandemic and do

not take into account seasonal population variation.

Rural areas provided a sanctuary during COVID-19 pandemic for rural and urban individuals. The observed lockdowns were easily relaxed in these low-population areas as social distancing was already in place, a circumstance that

**Our core belief is that rural patients deserve surgical services comparable to their urban counterparts.**

seemed to attract people to live in rural areas. One of the prerequisites for choosing rural areas is the availability of a local hospital with optimal surgical services.

However, recruiting rural surgeons to perform outpatient surgery exclusively, without the ability to address their own complications in their hospitals, is an unappealing proposal. Unfortunately, this approach could lead to hospital



## Using robots in rural hospitals and establishing local niches in general and orthopaedic surgery is promising.

closures and catastrophic economic consequences for the community. The astronomical cost of rebuilding collapsed rural services will eclipse the money necessary to support current services.

My hospital, Aspirus Iron River Hospital in Michigan, is a prime example of making surgical care available to patients locally. This critical

access hospital is located in the Upper Peninsula of Michigan, in a town with a population of approximately 3,000 people. Our core belief is that rural patients deserve surgical services comparable to their urban counterparts.

In addition to bread-and-butter surgeries, the hospital provided specialized foregut procedures—a rewarding

decision that produced excellent outcomes for new procedures with long follow-up.

We initially attracted patients from nearby communities, and then—in a reversal from the typical rural-to-urban patient travel—more urban patients from different states traveled to our rural hospital to have their antireflux procedures performed.

This practice ensured financial stability before and during the COVID pandemic.

The hospital established an antireflux program in a stepwise fashion over 8 years, evaluating approximately 1,100 gastroesophageal reflux disease (GERD) patients.

Patients received a comprehensive diagnostic workup with endoscopy, wireless pH studies, endoFLIP, and manometry. We also performed endoluminal (the Stretta procedure and transoral incisionless fundoplication) and laparoscopic/revisional antireflux operations. Some of these procedures were completed locally in large numbers prior to their implementation in larger hospitals.

Aspirus Iron River Hospital recently added sedation-free, robotically controlled capsule endoscopy. It is one of only eight hospitals in the US, and the only critical access hospital, using this new technology (see photo, page 48). The capsule can be maneuvered with robotic assistance to thoroughly examine the stomach without the need for sedation, preoperative lab work, or discontinuing anticoagulants.

Using the technology, we were the first hospital in the world to visualize antireflux valve (transoral incisionless fundoplication [TIF]) in the collapsed normal

position without being stented by a gastroscope.

This breakthrough has the potential to allow surgeons to examine the dynamics of the gastroesophageal junction in an awake GERD patient without endoscopy. We presented this discovery at an emerging technology session of the Society of American Gastrointestinal and Endoscopic Surgeons 2023 annual meeting.

My hospital is one of many inspiring examples of rural centers that embraced modernizing or even revolutionizing surgical services. Using robots in rural hospitals and establishing local niches in general and orthopaedic surgery is promising.

Proponents of this approach are not opposed to judicious cuts in particular services or supplies; however, they acknowledge that rural hospitals simply cannot cut their way to success. It is growth and expansion that ensures a hospital's financial survival.

In summary, skeletonizing the scarce resources of rural hospitals has theoretical advantages, which evaporate with the realization that it may result in the malfunction, and possible collapse, of both the rural and urban health systems.

A better investment is to modernize and train surgeons to have thriving careers in

rural America where they can serve the rural patients in their own communities.

Until serious strides are made, every rural surgeon should ask themselves one question: What services do I provide that will make patients bypass other hospitals to come to me? **B**

#### **Disclaimer**

The thoughts and opinions expressed in this article are solely those of Dr. Fanous and do not necessarily reflect those of the ACS.

**Dr. Medhat Fanous** is a general surgeon at Aspirus Iron River Hospital in Michigan.

Opposite:  
Dr. Medhat Fanous uses robotic-controlled capsule endoscopy to examine the stomach of an awake patient.

# SSA Program Supports Next Generation of Inclusive Leadership

Alexander Perez, MD, MSHCT, FACS  
Ronda S. Henry-Tillman, MD, FACS  
Mary E. Klingensmith, MD, FACS  
Robert S. D. Higgins, MD, MSHA, FACS  
William C. Chapman, MD, FACS  
V. Suzanne Klimberg, MD, PHD, MSHCT, FACS



# More than a year after the Southern Surgical Association (SSA) launched a Leadership Development Program (LDP), the inaugural class of surgeon-scholars is putting the lessons learned into practice.

IN JUNE 2021, THE ACS CONVENED a virtual meeting—the Promoting Diversity, Equity, and Inclusion (DEI) & Anti-Racism: Professional Surgical Society Retreat—in response to disparities in leadership and differential advancement opportunities for underrepresented groups in surgery. More than 50 surgical organizations, including the SSA, participated. The group worked to identify hurdles that lead to healthcare disparities and develop strategies for improving access to membership and leadership within these organizations.<sup>1</sup>

The SSA was founded in 1887 as a small group of prominent local surgeons in Birmingham, Alabama, and has grown into an organization of more than 800 fellows nationwide. In 1900, cofounder W. E. B. Davis stated, “This association has grown and expanded until it is only a Southern association in name. It is a national organization in every sense of the word.”<sup>2,3</sup>

The SSA has a longstanding commitment to DEI. Since 2013, the Claude Organ, MD, Lectureship, supported by the SSA and The Society of Black Academic Surgeons, has celebrated contributions to the field of medicine made by Black physicians. In 2018, the SSA began hosting the Women Surgeons’ Breakfast at the SSA annual meeting, and a few years later, the event evolved into the Justice, Equity, Diversity, and Inclusion Breakfast.

In 2021, SSA leadership appointed a DEI Task Force. After reviewing the SSA’s organizational composition, the group sought to create membership opportunities for people of diverse backgrounds by identifying and encouraging applications from minority candidates.

Additionally, the task force created dedicated programming related to disparities in outcomes and health equity at the annual meeting to attract a more diverse membership. In 2022, SSA leadership

granted the DEI Task Force the status of “standing committee”—the only one of its kind in the SSA.<sup>4</sup>

## Innovative Grant for DEI and Antiracism Programs

Through a competitive granting process, the ACS provided a \$25,000 award, to be matched by the SSA, for an SSA leadership development program that promotes excellence in diverse young surgeons.<sup>5,6</sup>

From this investment, the SSA DEI Task Force created the LDP, which is an initiative intended to expand the SSA’s standards of justice, equity, diversity, and inclusion; promote innovation and discovery; and better serve patients and the professional mission.

The program focuses on mentorship and leadership development for a group of diverse young surgeons and prepares them for future membership in the SSA. The initiative includes career coaching, lectures on topics such as contracts and negotiations, meta-leadership, workplace culture, health equity, networking opportunities, and the ability to work individually with mentors to achieve career goals.

Monthly meetings are held throughout the year to provide ongoing personalized mentorship. Many members of the SSA generously volunteer to serve as mentors, sponsors, and lecturers for the LDP.

The inaugural ACS Medical Director of the Office of DEI, Bonnie Mason Simpson, MD, has served as a lecturer for the LDP, highlighting the collaboration between the SSA and the ACS, which has been integral to the success of the program.

## Inaugural Class of LDP Scholars

Nominations for LDP candidates were solicited via email notification to the entire SSA membership. Candidates submitted their application packets,

**Opposite:**  
The inaugural class of LDP scholars met with their mentors at the SSA Annual Meeting in December 2022.

**Front row:**  
LDP scholars (from left) Drs. Asishana Osho, Shaneeta M. Johnson, Crystal N. Johnson-Mann, Jacquelyn S. Turner, Carolina Martinez, and J. W. Awori Hayanga

**Back row:**  
LDP faculty Drs. Gilbert R. Upchurch Jr., Keith A. Delman, Ronda S. Henry-Tillman, Erica Sutton, V. Suzanne Klimberg, Robert S. D. Higgins, and Alexander Perez

By assisting with leadership development, we anticipate that the pool of surgeon-leaders ready and able to serve in their communities, departments, and organizations will be more diverse than if this program did not exist.

which included their curricula vitae, biographies, and 1-, 3-, and 5-year career goals.

A total of six LDP scholars were selected from a pool of 26 candidates by the SSA DEI Task Force based on their accomplishments and aspirations. These scholars were paired with SSA mentors, attended monthly group lectures, and were sponsored to attend the 134th SSA Annual Meeting in December 2022. The support and leadership of the SSA and ACS DEI grant made possible the graduation of the inaugural class of LDP scholars (see photo, page 50).

Outcomes of the LDP were assessed using monthly surveys of scholars to self-report satisfaction with the yearlong course content and mentorship sessions, as well as the impact of the course on individual professional development and leadership position attainment within their departments, communities, regions, and the nation.

Monthly surveys of the first cohort of LDP scholars showed uniformly high rating (4–5 on a 5-point Likert scale) for the relationship and communication with their mentor, the quality of the monthly lectures, course satisfaction, progress with mentor goals, and likelihood of recommending the program to a peer. Scholars commented favorably regarding networking opportunities, intentional career and promotion planning, and sponsorship opportunities.

The impact of this program on the success of participants achieving leadership positions as well

as membership status in the SSA will be tracked long term. When criteria for SSA membership are attained (often around 10 years of practice), current SSA members will sponsor the LDP scholar's SSA membership application.

Over time, our goal is to demonstrate that these diverse young surgeons included in the LDP achieve career progression and success as evidenced by metrics such as SSA membership, leadership roles in their home institutions and/or other national organizations, and ongoing professional development and progression.

By assisting with leadership development, we anticipate that the pool of surgeon-leaders ready and able to serve in their communities, departments, and organizations will be more diverse than if this program did not exist.

The SSA's commitment to DEI is a result of the organization's acceptance, culture, and values that have evolved to its current state of awareness under the steadfast leadership of the SSA Council (composed of the past five presidents) and through the generous support of the SSA membership. **B**

**Dr. Alexander Perez is the Le Roy Hillyer, MD, Endowed Chair in Surgery, vice-chair of quality, and chief of minimally invasive and foregut surgery in the Department of Surgery at The University of Texas Medical Branch in Galveston.**

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# ACS Launches “The Power of Quality” Campaign

The ACS officially launched The Power of Quality Campaign last month, just ahead of its Leadership & Advocacy Summit.

THIS NATIONAL, MULTIYEAR CAMPAIGN IS AIMED at improving care for all surgical patients by increasing awareness about the importance of quality and bringing ACS Quality Programs into every hospital in America.

“We are driving a national conversation about quality and the key role that programs like ours can play in improving care for patients everywhere. This means engaging with hospitals, policymakers, payers, and patients to ensure the entire health care ecosystem understands the Power of Quality,” said Patricia L. Turner, MD, MBA, FACS, ACS Executive Director and CEO. “This means having meaningful conversations about how we can all work collaboratively to improve quality.”

The College was built on a foundation of quality in 1913—and surgeons have long known that quality care is not only good for patients but also is good for healthcare processes and financial efficiencies.

“Quality has become so much more complex and sophisticated,” said Clifford Y. Ko, MD, MS, MSHS, FACS, FASCRS, a colorectal surgeon at the University of California, Los Angeles and Director of the ACS Division of Research and Optimal Patient Care. “We now have so many different domains of quality and metrics that healthcare teams don’t know how to improve those metrics. The College can help ‘improve the improvement’ because we have standards that describe the things we need to do and explain what the infrastructure and resources are needed to do them.”

The ACS has 18 Quality Programs that provide roadmaps for specialties such as trauma, cancer, geriatrics, bariatrics, and children’s surgery, including a program that addresses processes for a hospital’s entire surgical system.

At the Inova Health System in Virginia, where urological surgeon J. Stephen Jones, MD, FACS, is the president and CEO, quality is not looked at in a silo by department or hospital but systemwide.





“We look at clinical excellence. Quality is a part of that, safety is a part of that, patient experience and financial stewardship are a part of that,” he said. “We need the mindset that we will continually improve to be the best and never accept that we can’t be better. And, by the way, we think this is the right business decision too. It’s not a tradeoff.”

### **An Evolving Quality Journey**

Another goal of The Power of Quality Campaign is to help policymakers and payers understand the relationship between quality and cost.

“If we decrease our costs, we don’t necessarily get better quality. Sometimes we get worse quality,” explained Dr. Ko. “However, if we prioritize quality and quality gets better, then there are fewer complications, fewer readmissions, and patients don’t have to go through the emergency department or have extra radiology exams. That saves money.”

He also articulated the importance of

incorporating patient-centered goals into reimbursement models. Having recently operated on a 32-year-old and a 101-year-old in the same week, he pointed out the obvious—that each patient had a different postoperative goal.

“We need to focus on individualized quality, what’s best for each patient, and how we can do it in an efficient, effective, and timely way,” he said. “These measures need to be aligned so that what’s in the patient’s best interest is also what surgeons are incentivized to do.”

The next steps include launching a public-facing campaign in test markets around the US, developing patient information materials, and working more closely with surgeons in those test-market areas to champion The Power of the Quality messages.

View a video of the discussion on the ACS website at [facs.org/quality-programs/the-power-of-quality](https://facs.org/quality-programs/the-power-of-quality), where additional information about the campaign also is available. **B**

Dr. Turner (at podium) leads “The Power of Quality” Campaign launch panel.



# Leadership & Advocacy Summit Proves to Be Powerful Catalyst for Change

Jennifer Bagley, MA

Washington, DC, served as the hub for aligning leaders, fueling collaboration, and strengthening advocacy strategies, as more than 600 surgeons descended on the nation's capital last month for the ACS Leadership & Advocacy Summit.

Drs. Robert Higgins and Paula Ferrada reveal their leadership wisdom, while asking the 360 Leadership Summit attendees, "Can you be a leader?"

THIS DYNAMIC EVENT—held at the Grand Hyatt Washington, April 15-18, in-person and virtually—connected like-minded professionals who engaged in meaningful discussions and learned from renowned experts about navigating the complexities

of leadership and advocacy in the field of surgery.

"The 2023 Leadership & Advocacy Summit was truly exceptional, bringing together ACS leaders and members and leaving us inspired, motivated, and equipped with invaluable

leadership and advocacy knowledge and skills," said Michael J. Sutherland, MD, MBA, FACS, Director of the ACS Division of Member Services. "The engaging sessions and thought-provoking panels were a testament to the power

of collective wisdom and shared experiences, while reminding us of the limitless potential of effective leadership and influential advocacy.”

### **Don't Lose Focus, Save the Salami**

A special preconference seminar, *Negotiation Practice and Principles: Tips, Tactics, and Traps*, was offered as an add-on for attendees. In this session, Cathy A. Constantino, attorney and professor of law at Georgetown Law School in Washington, DC, promised to talk about “practical stuff.” She encouraged surgeons to use the same problem-solving skills that they use to treat patients within a negotiation.

She also underscored the importance of not losing focus during a negotiation and using words that make you stand out from competitors.

“You don't want to tell them you are different. You are not different; you are unique. Tell me what makes you special. What do you bring that no one else does?” Constantino advised.

In addition, she detailed how to make offers and counteroffers by adding visuals to the conversation to help increase the likelihood of a successful negotiation. She also explained how to become more comfortable with saying “no.” Constantino shared a “trick” that she uses often—the “no sandwich.” This method involves sandwiching something negative between two positives.

“Yes, I understand that your hospital has very specific needs and that you're under a budget crunch right now. No, I'm not in a position to accept your offer. But yes, I think if we keep working on this, we might be able to come up with something,” she said. “Yes. No. Yes. It goes down easier.”

At the same time, when or if the negotiations reach a haggling stage, Constantino warned against what she calls “salami.” The “one more slice, one more slice, one more slice” likely will annoy the potential employers on the other side of the table. Instead, step away, come up with all your “one more whatever,” and confidently return with your asks. In other words, know what you want—which includes non-monetary options—and what your concessions are.

### **Intersection of Ability and Aspiration**

The Leadership Summit officially kicked off on Sunday morning, with strong messages from Kimberly M. Lumpkins,

MD, MBA, FACS, FRCS(Eng), surgeon-in-chief at the University of Maryland Children's Hospital in Baltimore.

In the session, *Defining Your Path: Your Personal Mission Statement*, Dr. Lumpkins started with a “hot take” on leadership: if someone wants to be a leader just for the title, prestige, and for people to follow them around, historical evidence suggests they are not going to be a very good leader. She urged everyone to understand their why.

“Why do you want to lead? You need to start by looking inside,” she said.

Dr. Lumpkins also encouraged attendees to find their “intersection of ability and aspiration.” Ability is what you

Inspiring and passionate leaders, including Drs. Kimberly Lumpkins, Clifford Ko, and Don Selzer, shared their experiences and insights during the Leadership & Advocacy Summit.



are good at; aspiration is what you love. When they overlap, it's a calling. You deserve to live at that intersection, she said.

Acknowledging that she was talking to a room full of successful surgeons, Dr. Lumpkins admitted that "it's a little too late for the 'what do you want to do when you grow up' talk." But a career, she explained, is not what you trained in. A career is a portfolio of projects that teaches you new skills, helps you develop new capabilities, and constantly reinvents you.

"Surgery is a toolchest that you have. It's not your straitjacket," Dr. Lumpkins said, sharing the example of trauma surgeon

Similar to the "unique" theme emphasized in the negotiation session, Dr. Lumpkins stressed the importance of a personal brand and identifying what makes you "indispensable." Uniqueness equals leverage, she said.

While identifying your uniqueness may sound simple, it's often very challenging. If you're struggling with finding your points of difference, look inward and outward, Dr. Lumpkins advised, while recommending that everyone should have their own "personal board of directors"—a group of three to five people who you trust and can talk to about these issues.

Once you know what makes you stand out, you're able to start

and thinking about podcasts and articles that interest you.

"What are the themes in talks you go to, articles you read, and podcasts you listen to? Somewhere within that, in those spaces, is your mission statement, and your mission statement will continue to change and evolve over your career, and that's just fine, because if you're not changing, you're dying," Dr. Lumpkins said.

### **Leadership in Times of Crisis**

In the session, Can We Find a Silver Lining? The Role of Leadership in Times of Challenge, Robert S. D. Higgins, MD, MSHA, FACS, president of Brigham and Women's Hospital and executive vice-president of Mass General Brigham, both in Boston, Massachusetts, detailed his career as a cardiothoracic surgeon and shared personal stories and "pearls" garnered from his leadership journey.

Can you be a leader? This important question was one that Dr. Higgins examined closely during his presentation. He shared, with candor, that he asked himself this very question about 18 months ago when he was considering his current position.

"I really had to do some soul-searching. Can I lead in such a distinguished academic environment? I'm not a funded investigator. I'm a surgeon and clinician. I'm an underrepresented minority in a predominately white organization. I'm the only person of color at the organizational leadership meetings. So, I had to decide if I could lead in that environment," Dr. Higgins said.

In addition to expert advice about becoming a leader,



Surgeons from the state of Washington, including Eileen M. Bulger, MD, FACS, and Douglas E. Wood, MD, FACS, discuss their plans for the in-person visits on Capitol Hill.

and leader L. J. Punch, MD, FACS, from the Washington University School of Medicine in St. Louis, Missouri, who is an activist in the fight against gun violence and runs programs to educate the community on how to reduce the impact of trauma, injury, and violence.

crafting your brand and creating your personal mission statement. When working on developing your statement, Dr. Lumpkins suggested "disabling" your frontal lobe and having a free stream of consciousness, writing down problems you are interested in solving and activities you enjoy,

he generously shared some wisdom he received from his late mother and that he lives by every day, including:

- Understand your challenges (preparation).
- Situational awareness is critical (adaptability).
- Pick your battles (prioritize).
- Rome wasn't built in a day (patience).
- You may lose battles and still win the war (resilience).
- Don't fight too many battles on too many fronts (focus).

## Get Off the Hamster Wheel

Paula A. Ferrada, MD, FACS, FCCM, division and system chief for acute care surgery and trauma at Inova Healthcare System in Falls Church, Virginia, carried on the conversation about growing as a leader.

In another popular session during the Leadership Summit, *Strategies to Get What You Deserve*, Dr. Ferrada recommended finding your why, understanding and managing your environment, “getting off the hamster wheel” and dedicating time to introspection, focusing on your happiness, and accepting that everything—especially things that are hard—is an opportunity.

“Nothing about this is easy, but every single thing we do is worth it. Are you going to persevere or not? That’s the difference. Be the hero of your own story,” she said.

## Executive Director’s Update

ACS Executive Director and CEO Patricia L. Turner, MD, MBA, FACS, provided a comprehensive overview of the College’s

performance, key achievements, interesting challenges, and future plans—all staying true to the ACS’s 110-year-old motto, “To Heal All with Skill and Trust.”

Importantly, she also outlined how the ACS is working to meet the needs of its members through quality, education, member services, advocacy, and communications. In the quality arena, Dr. Turner recognized how the ACS is embracing an “ambitious goal.”

“We are working to bring ACS Quality Programs to every patient cared for in every hospital in this country,” she said. “We lean into this unabashedly because we know that we can make the care of the surgery patient better by using our Quality Programs.”

Dr. Turner discussed future plans for the College and its members, explaining that the ACS thoughtfully works to make it “impossible” that surgeons of any specialty would not engage with the College. Among the membership value-adds is that the ACS meets the learners where they are with “just-in-time education.”

“We have learners in medical school and up to and through retirement, so when we think about what is on the cutting edge, we are thoughtful and make sure we know what you need as members and that we bring you the education that will help you in your day-to-day practice,” said Dr. Turner. “We need to be the gold standard...the arbiter of all things surgery.”

Also during the Leadership Summit, leaders from three ACS chapters—San Diego, New York, and Bolivia—shared their success stories. Additional sessions included *A Novel Approach to Understanding Surgeon Burnout* and *Operationalizing Solutions at*



*Individual Institutions, Effective Performance-Based Teaching: Lessons from Aviation, and The Equity Imperative of Graduate Medical Education.*

## Advocacy Summit

For the first time since 2019, the Advocacy Summit included in-person visits on Capitol Hill.

In preparation for the visits, attendees engaged in several lively panels and educational sessions to better understand the College’s legislative priorities and what information to present when meeting with elected officials and their staff members.

“We’re not just talking about problems. We’re also talking about solutions and bringing those solutions forward,” said Christian Shalgian, Director of the ACS Division of Advocacy and Health Policy (DAHP). “Those solutions are a critical component of what makes us unique and are an important part of this conversation.”

## Less Transactional, More Partnership

In the first panel, *The Value of a Surgeon: Exploring the Nuances of the Contributions Surgeons Make to Healthcare*, moderator Don Selzer, MD, FACS, chief of the Division of General Surgery and associate chair

Dr. Frank Opelka stresses the value of transparency during the panel, *A Conversation with CMS about Updates in Quality.*



**Left:**  
Rep. Kathy Castor shares her thoughts on important healthcare issues that impact surgeons and their patients.

**Right:**  
In advance of Hill Day, Speaker of the House Kevin McCarthy stops by the Advocacy Summit, touching on topics such as the MISSION ZERO Act, telehealth, surgeon workforce, and rural healthcare access.

of the Department of Surgery at the Indiana University School of Medicine in Indianapolis, led a robust discussion on the evolving landscape of surgeon compensation and developments in value-based care.

Dr. Selzer asked audience members if they understand how their compensation is determined. Using their phones, 8% responded that they understood their compensation completely; whereas 27% said they had no idea how their compensation was calculated.

According to Kimberly Russo, MBA, MS, CEO at George Washington Hospital in Washington, DC, “This is a sign that the industry must pivot. It’s a true indicator that we have some work to do around being much more of a partnership and understanding the valued contributions of surgeons. We have to start moving toward a much less transactional approach to how we are engaging.”

### **What Does Good Look Like?**

Advancing health equity, simplifying and refining quality measures, and improving health outcomes were some of the topics discussed during A Conversation with CMS about Updates in Quality, featuring Clifford Y. Ko, MD, MS, MSHS, FACS, FASCRS,

Director of the ACS Division of Research and Optimal Patient Care, Doug Jacobs, MD, MPH, chief transformation officer in the Center for Medicare within the Centers for Medicare & Medicaid Services (CMS), and Courtney Collins, MS, MD, FACS, clinical assistant professor of surgery at The Ohio State University in Columbus.

Dr. Jacobs touched on the concept of Universal Foundation—a CMS initiative to drive meaningful quality by standardizing and better aligning measures used to report quality performance across the agency’s many healthcare programs. The program also aims to reduce administrative burden for physicians, support CMS efforts to advance health equity, allow for cross-comparisons across programs, and help identify measurement gaps.

It’s likely that hospitals have hundreds of quality metrics that they’re “chasing to look good to CMS,” which diverts the attention of healthcare providers, including surgeons, and prohibits them from being able to concentrate on taking care of patients, according to Dr. Ko.

“What does good look like? What would good look like in our system, not in the confines of this role, that policy, or this program? What does good look

like for our patients, and how do we get there?” he asked. “There are a lot of really smart people who define good care. So, if we all understand what quality is, why aren’t we there?”

One of the first steps, Dr. Ko explained, is “sunsetting a lot of these things and working with CMS to get a unified, much more integrated way of looking at the measures.” He also recommended that when attendees visit the Hill, they deliver two important messages: the current system is not working for surgeons, but more importantly, it’s not working for the patients; and the College has data-driven, evidence-based Quality Programs proven to enhance patient care.

In the Inside Politics and Policy Experts session, Frank Opelka, MD, FACS, ACS Medical Director for Quality and Health Policy, echoed much of what Drs. Jacobs and Ko said. “There is a need to measure the things that are meaningful to us and our patients.”

Dr. Opelka also stressed the value of transparency, which “serves you better than anything and just makes you better.” He shared the story of the Martini-Klinik—a highly specialized private clinic in Hamburg, Germany, that treats patients with prostate cancer and shares long-term outcomes data from more than 34,000 previous patients.

“The Martini-Klinik is the largest prostate cancer treatment program in the world. That’s because they publish their results: Here’s our complication rate. Here’s our success rate. Here’s our stage IV survival rate. Here’s what the treatment costs,” said Dr. Opelka. “People from all over the world are flocking to the clinic because it holds itself publicly accountable to the social contract and social good they have with the patient community.”

### Congressional Asks

After an almost full day of informative panels, staff members from the ACS DC office detailed the “asks” and provided background information in preparation for the in-person visits to the Congressional offices. The attendees broke into groups by state to prepare for their visits and discuss the following issues:

- Stop cuts to Medicare physician payment
- Support legislation banning non-compete agreements
- Ensure access to general surgery
- Support the physician workforce by addressing student loan debt
- Ensure funding for ACS priorities in fiscal year 2024 (MISSION ZERO Act, cancer prevention research, firearm injury prevention research, National Health Care Workforce Commission, neglected surgical conditions)
- Support ACS priorities in the Pandemic and All Hazards Preparedness Act (National

Trauma and Emergency Preparedness System, MISSION ZERO Act, Prevent BLEEDing Act, Good Samaritan Health Professionals Act, and the Bipartisan Solution to Cyclical Violence Act)

Just before the official advocacy training started, Speaker of the House Kevin McCarthy (R-CA) stopped by the Advocacy Summit for a surprise visit to discuss the important role surgeons play in advocating for their patients and shaping federal healthcare policy.

Several other invited congressional speakers—Reps. Mariannette Miller-Meeks, MD (R-IA), Drew Ferguson, DDS (R-GA), Kathy Castor (D-FL), and Susan Wild (D-PA), as well as Sen. Ben Cardin (D-MD)—underscored the importance of the College’s legislative efforts such as firearm injury prevention and Medicare physician payment.

On Hill Day, 263 Advocacy Summit attendees representing 39 states participated in 211 meetings. (See photo selections from Twitter on pages 62–63.)

### Advocacy and Health Policy Abstract Competition

Another highlight of the Leadership & Advocacy Summit was the inaugural Advocacy and Health Policy Abstract Competition for ACS residents and trainees. Ten authors were invited to present their abstracts at the summit, and the top three were recognized:

- First place (\$500): Stephanie Jensen, MD—State Helmet

Laws Greatly Increase the Use of Helmets and Protect Motorcycle Crash Victims

- Second place (\$250): Courtney H. Meyer, MD—Improving Equitable Access to STOP THE BLEED® Training Courses through Multilingual Outreach Initiatives
- Third place (\$100): Madeline Matthys—Actionable Sustainability Guidelines for Surgeons, by Surgeons

Individuals still can register for the Leadership portion of the Summit to access on-demand content at [facs.org/summit](https://facs.org/summit).

Registrants can earn up to 4.75 *AMA PRA Category 1 Credits™* for attending or viewing the Leadership Summit; another 2.0 *AMA PRA Category 1 Credits™* are available for the Negotiations Seminar. The deadline to access content and claim CME credits is **July 31, 2023**.

The 2024 Leadership & Advocacy Summit will be in Washington, DC, April 13–16. **B**

### Note

The following spread features ACS Hill Day photos provided by Drs. Doug Wood, Jason Wilson, Joshua Mammen, Amy Liepert, Angela Thelen, Elise Fannon, and Samuel Wade Ross.

*Jennifer Bagley is the Editor-in-Chief of the Bulletin and Senior Manager in the ACS Division of Integrated Communications in Chicago, IL.*



# #ACSLAS23 Hill Visits









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*House of Surgery*, *The Operative Word*, and *Surgical Readings from SRGS* are available on Apple Podcasts, Spotify, Podbean, iHeartRadio, or wherever you listen to your podcasts.

[facs.org/podcasts](https://facs.org/podcasts)

**ACS** / AMERICAN COLLEGE  
OF SURGEONS

# New Educational Resource on Cancer Surgery Protocols Is Available

Amanda B. Francescatti, MS


THE ACS CANCER Surgery Standards Program (CSSP) recently published new cancer surgery protocols—*ACS Protocols for Cancer Surgery Documentation*—which provide guidance on the collection of essential data and key aspects of cancer surgery via the operative report. This series can serve as a useful educational tool for surgeons and surgeons in training.

The mission of the CSSP is to define and implement cancer surgery standards so that surgeons and institutions can readily adopt and easily integrate them into their daily workflow.

Developed by subject matter experts as part of the CSSP, each protocol includes a comprehensive list of data fields in synoptic format, followed by supporting explanatory comments and reference materials.

Data elements include fields auto-populated from the electronic health record and cancer-specific information such as intent of surgery, preoperative diagnosis, tumor location, and lymph node dissection.

Each data field has a corresponding explanatory comment with background information, such as evidence from the *Operative Standards for Cancer Surgery* manuals and the *American Joint Committee on Cancer's Cancer Staging Manual*, as well as coding information from the *National Cancer Database Standards for Oncology Registry Entry* manual. Illustrations for anatomic considerations during surgery are also included in the protocols.

Protocols for melanoma, breast, and colon cancers now are available on the Amazon website via Kindle and in print, and protocols for thyroid, pancreatic, and lung cancers are available via Kindle by searching for “Protocol for Cancer Surgery Documentation.” Gastric and adrenal cancer manuals will be released in the future. 

**Amanda Francescatti** is the Senior Manager of the ACS Clinical Research Program and the Cancer Surgery Standards Program in the ACS Division of Research and Optimal Patient Care in Chicago, IL.

To learn more about the new cancer surgery protocols, visit [facs.org/cssp](https://facs.org/cssp).

## If You're Reading This, You May Be Eligible for CME Credit

Did you know that reading the *Bulletin of the American College of Surgeons* is a CME-eligible activity?

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The Bulletin of the American College of Surgeons is the College's monthly member magazine. It contains articles on topics that affect surgical practice and the surgical profession, including socioeconomic trends, surgical innovation, advocacy, professionalism, the surgical workforce, and more.

# Register for the 2023 ACS Quality and Safety Conference

HEALTHCARE PROFESSIONALS dedicated to raising the bar on the quality of surgical care and patient safety are invited to attend the 2023 ACS Quality and Safety Conference (QSC), July 10–13, at the Minneapolis Convention Center in Minnesota. Registration is now open at [facs.org/qsc2023](https://facs.org/qsc2023).

This year's conference theme, The Patient Voice, will be featured prominently as surgeons, nurses, quality improvement (QI) professionals, and other healthcare providers share their knowledge and experiences to help improve care of the surgical patient.

Sessions at this year's conference will feature content from the 18 ACS Quality Programs, including:

- ACS Quality Verification Program
- National Surgical Quality Improvement Program
- Cancer Programs
- Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program
- Children's Surgery Verification Program
- Geriatric Surgery Verification Program

A new track this year, Emergency General Surgery (EGS), will focus on content from the EGS Verification Program, and the Quality Improvement Principles track will present the new ACS Quality Framework and toolkit.

Plenary sessions will include:

- Equity in quality
- Moving beyond traditional leadership
- Latest discoveries in QI
- Importance of good data

In addition, "The Power of Quality" campaign (see page 54) will be explored in two sessions.

## Other Conference Highlights

Back by popular demand, the QI Basics Preconference Workshop, will be held as a two-part series on the afternoon of Sunday, July 9, and the morning of Monday, July 10.

In addition, a new QI Basics Residents Preconference Workshop will be held. This workshop will run parallel to the QI Basics Preconference Workshop and will be a condensed version of the original QI Basics Workshop, focusing on elements of QI that are most important to surgical residents. All workshop participants will be given access to the online QI Basics course.

The ACS QSC continues to be a robust venue for abstract and poster presentations. This year, the conference will feature expanded abstract submission categories, including Health Equity and Access and Health Informatics for Quality. Selected abstracts will be shared during 20 quickshot-style sessions.

The meeting also offers an opportunity to learn directly about the ACS Quality Programs and sign up for consultations with ACS staff members from the statistics and clinical support teams. Information tables from Member Services, Advocacy, and Patient Education also will be available.

Some special events include:

- Monday, July 10: Welcome reception at the Mill City Museum in downtown Minneapolis
- Tuesday, July 11: Abstract Poster Reception featuring more than 400 abstract posters
- Wednesday, July 12: Quality Programs Social

Attendees will be able to claim educational credits for up to 90 days after the conference concludes. **B**

**REGISTER NOW**

**QSC** | 2  
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3

Quality and Safety Conference  
July 10-13, 2023  
Minneapolis, MN



## Thank You National Doctors' Day Contributors

On National Doctors' Day, 46 people contributed to the ACS Foundation, in recognition of those who helped inspire their careers. Donations will be used to support scholarships, grants, and other ACS programs to ultimately promote better patient outcomes.

We thank everyone who participated and encourage you to donate throughout the year at [facs.org/acsfoundation](https://facs.org/acsfoundation).

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# Members in the News

## Stain Assumes Role as ASA President



ACS Regent Steven C. Stain, MD, FACS, recently was named president of the American Surgical Association, the oldest surgical organization in the US.

Dr. Stain, a nationally recognized hepatobiliary and general surgeon, is the chair of the Department of Surgery at Lahey Hospital & Medical Center in Burlington, Massachusetts. He previously served at Albany Medical College in New York, as well as at Meharry Medical College and Vanderbilt University School of Medicine in Nashville, Tennessee.

Within the ACS, Dr. Stain has been Chair of the Board of Governors Executive Committee, a member of the ACSPA-SurgeonsPAC Board, a member of the Foundation Board of Directors, and an active participant in his local ACS chapters. In addition, he has served on the Board of Regents Finance Committee, Committee on Antiracism, Nominating Committee, and others.

## Lorenz Appointed President of Cleveland Clinic London



Otolaryngologist Robert Lorenz, MD, MBA, FACS, has been appointed president of the Cleveland Clinic London in the UK. Dr. Lorenz's role begins on June 1. He currently serves as medical director of payment reform, risk, and contracting for the Cleveland Clinic in Ohio, where he has practiced for more than 20 years.

For the ACS, Dr. Lorenz has served on the Advisory Council for Otolaryngology—Head & Neck Surgery, as a liaison for the Program Committee, and on the Committee on Video-Based Education.





Have you or an ACS member you know achieved a notable career highlight recently? If so, send potential contributions to Jen Bagley, MA, *Bulletin* Editor-in-Chief, at [jbagley@facs.org](mailto:jbagley@facs.org). Submissions will be printed based on content type and available space.

## Hong Leads Abdominal Organ Transplant Program



Internationally recognized leader in transplantation Johnny C. Hong, MD, FACS, now leads the abdominal organ transplant program at Penn State Health Milton S. Hershey Medical Center in Pennsylvania. Dr. Hong joined as chief of the Division of Transplantation and director of liver transplant surgery in November 2022, after having served as a transplant surgeon and educator at locations such as the Medical College of Wisconsin in Milwaukee and the University of California, Los Angeles.

## Vollstedt Is New CMO in Ohio



Keith Vollstedt, MD, FACS, is the new chief medical officer of MercyOne Western Iowa, which provides care to 33 counties in western Iowa, eastern Nebraska, and southeastern South Dakota. A general surgeon, Dr. Vollstedt has practiced for more than 30 years in Iowa, specializing in bariatric and laparoscopic surgery. **B**



# Celebrate STOP THE BLEED Month in May

MAY MARKS the annual National STOP THE BLEED® Month, and May 25 is the sixth annual National STOP THE BLEED Day.

Uncontrolled bleeding from trauma is a major cause of preventable death for all ages, and the ACS STOP THE BLEED program, which is a collaborative effort with the US Department of Defense, has played an integral role in increasing public and healthcare professional readiness response to bleeding emergencies. More than 2.6 million individuals are now trained in STOP THE BLEED techniques.

“When severe bleeding injuries occur, every second matters. STOP THE BLEED training from the ACS is a simple and effective way to educate the public on how to safely intervene to help prevent death from traumatic injuries,” said Patricia L. Turner, MD, MBA, FACS, Executive Director and CEO of the ACS. “The ACS is proud to


promote efforts that will make STOP THE BLEED training as common as CPR training and other first aid techniques.”

Media interviews this month featured Kenji Inaba, MD, FACS, FRCS, Chair of the ACS Committee on Trauma (COT) Stop the Bleed Committee, and Nilda Garcia, MD, FACS, Chair of the ACS COT Verification Review Committee. They are among the surgeons and STOP THE BLEED advocates spreading the word about the importance of bleeding control training.

The program has been the center of several important advocacy and outreach activities. In September 2022, the ACS chapters in California helped advocate for and secure passage of the state’s STOP THE BLEED bill, which requires the installation of trauma bleeding control kits in newly constructed public and private buildings throughout the state. Nineteen other states have

introduced legislation related to STOP THE BLEED priorities.

In March, the Chicago Cubs and Wrigley Field took an important step to keep fans, staff, and players safe by becoming the first Major League Baseball stadium to have trauma kits installed. On May 25, the ACS, in collaboration with the Cubs and the City of Chicago’s Office of Emergency Management and Communications, will provide training and information about STOP THE BLEED outside Wrigley Field before a Cubs game.

For more details about STOP THE BLEED, including training opportunities and kit sales, visit [stopthebleed.org](http://stopthebleed.org). 

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