

# Bulletin

**ACS** / AMERICAN COLLEGE  
OF SURGEONS



**Surgeon Inventors  
Transform  
Patient Care**



Surgeons  
Sowing  
Hope

Save  
the  
Date

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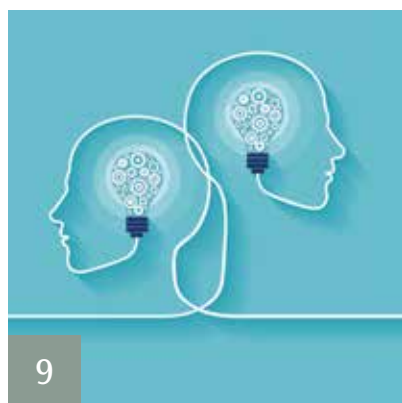
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# Contents

## FEATURES



9 **COVER STORY:** Surgeon Inventors Transform Patient Care with Creative Problem-Solving  
Tony Peregrin

---

16 Dr. Bartley P. Griffith Discusses Landmark Pig Heart Transplant  
Tony Peregrin

---

18 SurgeonsVoice and Grassroots Advocacy: Your Questions Answered  
Katie Oehmen

---



22 The Surgeon's Voice Is Critical on Capitol Hill: Make Sure Yours Is Heard  
Patrick V. Bailey, MD, MLS, FACS

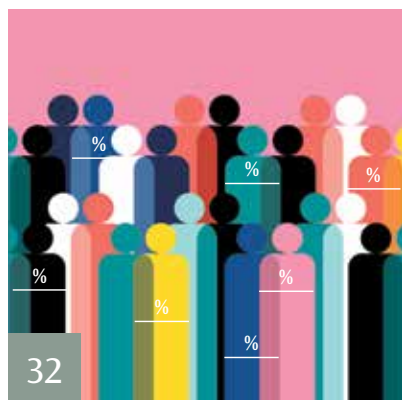
---

24 Why Should You Engage in ACSPA-SurgeonsPAC Activity?  
Samuel Mandell, MD, FACS, MPH, and  
M. Ashraf Mansour, MD, FACS

---

28 Take a Seat: How Surgeons Can Influence State Telehealth Legislation  
Rebecca King, MHA, and Ross F. Goldberg, MD, FACS

---

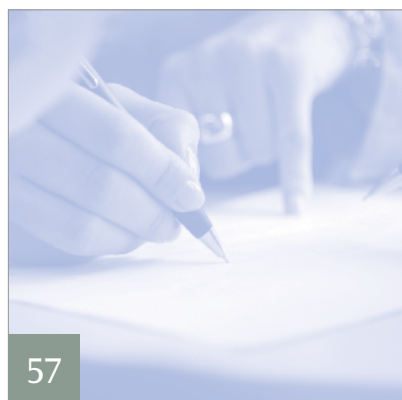
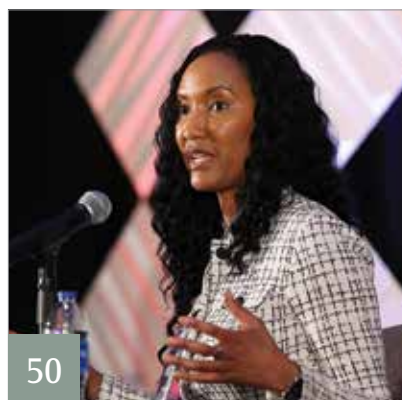


32 The Role of Social Determinants of Health on Cancer Screening  
Fedra Fallahian, MD, Heidi Nelson, MD, FACS, and Susan Pories, MD, FACS

---

*continued on next page*

# Contents *continued*



## DEPARTMENTS

### COMMENTARY

- 7 Executive Director's Update:  
*Embracing Innovation*  
Patricia L. Turner, MD, MBA, FACS

### FOR YOUR PATIENTS

- 38 ACS Cancer Research Program:  
*To Operate or Not in De Novo  
Stage IV Breast Cancer: Is That  
Still a Question?*  
Preeti D. Subhedar, MS, MD, FACS,  
Sarah Blair, MD, FACS, and Judy C.  
Boughey, MD, FACS

### FOR YOUR PRACTICE

- 41 A Look at The Joint Commission:  
*Joint Commission, NQF  
Announce Recipients of  
2021 Eisenberg Awards*  
Lenworth M. Jacobs Jr., MD,  
MPH, FACS

### FOR YOUR PROFESSION

- 44 From Residency to Retirement:  
*"Toto, I've a Feeling We're Not in  
Kansas Anymore"*  
James Jeng, MD, FACS
- 47 DEI in Action: *ACS Profiles  
in Diversity Podcast: Lessons  
Learned and Strategies  
Implemented*  
Avilasha Sinha and SreyRam  
Kuy, MD, MHS

## NEWS

- 50 2022 ACS Leadership &  
Advocacy Summit Focuses  
on Surgeon Well-Being,  
Legislative Priorities  
Diane S. Schneidman, MA
- 57 Report on ACSPA/ACS  
Activities, February 2022  
Danielle Saunders Walsh, MD,  
FACS, FAAP
- 63 Associate Fellows: Apply Now  
for ACS Fellowship
- 64 More than 2 Million People  
Prepared to STOP THE BLEED®

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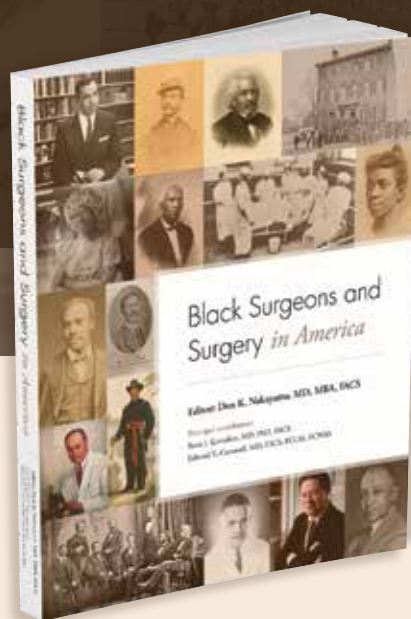
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## Embracing Innovation

by Patricia L. Turner, MD, MBA, FACS

Surgeons have historically been on the frontlines of innovation.

We are natural problem-solvers, and we thrive on developing solutions—always doing what's best for the patient. Those solutions may include minimally invasive approaches, individualized operations, or advances that make surgery itself obsolete.

Over the years we've developed catheter-based interventions, laparoscopic procedures, and robot-assisted therapies. We are committed to providing our patients with excellent outcomes and helping them heal with less pain, less scarring, shorter hospital length of stays, and earlier return to function.

As a minimally invasive surgeon, I thrive on innovation, collaboration, and creativity. As surgeons, we are all motivated by time spent with colleagues who constantly refine techniques and push the envelope to perform more complex operations with precision, flexibility, and control.

In this issue, the *Bulletin* highlights three innovative surgeons who presented at last year's Clinical Congress and their groundbreaking work (see pages 9–15). It also features an interview with a pioneer in xenotransplantation (see pages 16–17). These trailblazers describe the processes which underpin their innovations and offer advice on how we can all transform amorphous concepts into tangible products, techniques, or solutions.

### Jacobson Innovation Award

This month, the ACS will present its Jacobson Innovation Award to Anthony Atala, MD, FACS, from the Wake Forest Institute of Regenerative Medicine in Winston-Salem, NC. Dr. Atala is the ACS Regent for Urology and is world renowned for creating the first functional lab-engineered organs to be successfully implanted in patients. He also developed breakthrough techniques to produce complex tissues and isolate cells for regeneration.

If Dr. Atala hadn't asked the question, "Can we grow organs instead of transplanting them?," we wouldn't have these lifesaving advances.

Dr. Atala will be the 28th recipient of this prestigious international award that honors living surgeons who have been innovators of a transformative development or technique in any field of surgery. The award is made possible through a gift from Mrs. and Dr. Julius H. Jacobson II, a general vascular surgeon known for his pioneering work in the development of microsurgery.

Previous recipients have included Professor Francois Dubois, from Paris, France, for his landmark work with laparoscopic cholecystectomy; Judah Folkman, MD, FACS, from Boston, MA, for his seminal developments in the field of angiogenesis; and Susan E. Mackinnon, MD, FACS, FRCSC, from St. Louis, MO, for her innovative use of nerve transfer procedures for the treatment of patients with devastating peripheral nerve injuries.

In addition to the Jacobson Innovation Award, the ACS also presents the Jacobson Promising Investigator Award, which recognizes outstanding residents, fellows, and young surgeons demonstrating early promise of significant contributions to the practice of surgery and the safety of surgical patients.

The first Jacobson Promising Investigator Award was presented in 2005 to Michael T. Longaker, MD, MBA, FACS, who currently is the co-director of the Stanford Institute for Stem Cell Biology & Regenerative Medicine and holds academic appointments that include vice chair of surgery at Stanford University, CA.

The College's early recognition and support of Dr. Longaker was critical as he investigated scar formation during wound repair and developed techniques to engineer tissue de novo. He remains on the frontlines of scar treatment and research today, and because of Dr. Longaker and other investigators in this field, scarless surgery is a real possibility.

**We, as a profession, will continue to advance and innovate, while retaining the highest quality of care that is our hallmark, and hewing closely to what the evidence shows us.**

### Transformative Science

Innovation in medicine often begins with a thorny problem that requires a creative solution. Research and development play an essential role in that process.

The ACS provides more than \$500,000 annually for more than a dozen research awards, including six resident research scholarships, four faculty research fellowships, NIH Research Career Development Awards, and several joint awards with other organizations and the NIH. These awards support the fundamental research that will accelerate innovations in surgery and advance patient care.

Surgeons in all specialties and in all career stages throughout the College—the House of Surgery—are performing extraordinary research every day and are improving surgical techniques in their everyday practice in our communities.

We also have a number of ACS awards that are specifically designated for the nonacademic community surgeon. These include health policy scholarships and traveling fellowships, among others.

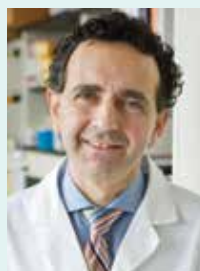
Details about each of these awards, along with application requirements and deadlines, are posted on our website.

### Cutting-Edge Skills

As research creates advances that continue to disrupt current practice, we all must hone our skills using these novel technologies and techniques to remain current on what the evidence shows us.

The ACS provides a wide range of skills-based courses and curricula so that we can remain up-to-date in our respective fields. From our Verification of Knowledge and Skills training program to the Advanced Skills courses during Clinical Congress, we offer essential programs to equip surgeons with the skills they need to achieve the best outcomes for our patients.

### JACOBSON INNOVATION AWARD



Anthony Atala, MD, FACS, will be presented with the 2022 Jacobson Innovation Award on Friday, June 10. A recap and photos from the event will be included in the July issue of the *Bulletin*.

### Visualizing the Future

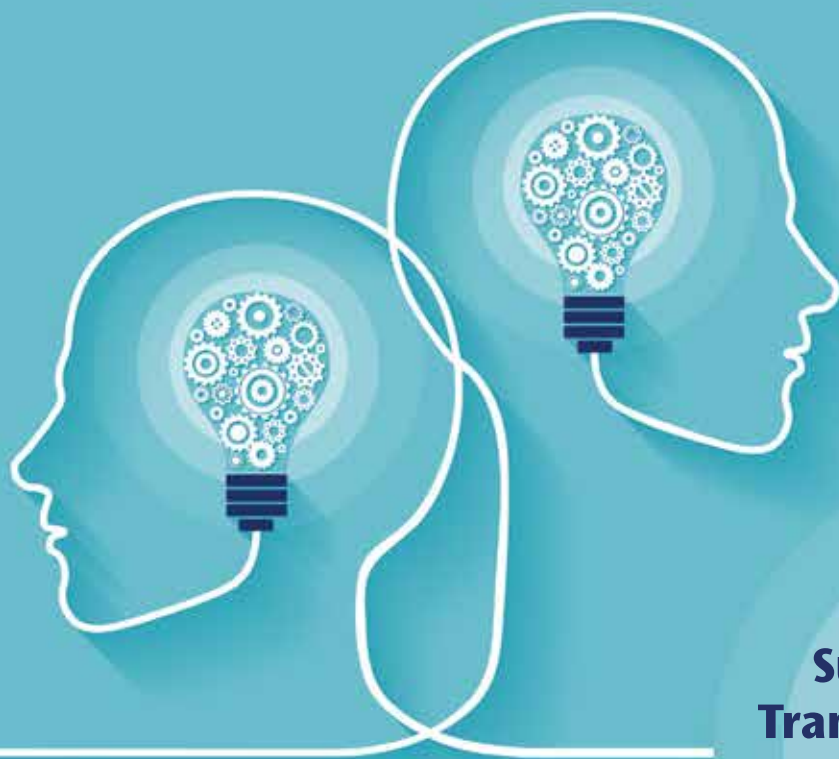
It is widely understood that surgeons are resilient and have an incredible work ethic. We also are required to think creatively as we tackle the problems of everyday practice while improving the care of our patients. We are creative practitioners of our craft, always seeking iterative improvements which enhance care.

I encourage you to tap into your creativity and visualize the ideal solution to the thorny problems facing us and our patients. We, as a profession, will continue to advance and innovate, while retaining the highest quality of care that is our hallmark, and hewing closely to what the evidence shows us.

Our clinical data registries and quality verification programs provide excellent opportunities for quality improvement initiatives. Collaboratives have been established across the country and remind us that innovation and quality are inextricably linked.

Let's continue to find ways to work collaboratively. Our specialty will reflect this growth, and our patients will benefit. ♦

If you have comments or suggestions, please send them to Dr. Turner at [executivedirector@facs.org](mailto:executivedirector@facs.org).



**Surgeon Inventors  
Transform Patient Care  
with Creative  
Problem-Solving**

**by Tony Peregrin**

## HIGHLIGHTS

- Describes factors driving surgical innovation today, including the shift to value-based care and more patients presenting with multiple chronic conditions
- Provides insights into developing and refining a novel idea or concept
- Outlines pathways for advancing a concept through the patent process, intellectual property rights, and FDA approval
- Identifies options for creating a device prototype
- Summarizes future trends for surgical innovation

June traditionally is when the American College of Surgeons (ACS) celebrates a surgeon who has developed creative solutions to surgical challenges with the presentation of the Jacobson Innovation Award. Considering the chief characteristics of a leading-edge inventor—tenacity and imaginative problem-solving—it’s unsurprising that surgeons often are at the forefront of transformative patient care. For example, surgeon-led innovations related to laparoscopy and thoracoscopy have resulted in new devices and treatment modalities that have enhanced these procedures and improved patient outcomes over the past decade. More recently, advancements in robotic control and 3-D visualization have enabled surgeons in multiple specialties to perform minimally invasive surgery (MIS).

“Surgeons work with patients who often have individual variability in terms of how they present with their diseases. And in the operating room (OR), we’re dealing with anatomy that can be atypical,” said Ali Tavakkoli, MBBS, FACS, chief, division of general and gastrointestinal (GI) surgery, and co-director, Center for Weight Management and Wellness, Brigham and Women’s Hospital, and associate professor of surgery, Harvard Medical School, Boston, MA. “In the OR, you have to think quickly about how to deal with these variations and adjust your approach and plan. I think that’s why surgeons are in a great position to lead innovations and advancements in patient care.”

Although taking an idea from napkin to marketplace can be a daunting, time-consuming process, with the typical time to market averaging 3 to 7 years, the global medical device industry continues to grow.<sup>1</sup> A total of 33,376 patents were granted to applicants between July 2021 and September 2021, marking a 2% increase over the previous quarter, according to the GlobalData Patents Database. Analysis of these

data also revealed that general surgery “was the most active technology application” in this category, with 952 patent grants during this period.<sup>2</sup> For medical devices that made it beyond the patent stage, the global medical device market in 2020 has been valued at \$456.9 billion and is expected to reach \$603.5 billion in 2023.<sup>3</sup>

Several factors are driving surgical innovation today, including the shift to value-based care, which emphasizes the provision of standards-based care, capacity and resource limitations that surfaced during the early stages of COVID-19, and an increase in complex conditions, including more patients presenting with multiple chronic conditions than a decade ago.<sup>4</sup>

This article provides insights into developing and refining an idea and identifies pathways for advancing a concept through the patent process, intellectual property rights, Food and Drug Administration (FDA) approval, and prototyping.

## Surgeon Inventors

“My personal advice for people who want to be an innovator is that, although need identification and brainstorming have been very successful approaches, there are other ways of doing it. You can take an instrument or a device or a procedure that already exists and think about how it can be used in a different setting or in different circumstances,” said Dr. Tavakkoli.

He did exactly that when his company re-engineered Sucralfate, a drug used to treat peptic ulcers, to create LuCI (luminal coating of the intestine), which can be used to coat parts of the intestine and control sugar uptake. Simply stated, AltrixBio, a biotech company Dr. Tavakkoli cofounded in 2019, seeks to replicate the results of gastric bypass surgery for type 2 diabetes in a pill.



Dr. Ali Tavakkoli

In 2018, Dr. Tavakkoli and colleagues published a study that showed a single dose of LuCI lowered glucose response in rodents.<sup>5</sup> In the January 2022 issue of *Metabolism*, this team demonstrated longer-term benefits of the drug on weight and insulin sensitivity in diet-induced obesity in rats.<sup>5,6</sup> According to the article, clinical trials are expected to begin within a year.

“Think like an engineer,” advised Marc Bessler, MD, FACS, professor of surgery at Columbia University, New York, NY. “Surgeons typically think, ‘Oh, this is how I’m going to solve this problem,’ and run with the solution. And there are definitely examples of when that sometimes will work and examples of when it doesn’t.” Engineers, on the other hand, are trained to identify a problem, evaluate all potential pathways for solving the issue, and then focus on the top solutions, he said.

In 2015, Dr. Bessler cofounded EndObetes, a medical device company that develops endoscopic devices to treat obesity and type 2 diabetes.<sup>7</sup> The EndoBypass device mimics the anatomic and physiologic changes of surgical gastric bypass, which delivers undigested food directly to the intestine, leading to increased release of insulin and satiety hormones to create dramatic weight loss and remission of type 2 diabetes. Dr. Bessler and team met with the FDA, resulting in a call for additional studies for longer periods of time.

“We’ve done some animal testing. The next steps are really to get it ready for human implantation and early feasibility testing in humans,” Dr. Bessler said.

Novice innovators should consider collaborating with a colleague, particularly in another specialty, noted Brian J. Dunkin, MD, FACS, chief medical officer, Boston Scientific Endoscopy, MA.

In 2016, Dr. Dunkin began pondering a novel approach to the surgery residency program selection process. These programs can have significant performance issues and attrition rates in part due to poor job fit, according to Dr. Dunkin. At the time, as a professor of surgery at Houston Methodist Hospital, TX, and the MIS fellowship codirector, he was

observing poor satisfaction rates among fellows in the MIS program. After discussing this conundrum with friend and colleague Aimee Gardner, PhD, an industrial organizational psychologist, they founded SurgWise, which provides science-based assessments to surgical training programs to better inform candidate selection.<sup>8</sup>

“We actually used my own fellowship to pilot the concept. That’s why we formed the company,” Dr. Dunkin said. “We needed a commercial entity that the hospital could contract with in order to get us the research funds to start this up.” Dr. Dunkin said the SurgWise assessments created a much more efficient and effective process. “The faculty in our fellowship were spending a lot less time selecting the fellows, and we were doing a much more thorough job of identifying their competencies,” he said, adding that the process increases candidate diversity and on-the-job satisfaction and performance.

As for medical device development, Dr. Dunkin also played a consulting role for a former research fellow, Albert Huang, MD, who founded Allotrope Medical. This company produces StimSite, a device that provides obstetric-gynecologic, general, and colorectal surgeons with the ability to use existing surgical instruments to locate and identify ureters using electrical stimulation.<sup>9</sup> Ureter identification is a critical step in safely advancing operations such as hysterectomies and colon resections. StimSite received FDA clearance in November 2020.<sup>9</sup>

## Patent Protection

Once an idea or concept has been refined and necessary collaborators have been identified, surgeon inventors should consider filing a patent to protect their intellectual property. According to the US Patent and Trademark Office, a patent holder has the “right to exclude others from making, using, offering for sale, or selling” the invention in the US for 20 years.<sup>10</sup> Two types of patents are relevant to surgeon innovators:





Dr. Marc Bessler

- Utility patents may be granted to anyone who invents or discovers a new and useful process, machine, article of manufacture, or composition of matter or any new and useful improvement
- Design patents may be granted to anyone who invents a new, original, and ornamental design for an article of manufacture

“Patent protection is important. I think people intuitively know that, but it can be a confusing landscape,” Dr. Dunkin said. “Patents help protect an idea from others using it, and it’s important to do that because it gives you the ability to get some benefit financially.”

Utility patents typically are related to a medical device that is new and useful. “A design patent is really more about just that—design. And, so, it’s all about the ‘ornamental features,’” Dr. Dunkin said. “Let’s say you came up with some new device. You will have a utility patent that covers the hardware design, and then you could have a design patent that covers the interface with it—how it stylistically looks and feels.”

“It’s great to have a patent—that is a powerful thing—but keep in mind it doesn’t necessarily give you the right to make and bring that product to the marketplace,” Dr. Dunkin added. “To truly understand your freedom to operate in a particular space and ensure you are not infringing on anyone else’s patent is something a patent lawyer will help you determine.”

### Intellectual Property Rights: Universities and Hospital Systems

Today, many surgeons work for large hospital systems or universities, many of which have the right to claim ownership of their employees’ innovations.

“I work for Columbia University, for example, and they claim ownership of anything I do regarding an

invention within the spectrum of medicine,” said Dr. Bessler. “I have to file an invention report with the university, and they have a finite period of time to say whether they’re going to take it forward and patent it or not and return it to me,” he said, noting that many healthcare systems have exceptions to this rule, for example if the employee is consulting with an outside company.

“I think working with your institutions early and keeping them informed as you make progress is important,” said Dr. Tavakkoli. “If you have a great idea, the key is to not do a public disclosure, such as presenting at a meeting, before some sort of intellectual property has been filed.”

“I think making sure you have a lawyer or an institutional representative who understands where you’re going with your idea is critical,” added Dr. Tavakkoli. “And I would say, although intellectual property ownership is really important, keep in mind that a lot of ideas never progress because people are too worried about protecting their concept. You want to be careful. You want to protect your ideas, but you also want to make sure this idea is communicated with others so that it can advance and progress.”

“If you are employed by a large entity, it’s likely that it has at least a claim to your ideas—and that’s not necessarily a bad thing,” said Dr. Dunkin. “I think people get worried that their idea is going to get taken away. But many institutions, particularly academic institutions, have technology transfer offices that can be quite sophisticated and can really accelerate protecting your idea and then bring it to life. The technology transfer office can be your friend, and it’s important to work with it, not only because it’s your obligation, but because it can help you.”

When Dr. Dunkin’s research fellow at Houston Methodist Hospital, Dr. Huang, came up with the idea that eventually became the StimSite device, their employer initially owned the idea. Working with the hospital’s technology transfer office, which helped patent the concept, Dr. Huang was able to license



Dr. Brian Dunkin

back the concept from the hospital, affording him the freedom to offer it as a commercial product.

The bottom line for novice surgeon inventors: If you are a hospital system or university employee, be sure to review your contract to determine your legal rights and obligations regarding intellectual property.

### FDA Approval

The FDA regulates medical devices in the US through the Center for Devices and Radiological Health (CDRH). CDRH's mission is to "assure that patients and providers have timely and continued access to safe, effective, and high-quality medical devices and safe radiation-emitting products." The center provides "consumers, patients, their caregivers, and providers with understandable and accessible, science-based information about the products [it] oversees."<sup>11</sup>

The three medical devices classifications, according to the CDRH, are class I, II, or III. Class I medical devices generally are deemed low risk, and class III medical devices are seen as the highest risk.<sup>12</sup> The FDA CDRH also uses two pathways to ensure device safety before marketing: 510(k) clearance and premarket approval (PMA). 510(k) clearance evaluates moderate-risk devices and relies on nonclinical and biomechanical and descriptive data, whereas PMA evaluates high-risk medical devices and requires clinical trials.<sup>12</sup>

"The 510(k) pathway says that I can show the FDA that this device is safe and effective because it's substantially equivalent to another device that's already on the market. For this pathway, I don't need new clinical trials. I just need to show that this device is similar to a predicate device that's already being used on patients. Then the FDA can use that evidence to determine that it's safe and effective," Dr. Dunkin said.

"The PMA pathway is used for device ideas that are very innovative," explained Dr. Dunkin. "The FDA wants to see clinical trial data to support your claim that this device is safe and effective. It involves a lot of investment and work because you've got to run

clinical trials in a responsible way in order to get the data that convinces the FDA that it should determine that this device is safe and effective."

"Advancing a device or a drug through the FDA process is complicated and challenging," added Dr. Tavakkoli. "But at the same time, there are companies that can assist you in doing this. And if your innovation is at a phase that requires that level of attention, I think connecting with experts in the field is important."

### Prototyping

Prototyping allows inventors to transform an idea or concept into something tangible. A prototype enhances the ability for partners and stakeholders to provide specific feedback, minimizing potential errors and other unanticipated issues. For medical devices, a couple of options are available for prototyping, including three-dimensional printing (sometimes called additive manufacturing) that uses "millions of coordinates to deposit small amounts of material in specific areas based on a computer-aided design (CAD)."<sup>13</sup> Inventors can purchase software to build CAD files or they can contract with a prototyping company that provides access to this technology.

"I think prototyping was actually one of the biggest hurdles that we faced as our innovation team worked through the various ideas we had developed, and I believe it is an important step where many good ideas fail due to lack of funding, resources, or know-how," said Dr. Tavakkoli. "However, I think that to create an early prototype that allows you to provide a proof of concept can be done relatively cheaply if people are imaginative and have access to some basic equipment."

Proof of concept prototypes do not need to be constructed from end-use materials, according to Dr. Tavakkoli, which can be expensive. For a basic physical representation of the device, the model can be developed using materials such as plastic resin that are more affordable.



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The costs associated with advanced prototyping—not to mention all the approval-related steps necessary to ensure successful product development—can be overwhelming. For developing more advanced prototypes, Dr. Tavakkoli suggests working with experts in the field. “I think to go from a basic prototype that can validate a concept to something more refined that can be presented to a potential investor can be challenging and often requires access to engineering expertise and certain machinery that is not readily available.”

“Sometimes you have the right idea and a solution to the problem, and you patent it, and you prototype it,” added Dr. Bessler. However, few companies these days are buying devices from a patent or a prototype. They want proof that it “has legs, that it gets traction, that it sells.” Dr. Bessler said one option is to partner with a company that can take ownership of the product and move it forward. In fact, finding a partner is often the best move for an inventor at this phase of development because of cost alone. Medical device development and rollout for FDA class I or II devices can average \$31 million or higher, whereas class III devices, which are subject to the more restrictive PMA process, can average \$94 million or higher to bring the product to market.<sup>14</sup>

## Future Trends

What topic areas are likely to be the focus of the next generation of surgeon innovators as they work to transform the delivery of healthcare?

“Robotics obviously is already here—but intelligent robots that are able to actually do some of the steps of surgery are coming down the pike,” said Dr. Bessler. “Actually, I think any device or procedure that reduces patients’ pain, recovery time, and cost in a big way will be a driving force in surgical innovation.”

“I think in terms of surgical robots, we’re going to see just an explosion, and we’re at the very beginning of that,” added Dr. Dunkin. “Clinically, there’s an explosion now in the use of robotics, especially in the general surgery space. And I think you’re going to see that field

## Surgeons are uniquely positioned to identify clinical needs and engage in innovative problem solving, no matter the specialty or topic area.

continue to grow in all specialties in surgery. And endoluminal surgery—surgery within the gastrointestinal tract instead of causing incisions and scars—that’s really the next generation of minimally invasive surgery, and a lot of headway is being made there.”

“I’ve always been interested in the idea of image augmentation and enhanced visualization,” Dr. Tavakoli said. “We do laparoscopic surgery by looking at a screen. There are probably opportunities for us to enhance or augment those images by using either computed tomography or other forms of enhancement.”

“Artificial intelligence is everywhere and it’s going to drive everything from decision-making at the point of care in the OR all the way to quality measures,” added Dr. Dunkin.

Surgeons are uniquely positioned to identify clinical needs and engage in innovative problem solving, no matter the specialty or topic area. Becoming a successful innovator and entrepreneur is a challenging undertaking. Taking the necessary steps to protect your idea and to strategically select collaborators to help advance it through the development and approval process will help turn your idea into a reality.

Attending a medical technology conference is a practical way for novice surgeon inventors to interact with like-minded colleagues, learn best practices, and stimulate idea development. The Society of American Gastrointestinal and Endoscopic Surgeons (SAGES) will host its third Innovation Weekend, June 9–11, to provide a forum for industry and healthcare providers to exchange ideas about surgical technology and surgical practice. And in April, the American Gastroenterological Association (AGA) hosted its 12th AGA Tech Summit, offering opportunities for clinicians, medical technology companies, and others to identify opportunities for licensing, get updates on the latest innovations, and more. The ACS also supports the development of innovative technology with the annual Surgeons and Engineers: A Dialogue on Surgical Simulation, which returns to a full-day meeting March 1, 2023. ♦

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## Dr. Bartley P. Griffith Discusses Landmark Pig Heart Transplant

by Tony Peregrin

**A** first-of-its-kind organ transplant performed earlier this year demonstrated that a genetically modified animal heart can function like a human heart without immediate rejection by the body.<sup>1,2</sup> Bartley P. Griffith, MD, FACS, performed the operation at the University of Maryland Medical Center, Baltimore, where he is director of the cardiac transplant program.

The US Food and Drug Administration (FDA) approved the procedure under its compassionate use rules for emergency situations.<sup>3</sup> This authorization is used when an experimental medical product, in this case a genetically modified pig's heart, is the only option for a patient with a life-threatening medical condition.

The pig heart underwent 10 genetic modifications. Four genes were knocked out, including one that causes an aggressive human rejection response.<sup>4</sup> Despite these advancements, David Bennett, age 57, the recipient of the porcine heart transplant, died 2 months after the procedure.

In this interview, Dr. Griffith, the Thomas E. and Alice Marie Hales Distinguished Professor in Transplant Surgery, University of Maryland School of Medicine (UMSOM), shares new details about the surgery and identifies future areas of focus for xenotransplantation.

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### **You conducted the first in-human xenotransplant of a genetically modified pig heart. What overall lessons did you learn from this experience?**

Although we had 5 years of run-up translating laboratory work to a human case, some aspects of the human case were unanticipated or could not have been learned from the animals. It began with how to translate the immunosuppressive protocols from healthy baboons into a sick human and expect the human to tolerate it. We pretreat our baboons with drugs to prevent acute rejection. We couldn't do that to the extent that we

wanted in the human, so we had to make modifications that we believed would be tolerated and serve the effect desired. And that was our best guesstimate [to pretreat the patient]...based on 20 or 40 years, in my case, of experience using similar drugs in human heart transplant patients.

We're currently in the process of writing up this experience [for a medical journal], but I will say that I think we want to be quicker in our ability to survey the status of the patient and the animal heart. For example, we want to be able to measure anti-porcine in the antibodies more frequently and more quickly so that we might react sooner. Currently, we can only measure antibodies once or, rarely, twice a week because it's done in our laboratory from cell culture.

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### **Discuss some of your creative decision-making during the procedure.**

One interesting aspect of the procedure was that our human recipient of the genetically engineered heart had very different anatomy than the baboons who had received similar but smaller hearts, because the baboons were smaller; but the baboons didn't have heart failure. So, their anatomy was a snap-fit, in essence, to the pig heart. The human anatomy, however, made the fit much more difficult to the size-appropriate but differently shaped heart. So, as the human got sick, the atria and the connections to the heart, the cavae and the great vessels, enlarged. And these came as a surprise during the operation and required some real nipping and tucking in order to get a traditional connection.

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### **What was the response of your surgeon colleagues?**

Very few people felt that we were walking the plank, so to speak. And what I heard from people included





comments like, ‘I really respect that you guys did the work,’ and, ‘This was a step that had to be taken.’ We often were called courageous, but I don’t think we had courage. I think we had daring. The courage was manifested in our patient.

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### **What do you want to say about your patient, Mr. Bennett?**

After 60 days of intense time with him, I knew so much about this man. And there were tears when we lost him. He was such a wonderful guy. I don’t know whether I could have been like him.

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### **Have you determined what specifically resulted in Mr. Bennett’s demise?**

He lived 60 days before he died, and we’re not yet sure why. That is under intense investigation. Something happened to his heart, but we’re not sure what. And that’ll come out in time, and as we understand it better, we’re certainly going to share it.

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### **What can you reveal about your future work in the area of xenotransplantation?**

We’re interested in a lot of facets of this. But I think we’re going to want to ultimately reduce the amount of immune suppression required for a patient. And that may require something we call tolerance, or something called ‘pro-tolerance’ strategies to try and trick the immune system into accepting the organ. Of course, that’s a holy grail for allotransplantation, but it may not be any more difficult for xeno.

Unfortunately, it’s very expensive to do this work because it’s done in nonhuman primates. Now that we’ve done it, hopefully there’ll be more commercial

interest and, maybe, more money freed up if commercial entities say, ‘Well, we didn’t believe this was going to go as fast as it did, now let’s get into it. Let’s put real research dollars at it.’ Even if that happens, it’s not likely anytime soon that thousands of American surgeons will be using these organs. I think it will be a thoughtful rollout in cadence with FDA guidelines and with commercial abilities. My guess is that our FDA IND (investigational new drug) application, which should be a multicenter trial of a porcine heart xenotransplant, will be approved, at the earliest, a year-and-a-half from now. ♦

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## SurgeonsVoice and Grassroots Advocacy: Your Questions Answered

by Katie Oehmen

### HIGHLIGHTS

- Summarizes the importance of surgeons engaging with lawmakers
- Illustrates effective strategies for grassroots advocacy
- Addresses frequently asked questions regarding grassroots advocacy

In today's increasingly special interest-focused political system, grassroots advocacy remains one of the most powerful, cost-effective, and often underused strategies available to organizations seeking to effect change. Broadly defined as the act of mobilizing individuals to influence public opinion and government action to achieve a shared goal, grassroots advocacy is driven by advocates "on the ground."<sup>\*</sup>

It is no surprise that organizations with skilled advocacy staff are more successful in achieving policy outcomes that benefit their overall mission. Equipped with policy, regulatory, and legislative experts, the American College of Surgeons (ACS) is no different.

<sup>\*</sup>Hall B. Giving voice: The power of grassroots advocacy in shaping public policy. Views from the field. *Grantmakers in Health*. November 15, 2010. Available at: [https://www.gih.org/files/usrdoc/Grassroots\\_Advocacy\\_Sunflower\\_Foundation\\_November\\_2010.pdf](https://www.gih.org/files/usrdoc/Grassroots_Advocacy_Sunflower_Foundation_November_2010.pdf). Accessed March 25, 2022.

# SurgeonsVoice

American College of Surgeons Professional  
Association Grassroots Network

However, what truly sets an organization apart from others inside the beltway is having members who play an active role in government. These members, also known as grassroots advocates, help bridge the gap between the organization's federal lobbying team and congressional staff by sharing professional expertise and personal experiences on the issues that affect communities across the country. Ultimately, lawmakers listen to the concerns facing the constituents and voters who helped elect them and ideally are more motivated to act accordingly. At the end of the day, grassroots advocacy plays a critical role in informing policymakers' perspectives.

Through the ACS Professional Association (ACSPA), ACS members can access the tools and resources they need to be successful grassroots advocates. Thousands of ACS members across the nation have risen to the challenge and engage in advocacy to advance ACS policy priorities in support of the surgical profession and, most importantly, in support of surgical patients.

Though the College seeks to make engagement easy for Fellows and surgeons at large, grassroots advocacy can be daunting. Thus, ACS Division of Advocacy and Health Policy (DAHP) staff are available to surgeons interested in learning more and participating in the College's grassroots efforts. Addressing questions ranging from the value of advocacy—particularly the effectiveness of grassroots activity—to requests for more information on specific policy priorities, such as recent ACS-led efforts to reduce cuts to Medicare physician payment, the ACS DAHP works to assure surgeons that they are prepared to become involved and actively participate.

Following is a sampling of frequently asked questions.

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## What is grassroots advocacy?

Grassroots advocacy takes many forms. Examples of grassroots advocacy include writing letters,

educating policymakers on specific issues, providing expert testimony before governing bodies, working with local, state, and federal agencies, and more. The purpose of grassroots advocacy is to demonstrate to policymakers that a particular issue has strong support among constituents.

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## Who are grassroots advocates?

Grassroots advocates are citizens who are passionate about an issue and interested in voicing their opinion to legislators and policymakers. Grassroots advocates help elevate awareness regarding specific issues at the local, state, or federal levels. By leveraging their voices through multiple mediums, such as email, social media, and other public policy forums, grassroots advocates can effectively motivate change.

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## How do grassroots advocates differ from grassroots advocates?

Grassroots advocates are seasoned grassroots experts who mentor peers and colleagues to encourage participation. They have preexisting relationships with their lawmakers, staff, and local organizations, and serve as trusted advisors.

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## Who are my elected officials, and how can I learn where my lawmaker stands on a specific issue?

Becoming educated about members of Congress, their backgrounds, committee assignments, voting history, and relevant leadership roles can help provide a better understanding of issues of importance to them. To identify and learn more about your legislators, visit the SurgeonsVoice Advocacy Center ([facs.org/advocacy/surgeonsvoice](https://facs.org/advocacy/surgeonsvoice)) and select "My Officials" from the dropdown menu.




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### How can I find out whether the ACS is working on issues that affect me?

The College's advocacy activities at the federal and state levels are established to represent interests of surgeons and surgical patients. Fellows are encouraged to regularly review issue briefs, position statements, find information regarding ACS advocacy and health policy priorities, and more at [facs.org/advocacy](http://facs.org/advocacy) or by emailing [ahp@facs.org](mailto:ahp@facs.org).

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### Do letters and calls to congressional offices really make a difference?

Absolutely. Writing and calling your lawmakers helps their staff become more educated about an issue and allows them to recognize that an issue is a priority to their constituents, especially for federal lawmakers who do not live in their districts full time.

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### How many letters or calls does it take to make an impact?

Each office is different, but unquestionably strength in numbers is key to effecting change. The more inquiries an office receives, the further the issue moves up the chain of command. Consistently communicating with your lawmakers further ensures your priorities are heard.

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### After sending a letter through SurgeonsVoice, why do I receive a generic response that does not necessarily address the issue raised?

Each office has a process for responding to inquiries. Each member of the House of Representatives serves roughly 700,000 constituents, so many have generic templates or form responses, simply to manage the sheer volume of constituent correspondence. This

is standard operating office procedure. Do not be offended if you receive a response that refers to you by first name, instead of addressing you as "Dr." And remember not to be discouraged if you receive a response that is delayed or less specific than you expected. Instead, use it to your advantage as an opportunity to follow up, establish rapport, and serve as a trusted resource.

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### Who answers the phone when I call a congressional office?

Typically, an intern or a staff assistant is responsible for answering the main office line. If you call the office directly, state your name, ask to speak with the health legislative assistant or another health policy staffer, and be prepared to briefly convey the reason for your call. Offices may receive hundreds of calls a day, so it is likely you will be asked to provide a callback number. Staff are trained to catalog constituent outreach, sometimes in as little detail as possible on an issue.

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### Does my member of Congress want to hear from me?

Constituent feedback is critical to policymakers. Because federal lawmakers spend much of their time in Washington, DC, they are eager to hear from constituents about issues facing the communities they were elected to serve.

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### Personally, I do not agree with my representative's or senators' position on many issues. Why should I contact their office on behalf of the ACS?

Advocating on behalf of all surgeons and surgical patients through the ACS is essential, which is why it is necessary to put your personal politics aside in order to effect change.

When lawmakers need to hear from their constituents to elevate a legislative priority, the ACS issues a “call to action” to encourage Fellows and other ACS members to contact their federal lawmakers.

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### What is a grassroots campaign?

Issues listed in the SurgeonsVoice Advocacy Center are considered grassroots campaigns. It is important to remember that only ACS-supported advocacy priorities that Congress is considering at present will appear in the Advocacy Center. These campaigns typically include an “ask”, such as requesting that the legislator cosponsor legislation, sign a letter, include ACS-supported policy proposal(s) in must-pass legislation, and so forth.

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### What is a “call to action”?

When lawmakers need to hear from their constituents to elevate a legislative priority, the ACS issues a “call to action” to encourage Fellows and other ACS members to contact their federal lawmakers. Calls to action may be urgent, ongoing, or involve efforts to thank legislators for their support. Surgeon advocate participation by responding to or answering various calls to action is imperative.

Calling, writing, and engaging with lawmakers via social media are the most common ACS-led calls to action. While it may appear an issue campaign remains unchanged, rest assured the SurgeonsVoice Advocacy Center is updated regularly to reflect current congressional activity.

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### How do I know if I have taken part in a campaign or if I need to take further action?

At present, ACS DAHP staff assistance is required to learn more about your personal activity history, including whether you have acted on specific campaigns. If you have questions about your personal activity history, contact ACS DAHP staff.

It is okay to respond to a campaign or call to action more than once. In fact, it is encouraged, because

engaging early and often helps raise the profile of an issue.

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### How can I request a meeting with a congressional office?

Use the “Schedule a Meeting” tool via the SurgeonsVoice Advocacy Center at [facs.quorum.us/campaign/27986](https://facs.quorum.us/campaign/27986).

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### I am not social media savvy. How can I engage?

To review brief snippets of advocacy and health policy-related information, follow @SurgeonsVoice on Twitter. For further engagement, use social media to connect with your colleagues and lawmakers, and help elevate surgical priorities through this more public forum. Nearly all congressional offices have staff who monitor social media accounts, which can lead to broader awareness about important issues.

### Conclusion

As evidenced by 2021 ACS-led efforts to reduce cuts to Medicare physician payment, surgeon involvement in advocacy is vital. Advocacy is a marathon, not a sprint. It can feel like a daunting space, but it is essential to protect surgical patients and the profession. Surgery continues to face many challenges, which is why a collective voice is increasingly critical. Participating in ACS advocacy and political activity is strongly encouraged and essential to maintaining a commitment to surgical patients and the communities surgeons serve. ♦





## The Surgeon's Voice Is Critical on Capitol Hill: Make Sure Yours Is Heard

by Patrick V. Bailey, MD, MLS, FACS

**T**he advocacy efforts in the fall of 2021 to stave off pending cuts to Medicare payment were successful. Collectively, surgeons were able to prevent a 9% pay cut, sustaining instead a much smaller 2% cut. To be sure, we would have been unable to mitigate that 9% cut without so many Fellows answering the American College of Surgeons (ACS) call to action and engaging in the political process. For many surgeons, it may have been their first time participating in ACS advocacy efforts.

Subsequently, we heard from some Fellows who found the advocacy process a bit frustrating. Some members indicated those challenges might make them less apt to participate in similar activities in the future. Though I clearly understand that engaging in the political process can be daunting at times, I also believe it is important that we continue to act collectively to move the needle for our profession and, most importantly, for our patients.

The frustrations expressed by some of our colleagues were largely centered on their legislators' offices' response to their electronic communications. Basically, these concerns fell into two broad categories: the impersonal nature of the response received, and political messaging in the response that differed from their personal political views.

First, it is important to remember that the purpose of sending a grassroots message to a congressional office is to make sure your voice is heard and provide cause for another check mark to be placed on the tally sheet that your legislator's staff keeps on the specific issue involved. This is why we often ask Fellows to

contact their legislators multiple times, which results in marks on the scorecards on multiple days.

To this point, it is helpful to remember that a primary objective of every member of the House and Senate is reelection. Representatives and senators know that a key strategy for getting reelected is to be responsive to their constituents; receiving multiple grassroots messages on the same topic gets their attention. As legislators receive more communications on the same issue, they tend to be more receptive to the message they are hearing from their home district and, hopefully, more apt to react by taking positive steps.

### Impersonal Nature of Responses Received

The electronic messages we transmit via SurgeonsVoice contain standard messaging, though it is infinitely modifiable to allow Fellows to edit as they wish. We do this to make participation easy and efficient so that the legislator clearly knows the viewpoint of our Fellows. The responses sent in reply to these messages also contain standard language generated to broadly address the concerns expressed. Stated differently, it is fair to view these responses as simply an acknowledgement that your message has been received, which is perfectly fine. Again, the goal is to ensure that our message gets through. The intended ends of the action were accomplished.

Typically, these responses will be impersonal, and it is common for them to be addressed to Mr. Smith or Ms. Smith and rarely to Dr. Smith. This salutation is not a sign of disrespect, but simply a function of the

To be blunt, it is imperative that we separate our personal political agenda from the advocacy efforts made on behalf of our profession and our patients. We must be able to work with legislators across the partisan political spectrum in a professional and respectful manner.

volume of responses legislative staff send in reply to constituent contacts daily. It also is important to note that sending these grassroots messages is a good first step toward building a positive relationship with your elected officials. Our hope is that Fellows can become a trusted voice and resource for their legislators on healthcare matters.

### Partisan Political Content in the Response

Some Fellows objected to or were offended by the inclusion of partisan rhetoric in the responses they received. This is a dilemma that we in the ACS Washington office face daily—separating one’s professional political agenda from one’s personal political beliefs. Unfortunately, this quandary has become even more significant in this hyper-partisan era.

To be blunt, it is imperative that we separate our personal political agenda from the advocacy efforts made on behalf of our profession and our patients. We must be able to work with legislators across the political spectrum in a professional and respectful manner.

Having said that, I realize this situation can be challenging. Most of us have deep-seated, long-held political beliefs—and for good reason. Political identity often has its roots in our earliest socialization from our family. For many individuals, it is at the core of our personal identity. However, as surgeons, we must recognize that regardless of the party with which we most often identify, at times our professional agenda will require us to engage with individuals who do not share our broader political agenda or, alternatively, with a political personality that we find objectionable.

In sum, there will be times when brutal, objective pragmatism in our professional politics should supersede the subjective passion of our personal political views. To that point, we should not take offense when the response received from legislators who are outside the party with which we identify contains political

rhetoric that uses the opportunity to take a shot at their political opponents. This is simply the state of politics in our country.

### Building Relationships

Finally, I want to urge you to build a relationship with your elected leaders so that you are a trusted voice and resource for them on healthcare matters. Here are a couple of suggestions to foster relationships with policymakers:

- Get to know your legislators when they are back home in the district. Attend events and talk with them. Let them know what you are thinking about issues of concern to you and your patients.
- Get to know the district director, district staff, and health policy staff, who are essential advisors to your elected officials. If you have a relationship with them, they will seek out your opinion on healthcare matters and share it with the legislator.
- Build bridges with elected officials to help ensure that they know the views of trusted medical professionals like our Fellows in their communities. Hopefully, they will keep that in mind as they cast votes on matters important to us and our patients.

In the meantime, we urge members to remain optimistic about the political process. Get engaged, stay engaged, and answer the call when we need to make our voices heard on Capitol Hill. Fellows made a real difference last fall in mitigating the Medicare payment cuts, and they can make a difference on whatever issues may be next on the horizon. ♦



## Why Should You Engage in ACSPA-SurgeonsPAC Activity?

by Samuel Mandell, MD, FACS, MPH,  
and M. Ashraf Mansour, MD, FACS

**A**s physicians, we use our expertise and empathy to protect and empower patients to be champions of their healthcare and well-being. Such commitment and conviction lead to mutually beneficial relationships between surgeons and their patients. However, if abused, distrust and skepticism can arise. This situation is akin to the current political environment, which is why it is critical that members of the American College of Surgeons (ACS) understand the College's advocacy and political efforts, including the importance of becoming more engaged at all levels of government.

Many surgeons continue to weigh the benefits and risks of political engagement, including participating in the ACS Professional Association Political Action Committee (ACSPA-SurgeonsPAC). Their hesitancy is reflected in the numbers: fewer than 2% of eligible members contribute to the PAC. Whether this lack of involvement is the result of apathy, conflicting personal and professional politics, or a misunderstanding of the vital role that surgeons play in the political

# SurgeonsPAC

American College of Surgeons Professional  
Association Political Action Committee

process, one unavoidable reality is clear: we must play a larger role and recruit others to get involved. Healthcare will change, with or without our input.

It is better for both the profession and our patients that our voices are heard. Having weighed the pros and cons of participating in these activities, the PAC undertook to effect change and improve access to quality surgical care. To encourage your engagement, we want to clarify what you can do and why your participation is important.

## Purpose and Principles of the ACSPA-SurgeonsPAC

The ACSPA was established in 2001 as a 501(c)(6) affiliate to ensure the College, as a tax-exempt not-for-profit organization, could maintain the standard-setting and educational activities at the heart of its mission. The ACSPA allows for a broader range of activities and services that benefit surgeons and patients, including expanded legislative advocacy and political programming.

As the SurgeonsPAC celebrates its 20th anniversary this year, it's important to note that the ACS always has recognized that for the profession to be successful, surgery requires a strong presence in Washington, DC. The ACS Division of Advocacy and Health Policy (DAHP) advances the College's health policy agenda through Congress via lobbying activities, grassroots engagement (SurgeonsVoice), and political affairs (SurgeonsPAC). To help propose and advocate for healthcare policies that are in the best interests of surgical patients, the DAHP liaises with Congress and government agencies, such as the Centers for Medicare & Medicaid Services (CMS) and other entities under the purview of the US Department of Health and Human Services.

So, what is a PAC? A PAC pools resources from like-minded individuals, contributes to candidates' campaigns, and advocates on behalf of its members' common interests.

PACs focus on policy, not politics, and remain among the most transparent and regulated campaign finance entities. PAC contributions and expenditures are monitored by the Federal Election Commission (FEC) and other independent groups, such as the Center for Responsive Politics. For more information about PACs, visit [OpenSecrets.org](http://OpenSecrets.org).

The ACSPA-SurgeonsPAC was established to promote access to quality surgical care for patients by supporting the election of federal officeholders who share surgery's perspective on relevant policies and priorities. All political efforts are financed through voluntary contributions from ACSPA members paid directly to the ACSPA-SurgeonsPAC. To learn more, visit [facs.org/advocacy/get-involved/surgeonspac](http://facs.org/advocacy/get-involved/surgeonspac).

Amid the ongoing political rhetoric, SurgeonsPAC serves as a united voice for you and your patients in Washington. Each year, we face many challenges unique to surgeons and surgical patients, which is why a collective, strong surgical presence in the political and policymaking process is increasingly vital. If the more than 98% of ACS members who do not participate in SurgeonsPAC decided to join, the potential to become a top industry PAC would be great.

## SurgeonsPAC Fundraising and Disbursements

SurgeonsPAC raises money from its eligible members to help elect and reelect candidates seeking federal office. All active, US dues-paying members and green card holders (and their spouses), as well as ACS employees, are eligible to join SurgeonsPAC. All voluntary contributions to SurgeonsPAC are considered "hard dollars." SurgeonsPAC uses all hard dollar funds to support congressional candidates, political campaign committees, and other PACs. Corporate contributions, or "soft dollars," include monies received from groups or private practices and are used for educational and administrative expenses.

It is important to note that SurgeonsPAC was established as a nonpartisan entity to unite surgery's





voice on Capitol Hill and therefore does not, and legally cannot, earmark contributions to specific members of Congress or contribute to candidates based on a single issue or legislative effort. SurgeonsPAC works to elect members of Congress but does not participate in presidential or state and local elections.

The ACSPA-SurgeonsPAC Board of Directors plays a key role in considering and evaluating congressional candidates seeking financial support. Representing various surgical specialties and interests, the SurgeonsPAC Board of Directors considers several factors before determining which federal campaigns to support, including candidates' viability, professional background, committee assignments (particularly committees with jurisdiction over healthcare issues), voting record on healthcare-related legislation that could affect surgery, and leadership positions within their political party.

As a PAC member, you can ask the PAC to support viable candidates running for federal office, deliver a PAC check at an in-district event, and more.

### Troubleshooting Misnomers

Misinformation regarding PACs is one reason prospective contributors may hesitate to give. Following is a sampling of frequently asked questions, comments, and responses about SurgeonsPAC.

#### **I do not want my money going to individuals I would not personally support.**

Neither do we. However, advocating for patients and on behalf of all surgeons often requires setting personal politics aside. Participating in SurgeonsPAC is meant to amplify, not replace, your individual advocacy efforts. You are encouraged to contribute to campaigns and other specialty PACs, in addition to supporting SurgeonsPAC. Participating not only ensures your voice

is heard in Washington and by decision makers, but also can help leverage your interests within the ACS.

#### **How can I learn more about candidates who receive SurgeonsPAC support?**

In line with the ACS mission, SurgeonsPAC upholds the highest ethical standards to ensure that contributions are distributed in a nonpartisan manner, in compliance with FEC regulations, and to individuals who support excellence in surgical care and exhibit professionalism when advocating on behalf of surgery.

Once logged in to SurgeonsPAC.org, all calendar-year contributions to candidates are available to review by state at [surgeonspac.org/Disbursements.aspx](https://surgeonspac.org/Disbursements.aspx).

#### **What if I already contribute to my specialty PAC?**

SurgeonsPAC serves as the voice for all of surgery regarding common issues across subspecialties. SurgeonsPAC works with other surgical specialty PACs and recognizes the critical role they play for their members.

The College has the membership and bandwidth to become the largest medical PAC in Washington, a tremendous benefit to all surgeons and specialists. Again, PAC contributions to individual surgical societies are a critical component of surgical advocacy, and SurgeonsPAC urges members to continue these contributions. That said, surgeons of all specialties are encouraged to consider contributing to the ACSPA-SurgeonsPAC.

#### **Does my support actually make an impact?**

Communicating with Congress can be frustrating, but the College must continue to play a proactive role in proposing meaningful health policy solutions for



In line with the ACS mission, SurgeonsPAC upholds the highest ethical standards to ensure that contributions are distributed in a nonpartisan manner, in compliance with FEC regulations, and to individuals who support excellence in surgical care and exhibit professionalism when advocating on behalf of surgery.

Congress and state legislatures to consider. Surgeon advocates need to become experts within this space and advocate for meaningful, practical policies at the federal and state levels.

Establishing yourself as a surgeon advocate is crucial to making your voice heard. Regular engagement with members of Congress and their staff and serving as a trusted resource on issues of importance to surgeons and surgical patients is essential. As a surgeon, your firsthand expertise and training provide a realistic perspective on health policy issues to members of Congress. As a result, many lawmakers, particularly your elected officials, will look to you for guidance on complex issues.

If politicians are getting bad advice, you can become their trusted resource. Meeting with your members of Congress in conjunction with the annual ACS Leadership & Advocacy Summit or through the Advocacy at Home program is a great way to witness advocacy in action and begin building relationships with lawmakers and their offices.

## Conclusion

Focusing on professional versus personal politics while recognizing the plethora of issues directly affecting our patients and colleagues can help us become more effective surgeon advocates. Whether this includes writing letters or scheduling meetings through SurgeonsVoice or deciding to join SurgeonsPAC, participation is paramount.

Successful advocacy starts with common goals, strength in numbers, and opportunities to engage elected officials and decision makers. The College advocates on behalf of surgeons, patients, and the surgical profession at the federal and state levels. With more than 84,000 members, the College has the potential to make a strong impact at all levels of government while advocating for a better future for surgeons and patients. It is our hope that more of our peers will join us, so that together we can be a powerful voice and catalyst for change. ♦

## Note

Contributions to ACSPA-SurgeonsPAC are not deductible as charitable contributions for federal income tax purposes. Contributions are voluntary, and all members of ACSPA have the right to refuse to contribute without reprisal. Federal law prohibits ACSPA-SurgeonsPAC from accepting contributions from foreign nations. By law, if your contributions are made using a personal check or credit card, ACSPA-SurgeonsPAC may use your contribution only to support candidates in federal elections. All corporate contributions to ACSPA-SurgeonsPAC will be used for educational and administrative fees of ACSPA and other activities permissible under federal law. Federal law requires ACSPA-SurgeonsPAC to use its best efforts to collect and report the name, mailing address, occupation, and the name of the employer of individuals whose contributions exceed \$200 in a calendar year. ACSPA-SurgeonsPAC is a program of the ACSPA, which is exempt from federal income tax under section 501(c)(6) of the Internal Revenue Code.



## Take a Seat: How Surgeons Can Influence State Telehealth Legislation

by Rebecca King, MHA, and Ross F. Goldberg, MD, FACS

### HIGHLIGHTS

- Describes a surgeon's experience with advocating for improved access to telehealth services in Arizona
- Summarizes the effect COVID-19 had on telehealth services at the state level
- Outlines current state telehealth policies and underscores the surgeon's role in shaping future policy

**W**hen Ross Goldberg, MD, FACS, coauthor of this article, first stepped into the Offices of the Arizona Governor in Phoenix, he noticed an eerie stillness that was unusual for the otherwise typically fast-paced environment. In early 2020, businesses and schools across the country had shut down in response to the COVID-19 pandemic. Consumed by endless updates on the rising number of cases, Dr. Goldberg was well aware of the importance of social distancing and masking in public spaces. Still, with most employees working from home, he sat in an empty waiting room and was reminded of the urgency of embarking on his next professional achievement—improving access to telehealth services for patients throughout Arizona.

At the time, Dr. Goldberg was the president of the Arizona Medical Association and the district medical group vice-chair of the department of surgery for Valleywise Health, Phoenix. He had been called on by Arizona Gov. Doug Ducey to provide his expertise in addressing the regulatory concerns and hurdles in providing telehealth services in the state. Dr. Goldberg's work as a general surgeon over the past decade and as a Governor of the American College of Surgeons (ACS) led him to this opportunity, and he understood the importance of representing surgeons of all specialties across the state.

Telehealth services seemingly expanded overnight to help mitigate the spread of COVID-19 and reduce the risk of hospitalization for patients. Telehealth services were being scaled faster than ever and, in the process, exposed policymakers to the regulatory barriers preventing widespread adoption.

Dr. Goldberg walked into the main conference room of the governor's office, admiring the views of Phoenix outside and took his seat, ready to begin the meeting.

### The Pandemic's Effect on Telehealth Services

Just 1 year after that first meeting with the governor, Arizona H.B. 2454 was signed into law.<sup>1</sup> Arizona was not the only state to prioritize legislation regarding telehealth since the onset of the pandemic. The ACS State Affairs team has been monitoring more than 100 state telehealth bills this legislative season.

States have been governing the practice of telehealth for decades, but healthcare systems and medical providers were slow to adopt the practice before the pandemic. Telehealth services seemingly expanded overnight to help mitigate the spread of COVID-19 and reduce the risk of hospitalization for patients. Telehealth services were being scaled up faster than ever and, in the process, exposed policymakers to the regulatory barriers preventing widespread adoption.

As a result, a stream of state executive orders declaring public health emergencies across the country relaxed telehealth laws, ranging from reimbursement rates and anti-payment parity laws to interstate licensing, insurance coverage, liability issues, and more. Now that many of the executive orders have expired, states are reassessing the value of telehealth as a tool to improve patient access to care. Several states have already taken legislative action to make certain public health emergency provisions permanent, and many more are expected to follow as the use of telehealth continues to rise.

### How Surgeons Can Impact State Telehealth Legislation

One provision of Arizona H.B. 2454 that became important during the negotiations with the bill's cosponsors, Reps. Regina Cobb and Joanne Osborne, as well as Governor Ducey, was providing clarification for out-of-state physicians on interstate licensing. Several

members of the team drafting the bill were concerned about allowing out-of-state physicians to practice in Arizona.

By engaging in discussions early in the process, Dr. Goldberg was able to provide his expertise and advocate for additional patient safety guidelines, while also protecting in-state physicians' abilities to practice. Specifically, the legislation certifies that insurance providers cannot use telehealth services to fulfill network adequacy requirements and replace in-person visits. Dr. Goldberg also helped to secure the creation of an oversight committee in the bill to ensure that telehealth services would be monitored and used appropriately.

Signed by Governor Ducey in May 2021, H.B. 2454 allows out-of-state physicians to provide telehealth services to Arizona residents if they register with the state's applicable healthcare provider regulatory board or agency. Out-of-state physicians are exempt from the registration requirements if they only provide follow-up care related to a procedure that was performed in another state.

No bill is perfect, and as with any negotiation, it was necessary to compromise on some issues. It would have been unrealistic to believe everyone would be happy with all aspects of the legislation, but advocates did their best to ensure that the physician community was well represented and that their main concerns were addressed.

### Surgeons Need to Take a Seat at the Table

State policymakers are responsible for a breadth of issues, including their state's economy, environmental concerns, taxes, housing, commerce, education, and more. Many state legislators have backgrounds, education, and even cultural experiences that differ from those of the medical community. Educating them and their staff on the complexities of healthcare systems, surgical care, quality improvement, and the day-to-day responsibilities of caring for patients is critical not just to developing smart policy, but also



to preventing the negative consequences of uninformed policy.

Surgeons are unique to the medical profession in that they are trained to be leaders from the first time they step into an operating room. They must be skillful in building relationships, bold in seeking solutions, and confident in their decision-making with patients—all qualities that are perfect for lobbying local representatives and advocating on behalf of the surgical community.

The earlier surgeons start engaging in state policy development, the better the outcome will be for surgeons and their patients. In terms of telehealth, federal legislation will go only so far. Many decisions are made at the state level and at times can supersede federal rules. It's often been said that "all politics is local," and this is another example of this truism.

### Outlook on Using Telehealth in Surgical Care

Until the pandemic, telehealth services in surgical specialties primarily were used for postoperative visits, but with many operations postponed or canceled, surgeons needed to rely more on telecommunications to manage the significant decrease in caseloads. According to the ACS Board of Governors Survey published in 2020, 65% of ACS Governors reported lower or much lower volumes than the previous year.<sup>2</sup> For nearly 70% of ACS Governors, the pandemic was the first time they used telehealth with their patients, with 75% primarily using it for outpatient care. Most ACS Governors surveyed (87%) believed that telehealth improved access to care.

In addition, the COVID-19 Healthcare Coalition—which comprises organizations representing healthcare, tech companies, academia, and not-for-profits—published results of a survey focused on the use of telehealth services in specialty care.<sup>3</sup> Survey participants included 1,594 physicians from six different specialty groups across the US.

During the pandemic, 30% of surgeons and anesthesiologists were scheduling six to 10 telehealth appointments per week. Nearly a quarter were averaging 11 to 20 telehealth appointments, and another 23% were averaging more than 20. Of the survey participants specializing in surgery and anesthesia, 60% agreed or strongly agreed they were motivated to increase their use of telehealth, and 60% agreed or strongly agreed their organization's leadership was motivated to increase the use of telehealth services in their practice.

In a follow-up survey conducted by the American Medical Association, more than 80% of participants indicated that patients have better access to care as a result of increased use of telehealth services, and 62% felt that patients experienced higher satisfaction.<sup>4</sup>

The benefits of telehealth to both patients and physicians are significant. Not only does telehealth provide opportunities for patients to receive timely specialty care, but surgeons also can reduce the risk of complications through wider channels of communication that allow them to build greater trust with their patients. Telehealth especially can benefit surgical patients diagnosed with chronic or complex disease, such as cancer, which may require long-term coordinated care.<sup>5</sup>

### Landscape for Current State Telehealth Law

Despite the benefits and increase in popularity, the medical community has yet to reach consensus on a single telehealth road map for the future. Troubleshooting negative implications for provider networks has been challenging, and concerns about liability and patient privacy further complicate the issue. Much of the debate centers on whether physicians should be reimbursed at the same rate for a telehealth visit as for an in-person visit. Technically the cost of a single telehealth appointment is considerably less than an in-person visit, but advocates for payment parity are calling for consideration of sunk and overhead costs.



Despite the benefits and increase in popularity, the medical community has yet to reach consensus on a single telehealth road map for the future.

At present, 46 states and the District of Columbia have telehealth laws in place, although they vary drastically from state to state. Using interstate licensing as an example, 17 states offer a special telehealth license, certificate, or waiver for out-of-state physicians to deliver telehealth services, whereas 18 states require physicians to hold a license in the state where the patient is located at the time of treatment. Utah only allows out-of-state physicians to practice without charging a fee, and Rhode Island only allows them to practice if they are employed by the US military, members of an air ambulance team, or staffing a visiting sports team. Six states—Iowa, Montana, New York, North Carolina, Ohio, and Wyoming—fail to specifically address physicians in their telehealth laws but do include other providers such as psychologists, physician assistants, audiologists, dental hygienists, and physical or occupational therapists.<sup>6</sup>

### Lessons Learned and Advice for Others

Decisions pertaining to healthcare policy and delivery of care will be written into law and implemented regardless of whether surgeons play a proactive role in the process. Surgeons who want to participate in shaping telehealth policy should be prepared, open-minded, and willing to compromise in negotiations. Know your talking points and the supporting data. Remember, this is a conversation, not a lecture. Be willing to listen to other points of views. Compromise is not a dirty word, but rather a necessary step in the negotiation process.

When advocating for an issue, you are not just acting on your own behalf, but for your patients and your profession. At times you may need to advocate for issues that do not directly affect you, which is okay, because the more united we are, the more we can help each other with our issues, and the more we can accomplish for our patients. ♦

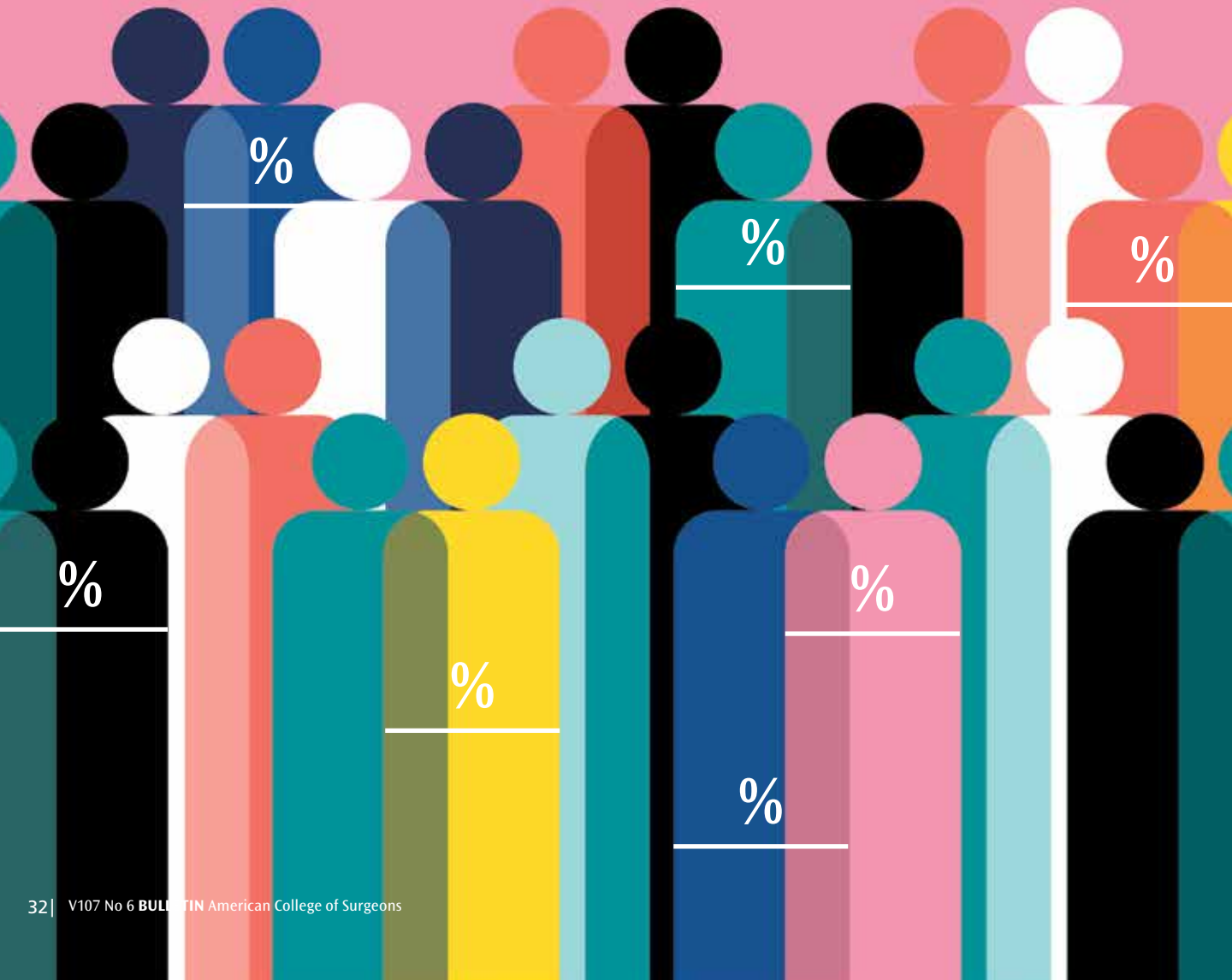
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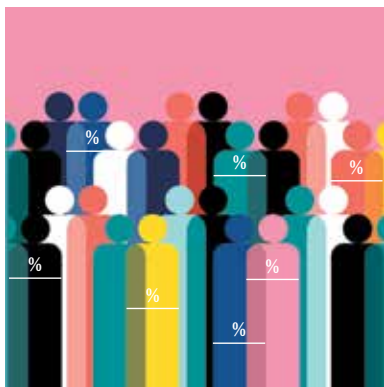
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# The Role of Social Determinants of Health on Cancer Screening

by Fedra Fallahian, MD,  
Heidi Nelson, MD, FACS,  
and Susan Pories, MD, FACS





## HIGHLIGHTS

- Describes the SDOH that affect access to breast, cervical, colorectal, prostate, and lung cancer screening
- Identifies how COVID-19 has contributed to the significant decline in cancer screening
- Highlights the role of surgeons to educate eligible patients on how to access preventive services covered by Medicaid or Medicare

**H**ealthcare equity affects the well-being of a nation as a whole. Although surgeons aim to serve all our patients equally, healthcare has never been uniformly accessible to all populations in the US.

The differences in cancer incidence and outcomes between people of varying racial and socioeconomic backgrounds have been well documented. The Centers for Disease Control and Prevention (CDC) has delineated social determinants of health (SDOH) to include “conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes.”<sup>1</sup> Healthy People 2030 categorizes SDOH into five key areas (see Table 1, page 34). Efforts to influence population health outcomes by enhancing quality of life, focusing on these five categories, have been under way, but more work is needed to achieve healthcare equity and equality. Previously published work in the *Bulletin* highlighted the role of surgery and SDOH and described strategies for surgeons to promote accessible, quality care for all patients.<sup>2</sup>

Cancer screening has been shown to reduce mortality from some of the most common cancers, including breast, cervical, colorectal, prostate, and lung cancer. In addition, screening enhances cancer prevention by identifying and removing precancerous lesions.<sup>3</sup> Access to healthcare historically has been the driving factor in patients undergoing preventive screening. Health insurance coverage is associated with greater rates of screening. Uninsured and underinsured individuals have significantly lower rates of screening for cancers.<sup>4</sup> It is imperative that we understand the obstacles that certain populations face in accessing breast, cervical, and colorectal cancer screening in order to optimize factors that allow for successful preventive care measures for all.

## Breast and Cervical Cancer

One in eight women in the US will be diagnosed with breast cancer during her lifetime, but mortality has been decreasing over the past 30 years, largely because of early detection by mammography.<sup>5</sup> Although mammography has been associated with better outcomes, access to this screening modality varies among different populations. Uninsured women and recent immigrants reported the lowest prevalence of mammography use.<sup>6</sup> Even after accounting for socioeconomic status, Black race has been shown to be an independent predictor of poor outcomes from breast cancer, highlighting the need for enhanced screening in this population.<sup>7</sup>

In 1990, the CDC created the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) to provide uninsured and underinsured women with access to breast and cervical cancer screening and diagnostic and treatment services.<sup>8</sup> However, up to 60% of all women who are eligible for the NBCCEDP were not screened for breast cancer. The reason for underuse of screening via this program likely is multifactorial.<sup>9</sup> Eligibility guidelines and supplemental state funding to assist with the costs of delivering care vary considerably.

The costs of delivering care, including transportation and direct care (mammograms), also varies between localities, and the number of eligible women may outpace the capacity and funding to provide care. Some eligible women also may access mammogram screening via Medicaid. However, almost half of the states chose not to expand Medicaid access, which also increased disparities in eligibility between states.

In addition, a woman’s insurance status may change over the course of the year, depending on employment status. Confusion about the age group that should be screened and the frequency

It is imperative that we understand the obstacles that certain populations face in accessing breast, cervical, and colorectal cancer screening in order to optimize factors that allow for successful preventive care measures for all.

**TABLE 1.**  
**EXPANDING OPPORTUNITIES**  
**TO SCREEN FOR CANCER**

SDOH	Pathways to Improve Cancer Screening
Healthcare access and quality	<ul style="list-style-type: none"> <li>• Ensure social as well as medical assessments</li> <li>• Assess barriers to screening</li> </ul>
Education	Provide navigators and advocates with cultural competency training to interface with healthcare systems
Social and community context	Collaborate with community health centers, hospital clinics, and government programs to ensure access to screening such as CDC programs: <ul style="list-style-type: none"> <li>• CDC NBCCEDP: <a href="https://cdc.gov/cancer/nbccedp/screenings.htm">cdc.gov/cancer/nbccedp/screenings.htm</a></li> <li>• CDC CRCCP: <a href="https://cdc.gov/cancer/crccp/how-crccp-increases-screening.htm">cdc.gov/cancer/crccp/how-crccp-increases-screening.htm</a></li> </ul>
Economic stability	Ensure patients are screened for eligibility for appropriate programs to support healthcare (Medicaid, Medicare, Affordable Care Act)
Neighborhood and built environment	Provide case managers to assist with housing and food needs

of screening also can lead to lower screening rates. Furthermore, women diagnosed with breast cancer through the NBCCEDP were diagnosed at a later stage compared with those diagnosed outside of the program.<sup>9</sup>

Disability also plays a role in access to cancer screening. Women with disabilities have been shown to be less likely to be up to date with breast cancer screening, although women both with and without disabilities fall short of the goal screening rate set in Healthy People 2020.<sup>10</sup>

### Colorectal Cancer

Colorectal cancer (CRC) is the second most common cause of cancer-related deaths and the third most common form of cancer in the US.<sup>11</sup> Screening is the most effective prevention method to decrease the burden of disease, and increased screening has been shown to reduce mortality.<sup>12</sup> According to the CDC, one-quarter of adults have not received adequate screening for CRC.<sup>13</sup> A variety of factors, including age, gender, ethnicity, insurance, and primary care clinic visits, affect access to and prevalence of screening. Both CRC screening and outcomes are influenced by socioeconomic and demographic factors, rural versus urban settings, and insurance coverage.<sup>14</sup>

Because primary care clinics are uniquely suited to promote health screening, there has been a push to amplify these efforts. The Colorectal Cancer Control Program, funded by the CDC, partners with clinics that serve populations from socioeconomically disadvantaged populations with the goal of increasing CRC screening rates and reducing disparities among these groups. Although these clinics had a lower overall screening rate (36.3%) than the overall US population, select evidence-based interventions, such as client and provider reminders, provider assessment and feedback, and reduction of structural barriers, have proven to increase screening rates.<sup>15</sup>

To address disparities in lung cancer screening, the USPSTF lowered eligibility thresholds. However, concerns remain that the revised guidelines simply perpetuate disparities by using age and pack-year criteria, which can limit referrals and access to screening facilities.

### Prostate Cancer

A significant reduction in the prostate cancer death rate has been shown in men who were offered prostate-specific antigen screening.<sup>16</sup> Inequities in access to treatment are evident among certain racial and ethnic groups. Black and Hispanic men are less likely than White men to receive treatment for prostate cancer.<sup>17</sup>

The incidence of prostate cancer and mortality from the disease is significantly higher in Black men compared with the rest of the population.<sup>18</sup> Previously, it was thought that biological differences could account for higher rates and worse outcomes in Black men. More recently, however, research has shown that after adjusting for nonbiologic differences, such as access to care, Black race was not associated with increased prostate cancer-specific mortality.<sup>19</sup>

However, using the National Cancer Institute Surveillance, Epidemiology, and End Results (SEER) data, researchers found that Black race was associated with statistically greater socioeconomic barriers to quality care.<sup>19</sup> Li and colleagues identified differences in rates of modifiable factors in different ethnic groups with prostate cancer and demonstrated varying levels of alcohol consumption, obesity, and receipt of pneumococcal vaccination between Black and White patients. Such findings underscore the need to develop evidence-based interventions to mitigate these risks.<sup>20</sup>

### Lung Cancer

The American Lung Association has shown that disparities in screening for lung cancer with low-dose computed tomography scanning as well as access to treatment have a direct effect on survival.<sup>21</sup> It is clear that late diagnosis leads to worse outcomes. Black Americans with lung cancer are 18% less likely to be diagnosed early, 23% less likely to receive surgical treatment, 9% more likely to receive no treatment, and 21% less likely to survive 5 years compared with White Americans.<sup>21</sup> Similar disparities were seen in Hispanic, Asian, and Native American populations.

To address disparities in lung cancer screening, the US Preventive Services Task Force (USPSTF) lowered eligibility thresholds. However, concerns remain that the revised guidelines simply perpetuate disparities by using age and pack-year criteria, which can limit referrals and access to screening facilities.<sup>22</sup>

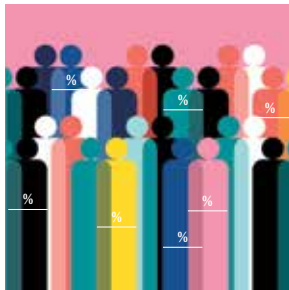
### COVID's Effects on Screening

The COVID-19 pandemic resulted in a significant decline in cancer screening. US studies have demonstrated that more than one-third of adults failed to receive recommended cancer screening during the pandemic.<sup>23</sup> The virus has disproportionately affected Black and Hispanic/Latino populations, the same patients who experience a high burden of cancer.<sup>24</sup>

Asian-American populations also experience barriers to screening, which vary considerably depending on ethnic subgroup, language, socioeconomic status, and cultural norms.<sup>25</sup> In addition, attacks on members of the Asian-American community during the COVID-19 pandemic likely have increased hesitancy to seek care.

Many mammography screening services were placed on hold during the pandemic, which adversely affected minorities in particular, as they already have more advanced-stage distribution of breast cancer. Furthermore, safety-net hospitals, where many socioeconomically disadvantaged patients receive their healthcare and cancer screenings, have been significantly burdened by the financial cost of treating COVID-19 patients and often were unable to support screening programs.<sup>26</sup> An estimated 12 million individuals have lost their employer-sponsored health insurance coverage, with a disproportionate impact on Black and Hispanic people.<sup>27</sup>

To overcome the backlog of screening COVID presented, the American College of Surgeons Commission on Cancer (CoC) joined forces with the American Cancer Society and the National Accreditation Program for Breast Centers to create the PDSA (plan/do/study/act) Collaborative Project on Return



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to Screening, a quality improvement project and clinical study as described at [facs.org/quality-programs/cancer/news/040821](https://facs.org/quality-programs/cancer/news/040821). This initiative encouraged cancer programs to prioritize safe, recommended screening for colorectal, breast, lung, and cervical cancer. The PDSA Collaborative enrolled 749 CoC-accredited programs in its study, and 814 quality improvement projects were initiated with the potential to achieve up to 70,000 additional screenings per month for 2021 if the screening targets were met, which helps to significantly move the needle toward pre-pandemic screening levels.

## Call to Action

Despite the far-reaching and ever-present impact of SDOH, physicians can work to limit these effects on cancer care. As surgeons, one of our most important roles is to encourage and facilitate appropriate cancer screening. We should ensure that eligible patients are empowered to access programs such as Medicaid or Medicare, which can help to cover the costs of preventive services. We can address modifiable risk factors, such as smoking, lack of exercise, and unhealthy eating habits.<sup>28</sup> Surgeons also can use their positions as experts in their fields and leaders in their communities to improve outreach and education efforts and to support and endorse



As surgeons, one of our most important roles is to encourage and facilitate appropriate cancer screening.

policies and legislation that increase access to care.

### Conclusion

Cancer screening has been linked to decreased incidence of cancer and associated mortality. Different racial and socioeconomic groups have varying rates of access to cancer screening and care, which has deleterious consequences. In addition, barriers to screening, such as reliable transportation, housing, food insecurity, language, and cultural differences, can affect the success of screening programs.<sup>29</sup> Sexual orientation, gender minority group biases, low health literacy, mistrust of the medical system, time constraints, financial concerns, and lack of insurance also play a role.<sup>22</sup>

It is crucial that all cancer surgeons understand these disparities in access to cancer screening and the impact on cancer outcomes, so we can all work together to mitigate these inequities. As individuals, we can strive to increase awareness of disparities, confront our own implicit biases, and work closely with our hospitals and social services to increase access to care in our communities.<sup>22</sup> ♦

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## CANCER RESEARCH PROGRAM™

Program of the American  
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# To Operate or Not in De Novo Stage IV Breast Cancer: Is That Still a Question?

by Preeti D. Subhedar, MS, MD, FACS,  
Sarah Blair, MD, FACS, and Judy C. Boughey, MD, FACS

Approximately 6% of newly diagnosed breast cancer cases are de novo stage IV with an intact primary at presentation.<sup>1</sup> Survival outcomes for this group of patients have been studied with both retrospective and randomized clinical trials (RCTs), but conflicting results have led to confusion about optimal therapy. The decision to offer locoregional therapy (surgery +/- radiation) to the breast primary in addition to systemic therapy is still hotly debated.

Studies using several large databases and registries—such as the Surveillance, Epidemiology, and End Results (SEER) Program and the National Cancer Database (NCDB)—have been published on this topic. Some studies have shown an improvement in overall survival with resection of the intact primary breast cancer, whereas others have not.<sup>2-4</sup> Additional studies have hinted at a benefit from locoregional therapy in young patients, those with favorable receptor subtypes, or with oligometastatic disease.<sup>5-7</sup> While these large datasets allow for the study of a question that would otherwise

take several years to answer in a randomized fashion, there are inherent issues with data capture and selection bias that cannot be completely controlled and should be taken into account when using retrospective data to make clinical decisions.

### Conflicting Clinical Trials

Fortunately RCTs have studied outcomes in de novo stage IV breast cancer; unfortunately, the results from these trials also have been conflicting. The RCT from India's Tata Memorial Cancer Centre and the ABCSG-28 POSYITIVE trials failed to show a benefit to adding locoregional therapy over optimal systemic therapy alone.<sup>8,9</sup> The Turkish MF07-01 trial has been the only RCT to show that the risk of death was lower in patients who received locoregional therapy to the primary breast tumor.<sup>10</sup> This discrepancy has made it difficult to arrive at the optimal recommendations for treatment of patients with this presentation of breast cancer.

The ECOG-ACRIN 2108 trial, led by Seema Khan, MD, FACS, was designed to evaluate the

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TABLE 1. RCTs OF LOCOREGIONAL THERAPY IN DE NOVO STAGE IV BREAST CANCER

Study Year	Sample Size	Result hazard ration (95% confidence interval)
<b>Studies showing no difference in survival between systemic therapy alone versus locoregional therapy</b>		
Indian Tata Memorial Cancer Centre trial 2015	350	Locoregional arm: 19.2 months Systemic therapy arm: 20.5 months HR 1.04 (0.81–1.34, p = 0.79)
ABCSG-28 POSYITIVE trial 2019	90	Locoregional arm: 34.6 months Systemic therapy arm: 54.8 months HR 0.691 (0.358–1.333, p = 0.267)
ECOG-ACRIN 2108 trial 2022	256	Locoregional arm: 54.9 months Systemic therapy arm: 53.1 months HR 1.11 (0.82–1.52, p = 0.57)
<b>Study showing improved survival with locoregional therapy versus systemic therapy alone</b>		
Turkish MF07-01 trial 2018	274	5-year overall survival: Locoregional arm: 41.6% Systemic therapy arm: 24.4%
		Hazard of death 34% lower in locoregional arm: HR 0.66 (0.49–0.88, p = 0.005)

role of locoregional therapy in de novo stage IV breast cancer patients with an intact primary breast tumor.<sup>11</sup> This latest RCT study adds further evidence that locoregional therapy does not appear to provide a benefit in overall survival.

This 2011–2015 prospective randomized phase III clinical trial was published in the *Journal of Clinical Oncology* in 2022. Patients received 4–8 months of systemic therapy, and those who did not have progression of distant disease were randomized into receiving additional locoregional therapy versus continuing with systemic therapy alone.

In all, 256 patients were eligible to be randomized; 131 were randomized into the systemic therapy-alone arm and 125 were randomized to receive locoregional therapy. The

study found a higher proportion of patients with locoregional progression in the systemic therapy-alone group versus the locoregional therapy group, 39.8% versus 16.3%, respectively (HR = 0.34, p <0.001). However, at a median follow-up of 53 months, no significant difference was seen in survival between the groups, with 53.1-month survival in the systemic therapy group versus 54.9 months in the locoregional therapy group (HR = 1.11, p <0.57).

#### Rationale for Locoregional Therapy

Although no survival advantage was seen in the ECOG-ACRIN 2108, Tata Memorial, or ABCSG-28 trials, proponents of locoregional therapy cite reasons such as the ability to

provide symptomatic relief, disease progression prevention, and patient preference as factors that should be considered when deciding whether to offer locoregional therapy in this cohort. To address these questions, Dr. Khan also included a health-related quality-of-life questionnaire that measured depression, anxiety, and well-being. Although patients who did not receive locoregional therapy experienced a higher rate of disease progression, quality of life at 30 months was similar for patients receiving systemic therapy alone and individuals undergoing locoregional therapy. In addition, both groups had similar patient-reported scores with regard to symptoms, worry, and functionality due to disease progression, contradicting

...[B]oth groups had similar patient-reported scores with regard to symptoms, worry, and functionality due to disease progression, contradicting theories that disease progression is a psychological burden for patients who do not receive locoregional therapy.

theories that disease progression is a psychological burden for patients who do not receive locoregional therapy.

The variety in metastatic presentation has led clinicians to postulate that locoregional therapy may benefit patients with limited oligometastatic disease. Although the ECOG-ACRIN 2108 was not designed to answer this specific question, 16% of patients did have oligometastatic disease, and again, no survival difference was seen between the two groups in patients with limited metastatic disease.

The ECOG-ACRIN 2018 trial is the latest RCT to add to previous data that show a lack of benefit to locoregional therapy in patients who have responded to systemic therapy. Neither a survival advantage nor an improvement in quality-of-life measures was seen in this trial. It is imperative that clinicians explain this lack of benefit to patients when discussing optimal management of the breast primary in the setting of stage IV disease. ♦

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## A Look at The Joint Commission:

# Joint Commission, NQF Announce Recipients of 2021 Eisenberg Awards

by Lenworth M. Jacobs Jr., MD, MPH, FACS

The Joint Commission and the National Quality Forum (NQF) announced the recipients of the 2021 John M. Eisenberg Patient Safety & Quality Awards in April. They were:

- National Level Innovation in Patient Safety and Quality: Prime Healthcare Services
- Local Level Innovation in Patient Safety and Quality: Kaiser Permanente Northern California
- Individual Achievement: Hardeep Singh, MD, MPH
- Lifetime Achievement: Mark R. Chassin, MD, FACP, MPP, MPH

The Eisenberg awards were established in 2002 as a tribute to former Agency for Healthcare Research and Quality (AHRQ) Administrator John M. Eisenberg, MD, MBA—an impassioned advocate for healthcare quality improvement and a founding member of NQF's board of directors. The awards recognize individuals, organizations, hospitals, and healthcare systems that have made significant and long-lasting contributions to improving patient safety and healthcare quality.

“The John M. Eisenberg awards were created to honor the enduring legacy of Dr. Eisenberg,” said David W. Baker, MD, MPH, FACP, executive vice-president, division of healthcare quality evaluation, The Joint Commission. “Twenty years later, they continue to showcase how innovation and dedication to process improvement can lead to sustainable solutions to some of healthcare’s greatest challenges. The recipients of this year’s Eisenberg awards uphold Dr. Eisenberg’s life’s work and those who have come before them in furthering the mission of improving patient safety and quality of care.”

### Kaiser Permanente Northern California

Kaiser Permanente Northern California was selected for its initiative that developed a predictive analytic scoring system called Advance Alert Monitor (AAM), which proactively identifies patients with a high risk of mortality or transfer to the intensive care unit (ICU), including integration of life care planning or palliative care. AAM alerts clinicians 12 hours before clinical deterioration, permitting early detection and more nuanced response. AAM analyzes electronic health record (EHR) data for medical and surgical inpatients, and then alerts the virtual quality nurse consultants who connect with rapid response teams at the patient’s bedside to develop a care plan. This system combines predictive analytics and has 99 elements, including laboratory tests, vital signs, neurological status, pulse oximetry, and all outpatient and inpatient diagnoses in the preceding 12 months. The AAM score is generated every hour on medical, surgical, and telemetry adult patients.





Dr. Hardeep Singh



Dr. Mark Chassin

The program standardized the workflows for addressing in-hospital emergencies and the needs of patients near the end of life. Evaluation of the program showed statistically significant decreases in mortality, with 550–3,020 lives saved over 4 years. Data supplied with the application also indicated:

- Lower unadjusted incidence of ICU admission
- Shorter hospital length of stay among survivors
- Lower in-hospital mortality
- Lower mortality within 30 days after an event reaching the alert threshold

### Prime Healthcare Services

Prime Healthcare Services was selected for developing and implementing a cohesive and systemwide approach to addressing social determinants of health (SDOH) that links and addresses SDOH to patient outcomes. By assessing patients' SDOH needs, Prime Healthcare Services helps providers more effectively deliver patient care and reduce healthcare disparities. Its facilities engage senior leadership, strengthen

relationships with community partners, and develop digital workflows that promote real-time patient monitoring and data use. To reduce healthcare disparities, Prime developed a roadmap to:

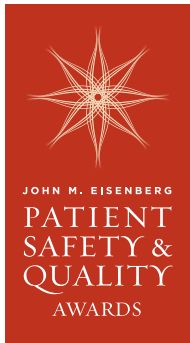
- Identify SDOH needs based on an opportunities index
- Design and implement care interventions
- Establish bidirectional flow of information

After implementing their new screening tool, community partnerships, and bidirectional communications flow, Prime Healthcare Services observed improvements in all-cause hospital-wide readmission rates.

### Dr. Hardeep Singh

Dr. Singh, chief, health policy, quality, and informatics program, Center for Innovations in Quality, Effectiveness and Safety, Michael E. DeBakey Veterans Affairs Medical Center, and professor, Baylor College of Medicine, Houston, was selected for being a pioneer in diagnostic and health information technology (IT) safety. Some of his significant accomplishments include:

- Developing “E-trigger tools,” sophisticated EHR-based algorithms that identify patients with missed opportunities in the diagnostic process
- Working with the Agency for Healthcare Research and Quality to develop tools and resources to measure and improve diagnostic safety, including “Diagnostic Safety Measurement for Learning and Improvement: A Resource to Identify, Analyze, and Learn from Diagnostic Safety Events” and “Common Formats for Event Reporting—Diagnostic Safety,” a standardized reporting format using common definitions to report diagnostic errors
- Codeveloping an eight-dimension sociotechnical model that now is accepted as a paradigm in health IT and patient safety work and the Office of National Coordinator for Health IT (ONC) Safety Assurance Factors for EHR Resilience (SAFER) guides that help hospitals perform a safety assessment of their EHRs to address a range of patient safety issues related to health IT use
- Conducting foundational research on defining and measuring diagnostic error, some of which influenced the



“Overall, the best part of working on the panel is seeing firsthand that the aspirations of John Eisenberg continue to inspire individuals and health systems across the country—and the bar keeps moving higher.”

—Carolyn M. Clancy, MD, MACP

2015 National Academies report, *Improving Diagnosis in Health Care*, which cited 32 papers he authored on diagnostic safety

### Dr. Mark Chassin

Dr. Chassin, president emeritus of The Joint Commission, was selected for a lifetime achievement award after leading The Joint Commission for 14 years, during which he made profound changes, such as shifting accreditation away from simply citing deficiencies and toward helping to drive improvement. A key part of his effort was the creation of The Joint Commission Center for Transforming Healthcare to work with the nation’s leading hospitals and health systems to create effective solutions for healthcare’s most critical safety and quality problems, including healthcare-associated infections (HAIs), hand-off communication failures, wrong site surgery, patient falls, and healthcare-associated pressure injuries.

He also ushered in great change to The Joint Commission’s internal improvement culture by introducing Lean, Six Sigma, and change management concepts and tools that were later incorporated into The Joint Commission’s Robust Process Improvement. Moreover, Dr. Chassin was a member of the

Institute of Medicine committee that authored *To Err Is Human* and *Crossing the Quality Chasm*. He is a recipient of the Founders’ Award of the American College of Medical Quality and the Ellwood Individual Award of the Foundation for Accountability.

### Selection Panel

The 2021 Eisenberg Award Panel consisted of:

- Carolyn M. Clancy, MD, MACP, Department of Veterans Affairs, panel chair
- Brent C. James, MD, MStat, Clinical Excellence Research Center, Stanford University School of Medicine, CA
- Richard Christopher Antonelli, MD, MS, Boston Children’s Hospital, Harvard Medical School, MA
- Meika Neblett, MD, MS, Robert Wood Johnson Barnabas Health, NJ
- Lisa C. Patton, PhD, JBS International, Inc., Bethesda, MD
- David M. Shahian, MD, Harvard Medical School
- Charleen Tachibana, DNP, RN, FAAN, Virginia Mason Franciscan Health, Seattle, WA

• Andrew M. Wiesenthal, MD, SM, Deloitte Consulting, LLP, San Francisco, CA

• Laurie Zephyrin, MD, MBA, MPH, The Commonwealth Fund, New York, NY

“Overall, the best part of working on the panel is seeing firsthand that the aspirations of John Eisenberg continue to inspire individuals and health systems across the country—and the bar keeps moving higher,” Dr. Clancy said. “Every year brings more ambitious and exciting submissions. Learning how systems across the country are pushing the limits of what can be considered excellence in healthcare is especially exciting for me.”

Learn more about this year’s recipients of the Eisenberg Awards by visiting [jointcommission.org/resources/awards/john-m-eisenberg-patient-safety-and-quality-award](https://www.jointcommission.org/resources/awards/john-m-eisenberg-patient-safety-and-quality-award) or scanning the QR code. ♦



### Disclaimer

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



## From Residency to Retirement: “Toto, I’ve a Feeling We’re Not in Kansas Anymore”

by James Jeng, MD, FACS

I am a native Washingtonian. I lived in DC most of my adult life and raised my four kids inside the Beltway.

I can remember a time I would sneak out of work every chance I got in the early afternoon and put Kid #1 in a jogging stroller. We lived in Georgetown, and we’d sit on the Lincoln Memorial steps with a juice box and cheddar crackers, then move on to the Washington Monument to fly a kite by the circle of American flags at the base of the obelisk. Back then, you could get on the elevator on a whim, ride it to the top, and look out the two tiny windows on each side to watch the jets land at National Airport in the distance.

My, how times have changed. You can’t just ride up that obelisk on a whim anymore. Security screenings and tickets are required in 2022. The same is true for wandering around the Rayburn, Longworth, and Cannon House office buildings and the Russell, Dirksen, and Hart Senate buildings to meet with lawmakers.

It’s anybody’s guess when in-person advocacy and lobbying on behalf of the American

College of Surgeons (ACS) will return to Capitol Hill. The years 2020 and 2021 brought changes that rocked our world irrevocably, and as Dorothy so aptly surmised in *The Wizard of Oz*, “Toto, I’ve a feeling we’re not in Kansas anymore.”

But the show must go on, and so the ACS expanded its Advocacy at Home program to ensure ACS members could continue to advocate on Capitol Hill. Those individuals taking the time to read this column likely are among the most farsighted American surgeons. This group knows deep down inside that our ability to practice the best medicine and provide the best surgical care to our cherished patients takes a path right through each of the legislative office buildings enumerated previously.

As a member of the Engagement Workgroup of the ACS Committee on Trauma (COT) Advocacy Pillar, I was tasked with seeking testimony from ACS advocacy veterans and weaving them into a tapestry that aptly fits our uncertain return to Capitol Hill and the pressing need to megaphone our voice in service of all Americans needing surgical care.

### COT Advocates’ Experiences

Kristan Staudenmayer, MD, FACS, a general and critical care surgeon from Stanford University Medical Center, CA, said she had a positive experience during her interactions with her representatives’ and senators’ offices. We talked about how jaded so many Americans have become about politics and how, coming into her advocacy sessions, she was unsure how she would feel afterward.

Happily, her elected officials seemed sincerely eager to hear constituent feedback and become educated on healthcare issues. We both quipped about how we’re all part of a grand and still evolving experiment of government of the people, by the people, and for the people.

Finally, Dr. Staudenmayer underscored how easy it was to connect with her representative and senators through the ACS Advocacy at Home program—truly a turnkey solution.

Brendan Campbell, MD, FACS, a pediatric trauma surgeon at Connecticut Children’s Hospital, Hartford, said, “My work through the COT has helped me better understand

As a member of the Engagement Workgroup of the ACS COT Advocacy Pillar, I was tasked with seeking testimony from ACS advocacy veterans and weaving them into a tapestry that aptly fits our uncertain return to Capitol Hill and the pressing need to megaphone our voice in service of all Americans needing surgical care.

the critical importance of advocacy in so many of the things we do as surgeons. First, interacting with federal lawmakers allows them to learn firsthand about the important clinical work that we do, but it is also an opportunity to educate them about the other important work that surgeons are involved with related to healthcare quality, disaster preparedness, trauma systems, and injury prevention, to name just a few.”

Dr. Campbell continued, “My friend and mentor, Lenworth M. Jacobs Jr., MD, MPH, FACS, has always known the value and benefit of interacting with federal lawmakers to garner support for important trauma-related programs, like developing the first aeromedical transport program in Connecticut, creating a simulation center for trauma and emergency medical services-related education, and expanding the STOP THE BLEED®. Dr. Jacobs is a master at engaging lawmakers with compelling patient stories and turning them into ardent supporters of the important projects he is developing.”

Amalia Cochran, MD, FACS, is deeply experienced in advocacy on behalf of both the ACS and the American

Burn Association, where she chairs the government affairs committee. Given her experience with meeting lawmakers in person, I was anxious to hear her thoughts on the new paradigm of telepresence advocacy.

She said, “The good news about this [model] is that it’s so easy to do Zoom meetings and calls with our legislators and staffers, which opens that option up to more of us. It also helps us to refocus on the importance of doing in-district visits with legislators and staff, particularly having the option of them visiting our facilities and seeing how we support their constituents.”

Ronald M. Stewart, MD, FACS, Immediate Past-Medical Director, ACS Trauma Programs, from The University of Texas (UT) School of Medicine, San Antonio, graciously spoke with me for a full hour to recount in great detail his take-home lessons from more than a quarter-century of direct and intensive advocacy efforts on behalf of American surgery—from the Statehouse in Austin to invited testimony live before the US Congress. This experience perhaps makes him one of the “deans” of ACS advocacy.

His first lesson was from the early days of trying to lobby for Texas State endorsement and funding of a statewide trauma system. The understandably disparate forces at play, in a state so large that it was its own nation before it became one of the lower 48, needed to be tamed and pulled exactly in the same vector on the tug of rope before achieving a legislative victory. Compromise leading to shoulder-to-shoulder consensus is a prerequisite for winning advocacy.

Dr. Stewart’s second lesson was that an emotional connection with lawmakers trumps sterile presentation of facts, numbers, and figures. Back in Austin fighting for more trauma system funding, stories about fabled trauma surgeon and syndicated television personality James Henry “Red” Duke, MD, FACS, from UT Houston, Memorial Hermann, and his uncanny ability to connect with Texas lawmakers carried the day when it was time to further fund the state trauma system. But even the late Dr. Duke was overshadowed by the compelling story of a Texas teenager who was shot and saved by the state trauma system. Not a dry eye remained in the Capitol when she related her story.



**Advocate at Home**  
American College of Surgeons

And the last lesson from Dr. Stewart's long campaign was when he testified before Congress to advocate for research into how firearm injuries occur. This experience was a real test of "harmony and invention," as he was able to gain and maintain the support of organizations defending the right to bear arms, as well as those focused on gun control. He concluded that no matter how polarized American politics may be, common ground can be found when driven by the universal concern to better our way of life.

\* \* \*

A last-minute footnote in the immediate aftermath of the May 24, 2022, massacre of 19 grade school students and their two teachers in Uvalde, TX: So much sacrosanct work remains incumbent upon this fellowship of American surgeons, and advocacy is the singular transcendental tool with which to fulfill our obligations.

Ours is a fellowship that spans the political spectrum on each and every intractable conflict that shakes the very foundations of this democratic experiment in self-governance. It is self-evident, however, that we can and must all come together when the trio

of infamous tragedies—2007 Virginia Tech, 2012 Sandy Hook Elementary School, and now 2022 Robb Elementary School—indelibly stain the most basic fabric of our peoples.

Let us all pick up the mace of advocacy to help strike down this woeful specter.

\* \* \*

### Concluding Thoughts

I would like to sincerely thank my four esteemed colleagues for generously sharing their time and unfiltered experiences tirelessly advocating for the ACS and all that is important for surgical patients.

This deep dive into ACS Advocacy for 2022 and beyond proves that we are truly "not in Kansas anymore." We must pivot to a new reality where we lobby from home, as the timing of return to in-person visits is anybody's guess. Thankfully, the advocacy infrastructure of the College has been prescient in developing the tools for Advocacy at Home. Moreover, key staff members at the College are just a phone call or email away to lend expertise so that we shine in our virtual visits.

Many of us have been effective advocates, as

the previous testimony demonstrates. Many more of us need to jump on the bandwagon in 2022 and beyond. It is so easy to do with the tools and support of the ACS Advocacy at Home webpage.

It's important. What are you waiting for? As Dorothy said at the end of *The Wizard of Oz*: "There's no place like home." ♦

### Disclaimer

The thoughts and opinions expressed in this column are solely those of the author and do not necessarily reflect those of the American College of Surgeons.





## DEI in Action: ACS Profiles in Diversity Podcast: Lessons Learned and Strategies Implemented

by Avilasha Sinha and SreyRam Kuy, MD, MHS

**D**iversity, equity, and inclusion (DEI) are important principles that all institutions should strive to incorporate. Achieving DEI not only benefits physicians themselves, but also the patients to whom they provide care. Incorporating DEI principles at the individual and systems level may even improve clinical outcomes.<sup>1</sup> Although significant progress has been made to increase DEI in surgery, much still can be accomplished.

Only 22% of general surgeons in the US are women, and this percentage drops even lower among surgical subspecialists, such as neurosurgeons (9%), thoracic surgeons (8%), and orthopaedic surgeons (6%).<sup>2</sup> Furthermore, only 10% of surgical trainees and 7% of surgical faculty members belong to racial or ethnic minorities who are traditionally underrepresented in medicine.<sup>3</sup>

Initiatives to promote DEI being implemented by surgeon leaders across the country are highlighted in the American College of Surgeons (ACS) Profiles in Diversity Podcast, which was cofounded by SreyRam Kuy, MD, MHS,

and Shubhada Dhage, MD, FACS, in 2019 through the ACS Committee on Diversity Issues. The ACS Profiles in Diversity videos can be accessed at [facs.org/about-acsgovernance/acs-committees/committee-on-diversity-issues/profiles](https://www.facs.org/about-acsgovernance/acs-committees/committee-on-diversity-issues/profiles).

This series of interviews explores how surgeon leaders, including ACS President Julie Freischlag, ACS Past-President Carlos A. Pellegrini, Paris Butler, Electron Kebebew, Colin Martin, Herb Chen (all MD, FACS), Estelle Williams, MD, and other surgeons work to promote DEI. Although these surgeons represent an array of backgrounds and experiences, the strategies they have implemented and lessons they have learned share many commonalities.

### Diversity Is Multifaceted

Through the interviewees' answers to the question of how to define diversity, it is clear that diversity is multifaceted. First, diversity extends beyond race, ethnicity, and gender, but also encompasses diversity of thought, experiences, and age. Many interviewees explained

how achieving multiple forms of diversity allows for the incorporation of numerous perspectives to improve collaboration and innovation. In their interviews, Drs. Freischlag and Martin summarized the significant benefits of diversity, explaining that “diversity means excellence.”

Multiple surgeon leaders discuss how diversity is not fully achieved through recruitment of people from different backgrounds alone. As Dr. Freischlag noted in her interview, recruiting trainees and faculty from underrepresented in medicine (URiM) backgrounds and then providing them with inadequate support can be even worse than not recruiting them in the first place.

Ensuring that faculty and trainees belonging to URiMs receive support and feel supported is critical for their well-being, protects against burnout, enables them to effectively care for their patients, and increases retention of URiM faculty and trainees. Effective strategies implemented to provide more support to underrepresented faculty and



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trainees include establishing and sustaining DEI journal clubs, social events, and networks to connect people of shared backgrounds and identities.

#### **Intentionality and Top-Down Change**

To bring about significant and enduring change, it is critical that efforts to promote DEI are intentional and fully conceived. Placing an emphasis on top-down changes allows surgeon leaders to harness their leadership skills, experiences, and stature to bring about much-needed change at their institutions.

By creating the expectation that efforts to promote DEI will originate at the top, the onus on trainees to be responsible for bringing about change is eased. As Dr. Butler noted in a podcast episode, it can be difficult for trainees to focus on and devote time to DEI efforts while meeting the demands of their training.

#### **Acknowledging and Addressing Implicit Bias**

Many of the interviewees discussed the importance of acknowledging implicit

biases. Implicit biases can hinder the promotion of DEI because surgeons may be unconsciously influenced to interact with people belonging to certain groups or identities in a manner that is more or less favorable than how they interact with others.

Because implicit biases often are incongruous with one's beliefs and behaviors, implicit bias training can help people to identify areas for improvement.<sup>4</sup> Drs. Butler, Freischlag, and Martin described how implicit bias training is mandatory at their programs. As Dr. Pellegrini said, just being aware of one's implicit biases is insufficient for ensuring that one treats others fairly and equitably. It is crucial that everyone—from medical students, to residents, to fellows, to attending surgeons—acknowledges their implicit biases and take steps to counteract them.

#### **The Importance of Mentorship**

Mentorship is crucial for surgical trainees and new faculty as it can enhance professional development, increase productivity, and increase career satisfaction.<sup>5</sup>

Given the rigorous and arduous nature of surgical training, the ability of trainees and new faculty members to interact with and learn from supportive mentors can provide meaningful encouragement and opportunities for advancement, and help them to feel included in their programs and institutions.

Accordingly, all of the interviewees discussed how mentorship can play a significant role in recruiting underrepresented trainees and helping them to thrive, flourish, and achieve their goals.

Some organizations mentioned in the podcasts that provide mentorship to URiMs include the Alliance of Minority Physicians, the ACS Women in Surgery Committee Mentorship Program, the PRISM (Pre-College Research Internship for Students from Minority Backgrounds) program, and the Society of Asian Academic Surgeons.

According to Drs. Chen and Williams, it is never too early to seek out and provide mentorship. Mentorship initiatives aimed at high school and undergraduate students have been successful in increasing representation of students and trainees belonging to underrepresented groups or identities in surgery. Given the rigorous and arduous nature of surgical training, the ability of trainees and new faculty members to interact with and learn from supportive mentors can provide meaningful encouragement and opportunities for

advancement, and help them to feel included in their programs and institutions.

### Conclusion

The ACS Profiles in Diversity podcast highlights valuable lessons learned and effective strategies for promoting DEI from surgeon leaders across the country. These discussions highlighting different components of diversity and the importance of intentionality, top-down change, implicit bias training, and mentorship can guide others in different programs and institutions to increase DEI and bring about enduring changes that will positively affect surgeons, trainees, and their patients. ♦

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# LEADERSHIP & ADVOCACY SUMMIT 2022

AMERICAN COLLEGE OF SURGEONS

## 2022 ACS Leadership & Advocacy Summit Focuses on Surgeon Well-Being, Legislative Priorities

by Diane S. Schneidman, MA

Approximately 700 individuals—220 in-person and 475 virtual attendees—participated in the American College of Surgeons (ACS) 2022 Leadership & Advocacy Summit, April 2–5, in Washington, DC. It was the first in-person summit that the College has hosted since COVID-19 struck the US in 2020.

Individuals still can register for the Leadership & Advocacy Summit on the ACS website to access the on-demand content available until **July 5, 2022**. Registrants can earn up to 4 *AMA PRA Category 1 Credits*<sup>™</sup> for attending or viewing the Summit.

### Leadership Summit

Speakers at the Leadership Summit offered insights on compelling topics, including second victim syndrome, surgeons as leaders, and diversity, equity, and inclusion (DEI) in surgery.

### Second Victim Syndrome

Haytham Kaafarani, MD, MPH, FACS, associate professor of surgery, Harvard Medical School, and a trauma surgeon at Massachusetts General Hospital (MGH), Boston, described his experience when he felt that he had failed a patient who

died from a postoperative soft tissue infection after many operations to treat injuries the patient suffered following impalement by a forklift.

Dr. Kaafarani was haunted by this experience, second-guessing his clinical judgment. He was neither the first nor the last surgeon to wonder what he could have done differently. He pointed to a study of Boston physicians that showed that more than 81% of surgeons experience anxiety, depression, self-blame, embarrassment, and other negative emotions when a patient dies or experiences another adverse outcome.

“We all hide our grief and suffer in silence,” Dr. Kaafarani said. “If this is not about surgeon well-being, then what is?”

“So, how can we turn this around?” he asked. The one factor he and his colleagues found that can help someone who is dealing with second victim syndrome is peer support, especially from surgeons who have been in similar situations.

He outlined how the department of surgery at MGH selected peer supporters, noting that the peer support program at MGH has gone “extremely well,” with approximately 50 successful interventions occurring annually.

### The Well-Being of Leaders

ACS Governor D. Rohan Jeyarajah, MD, FACS, moderated a well-received panel session on surgeon well-being. Tips and lessons learned came from ACS President Julie A. Freischlag, MD, FACS, DFSV, ACS Regent Douglas E. Wood, MD, FACS, FRCSEd, and Melanie A. Edwards, MD, FACS, a member of the ACS Women in Surgery Committee.

“Well-being is a real concern for surgeons at all stages, especially when you’re a leader,” Dr. Jeyarajah noted.

Dr. Edwards emphasized the importance of carving out time for well-being, even if it’s only 5 minutes a day for exercise.

In addition to exercise, Dr. Freischlag said it’s important to enjoy “mini pleasures,” such as going for a walk, checking out the sights in the vicinity, or leaving early from a meeting to engage in an activity that you enjoy.

Achieving work-life equilibrium plays a factor in surgeon wellness. Dr. Wood said that when his daughters were young, he made a point of “going to every soccer game, every parent-teacher conference, but there were also a lot of times when I was gone, and I felt guilty about that.” Often, it’s a matter of compromise and deciding when you need

“The COT created a culture of safety that puts the injured patient first.”

—John H. Armstrong, MD, FACS, FCCP

to be with your family rather than at a work-related event.

### 100 Years of the COT and CoC

The Committee on Trauma (COT) and Commission on Cancer (CoC) both are celebrating 100 years of improving patient care in 2022.

John H. Armstrong, MD, FACS, FCCP, Chair of the Advocacy Pillar, and a member of the ACS COT Executive Committee, summarized the history of the COT. He noted that the COT grew out of the Committee on Fractures, created largely to ensure that injured patients would receive optimal care. Since then, the COT (formally established in 1949) has developed into a standard-setting and accreditation organization with the publication of *Resources for Optimal Care of the Injured Patient*, now in its seventh edition.

The COT also provides education to emergency medical services personnel and other trauma care professionals through the Advanced Trauma Life Support® program and to bystanders at the scene of incidents involving rapid blood loss through STOP THE BLEED®, Dr. Armstrong noted. COT leaders also have led the charge to improve motor vehicle safety and have created regional trauma systems.

“The COT created a culture of safety that puts the injured

patient first,” Dr. Armstrong said. Spurring these innovations and activities, he said, is the COT constantly questioning, “What can we do better?”

Similarly, Timothy W. Mullett, MD, FACS, Chair of the CoC, provided an overview of the commission’s growth from the ACS Committee on Cancer to a standard-setting and accreditation body with more than 50 cancer-related organizations in partnership with the American Cancer Society. The CoC now accredits 1,500 cancer care facilities and issues 91 standards designed to ensure optimal care of cancer patients.

“The CoC is not sitting on 100 years of laurels,” Dr. Mullett noted. The CoC promulgates operative standards and staging guidelines. Many of these standards and guidelines are based on data monitored through the National Cancer Database and submitted by the CoC-accredited cancer program.

Advancements and enhancements, such as the introduction of synoptic reporting, are ongoing.

The CoC and the ACS National Accreditation Program for Breast Centers also recently launched the Just ASK study to increase and improve the integration of smoking assessment as a standard of care.

### Advocacy and Activism: A Surgeon’s Journey

Marion C. W. Henry, MD, MPH, FACS, FAAP, professor of surgery, pediatric surgery, University of Chicago, IL, said her journey into advocacy began in December 2012, around the time of the massacre at a Connecticut school. “I dropped my son at school that day and went to work. I was lucky. I picked up my son from school, and we went home that afternoon—something the parents of 20 students at Sandy Hook Elementary School could not do that day,” she said.

As she saw the number of mass shootings rise, including one on the East Coast Navy Base where she worked, alongside daily death tolls from firearm violence, she knew it was time to get involved. After leaving the Navy, Dr. Henry began to speak out on healthcare issues as a private citizen. Soon thereafter, then-president of the American Pediatric Surgical Association (APSA) and ACS Second Vice-President-Elect Mary E. Fallat, MD, FACS, asked her to serve as vice-chair of the organization’s health policy and advocacy committee.

“Both APSA and the ACS have outstanding resources to help you get involved,” Dr. Henry said, including the opportunity to participate in the Health Policy and





Dr. Patricia Turner's Executive Director video is available at <https://www.youtube.com/watch?v=p4d0ixRcxlg>.

Leadership Program at Brandeis University in Boston, MA.

She also found mentors at the ACS, APSA, and American Academy of Pediatrics who helped her get involved at the state and federal levels.

Dr. Henry said it is important that surgeons learn early in their careers about the importance of advocacy. She proposed a new “quadripartite mission of academia,” which includes not only the traditional elements of education, clinical care, and research, but also social accountability.

### Surgeons May Be Better Leaders than They Think

“Most surgeons assume that they become a leader when they get a title, and that means when you become a director, a chief, a chair, and so forth. But the truth is every healthcare organization depends on the leadership of every healthcare professional every day,” said Jon A. Chillingierian, PhD, a professor at Brandeis University and adjunct professor of public health and community medicine at Tufts University School of Medicine, Boston.

“Leaders can never see themselves clearly until they see themselves through the eyes of others,” Dr. Chillingierian said. With that thought in

mind, he asked surgeon leaders to self-evaluate and seek out anonymous assessments from their peers. He found that surgeons generally rated themselves in the 50th percentile on a scale of leadership qualities, whereas their colleagues generally ranked them in the 70th percentile. “So, surgeons are actually better leaders than they think they are,” he noted.

### Chapter Success Stories

Leaders from three ACS chapters shared their success stories:

- Jose J. Diaz, MD, FACS, Governor and President of the ACS Maryland Chapter, described how his chapter tackled the challenges posed by COVID-19 pandemic and the rising interest in DEI.
- Lindsay Strader, DO, FACS, FASCRS, Co-Chair of the ACS Kansas Chapter Program Committee, explained how the chapter successfully and safely used a hybrid approach to its annual meeting.
- Guiseppe Nigri, MD, PhD, FACS, Secretary of the ACS Italy Chapter, spoke about the chapter's contributions to the ACS *Gastrointestinal Surgical Emergencies* textbook and global surgery.

### Leadership Imperative for DEI in Surgery

Bonnie Simpson Mason, MD, FAAOS, Medical Director, ACS Office of DEI, noted that DEI is not always a welcome topic of conversation, but communication is key to reducing the disparities in healthcare and the surgical workforce.

She emphasized cultural humility—acknowledging that surgeons of different backgrounds, races, ethnicities, and genders do not have shared experiences.

“We need everyone to approach this work with a lens of curiosity—like the one we had our first year of medical school,” Dr. Mason said. “The work starts with us, especially those of us who are leaders.”

Efforts to improve DEI are not competitive in nature. “We need to create a safe, trauma-free space where there is no judgment. We can have these conversations without confrontation. We don't have to agree,” but we do need to be respectful, she said.

### Executive Director Update

ACS Executive Director Patricia L. Turner, MD, MBA, FACS, outlined her vision for the College moving forward.

“Our motto is “To Heal All with Skill and Trust,”” Dr. Turner said. Implicit in this



Bob Woodward



Vinita Mujumdar

statement is inclusivity and advocacy. “We cannot heal all if we don’t have all surgeons at the table in the College. That means all specialties, that means all practice patterns, that means all ages,” she noted.

The ACS motto also implies that its members are skillful. Hence, the College needs to be mindful of providing training and educational opportunities to help surgeons attain, maintain, and enhance the skills they need to provide optimal care, she noted.

“This notion of trust is incredibly important,” Dr. Turner said. “The public, our patients, place their trust in us in a way that is different from any other physician.”

“Part of our strategy moving forward will be to enhance communication and be sure we are sharing all that we do and ensuring that we can support our surgeons and support the patients of those surgeons,” Dr. Turner said.

The College needs to communicate with legislators, policymakers, the media, and the public “writ large” that this organization is a trustworthy source of information “on all things surgical,” she added.

Dr. Turner’s Executive Director’s Report video is available online; see page 52 for the link and QR code.

### Advocacy Summit

The Advocacy Summit kicked off with a Keynote Dinner, during which *Washington Post* associate editor Bob Woodward shared his views on the political climate. Another political journalist, Jake Sherman, founder of Punchbowl News, spoke at a luncheon sponsored by the ACS Professional Association Political Action Committee—ACSPA-SurgeonsPAC.

### Medicare Payment: MACRA and the MPFS

As Matt Coffron, MA, Chief, Health Policy Development, Division of Advocacy and Health Policy (DAHP), noted, “All laws are flawed,” and the Medicare Access and CHIP Reauthorization Act (MACRA) is no different.

The law was passed with the intention of replacing the sustainable growth rate Medicare physician payment mechanism with the Quality Payment Program (QPP)—a value-based system. The plan was that initially most physicians would be paid using the Merit-based Incentive Payment System (MIPS), but ultimately would move into Alternative Payment Models (APMs).

The law provided opportunities for specialty organizations to develop APMs

and to accurately value the work that specialists do. Since implementation began in 2016, the Physician-Focused Payment Technical Advisory Committee (PTAC), which advises the Administration on implementation of APMs, has received 39 specialty proposals for APMs, including recommendations from the College, Mr. Coffron said.

However, the Centers for Medicare & Medicaid Services (CMS) has yet to test these proposed APMs.

CMS and the ACS “have completely different perspectives on quality,” Mr. Coffron said.

Jill Sage, MPH, Chief, Quality Affairs, ACS DAHP, said, “The ACS understands quality. The ACS was built on quality.”

The ACS maintains that “quality is a program—not a measure,” she added. Although CMS agrees with the College’s perspective, “they don’t really know how to disrupt the payment system that they have created over the decades,” Ms. Sage added.

Furthermore, “Defining value remains incomplete,” she noted. The ACS has asserted that value is more than weighing quality against costs and that it must account for what matters most to the individual patient, Ms. Sage said.



Dr. Sandra Ford



Dr. Charles Mabry

Vinita Mujumdar, JD, Chief, Regulatory Affairs, DAHP, spoke about short-term fixes to the Medicare physician fee schedule (MPFS). Without these changes, surgeons will once again face the threat of significant payment reductions starting in January 2023.

More specifically, Mujumdar said, the College is asking Congress to hold hearings on the projected payment cuts in 2023. The goal is to “immediately reverse all reductions in the Medicare physician fee schedule caused by PAYGO [a budget rule requiring offsets for tax cuts and mandatory spending increases], sequestration, and budget neutrality adjustments to the conversion factor,” she said.

The College also is asking that the updates to evaluation and management (E/M) codes for in-office visits be applied to the E/M portion of global surgery codes, Mujumdar said.

In addition, the ACS is asking that physician payment updates “reflect medical inflation and increased practice costs,” among other requests, she said.

### **Paving the Way for NTEPS**

During his presentation on the COT at the Leadership Summit, Dr. Armstrong said, “It is time to establish a national trauma system.”

Building on this proposition, Robert Kadlec, MD, Senior Counsel for the Senate Committee on Health, Education, Labor and Pensions, said, “Clearly, the ACS has been a leading voice in this kind of movement.”

Noting that the COVID-19 pandemic, the war in Ukraine, and North Korea’s missile development efforts have rendered the US’s previous emergency response system archaic, Dr. Kadlec called for change. “We need an operational component that can stitch together” federal and private sector capabilities to respond to healthcare crises—regionally and nationally, he said.

Eileen M. Bulger, MD, FACS, Medical Director, ACS Trauma Programs, described the COT’s efforts to establish such a system, known as the national trauma and emergency preparedness system (NTEPS).

“COVID really highlighted the problems we have in dealing with national trauma capacity,” Dr. Bulger said.

“We think there is broad variability in quality, continuity, and access to care,” she said. “Can we come together now and harness the lessons we learned from COVID to develop a system that meets these needs?”

A multidisciplinary group has united to develop five constructs

that are essential to NTEPS, Dr. Bulger noted, including:

- Better coordination of trauma care across facilities
- A real-time system to monitor care in a healthcare emergency
- Issuance of best practices for patient care
- Consultation with experts on the public health crisis at hand
- Standards of care that healthcare systems need to meet to receive federal funding

“Our systems often don’t know what they don’t have until they need it,” Dr. Bulger said. “Perhaps this is the time to move the needle forward on our trauma healthcare systems.”

### **Analyzing Data to Advance Advocacy**

Charles D. Mabry, MD, FACS, a former ACS Regent and Chair of the ACS Health Policy Advisory Council, explained that hospitals are paid under Medicare Part A, whereas physicians are paid under Part B. Medicare Part A is funded through income taxes, and payment is based on diagnostic-related groups, whereas Medicare Part B has a budget, and payment is

“While we can all wring our hands about the increased expenses of Medicare, unfortunately physicians are not the ones driving the boat.”

—Charles D. Mabry, MD, FACS

based on the resource-based relative value scale (RBRVS).

“While we can all wring our hands about the increased expenses of Medicare, unfortunately physicians are not the ones driving the boat,” Dr. Mabry said. Reimbursement to physicians has dropped by approximately 4% of total Medicare spending, and surgeons are bearing the brunt.

Part A gets a mandatory update every year. On the other hand, physician payment updates are tied to overall expenditure, so surgeons are not getting annual payment increases.

Margaret C. Tracci, MD, JD, FACS, explained that payment increases have not kept pace with inflation. “We all feel that we are doing work that we’re not compensated for,” she said. Moreover, inflation has outpaced surgeon payment by up to 30% over previous decades.

Surgeons bring “tremendous value to the healthcare system, largely unseen,” Dr. Tracci said.

### No Surprises Act

Patrick V. Bailey, MD, MLS, FACS, Medical Director, ACS Advocacy, provided an overview of the No Surprises Act, which took effect at the beginning of this year. The legislation is designed to protect patients from unexpected and often costly medical bills. The legislation also calls for establishing an independent dispute resolution (IDR) process

to resolve disputes between payers and providers, he said.

These provisions are intended to take patients out of the middle of these disagreements, Dr. Bailey said.

Robert Jasak, JD, vice-president, coverage and payment policy, Hart Health Strategies, Washington, DC, explained that the legislation includes other provisions intended to better inform patients about what charges to expect and their rights under the law. For instance, providers must post disclosures in their offices and on their websites, provide patients with a notice of their rights under the law, and must offer good faith estimates of how much patients will be billed.

If a patient requires emergency care or seeks nonemergency care from out-of-network physicians at in-network facilities, “providers cannot balance bill the patient for those services,” Jasak said.

For uninsured and self-pay patients, surgeons must reach out to all providers and facilities that will be involved in delivering care and provide a comprehensive good faith estimate of total charges, he said.

Katy Johnson, JD, senior counsel, health policy, American Benefits Council, said health plans must make an “initial payment amount” to providers within 30 days of service. If the plan disputes the claim, it goes to IDR. Arbitrators are to look at the qualifying payment

amount (QPA), training and experience of the provider, and whether the procedure is done at a teaching hospital, Johnson said.

The federal agencies involved in issuing guidance on implementation of the law have said IDR arbitrators should select reimbursement amounts that are closest to the QPA. The agencies also issued the final rules without issuing proposed regulations. Further complicating matters, Johnson said, is the fact that the federal regulations apply only in states without surprise billing legislation already in place.

### Advancing Equity

The number of non-White physicians working in the US is strikingly small, according to Sandra E. Ford, MD, MBA, a pediatrician and Special Assistant to the President for Public Health. Yet, “studies have shown that having a clinician who looks like you or shares your culture and speaks your language increases your trust.”

The White House is very much engaged in ensuring we have equity across the board,” she said.

Equal access to healthcare also is a priority for the College. Dr. Turner noted that Dr. Martin Luther King Jr. once said, “Of all the forms of inequality, injustice in healthcare is the most shocking and inhumane.”

Thus, she said, “It is fairly obvious that we should achieve equity, but how do we do that?”





Dr. Timothy Mullett

Dr. Bonnie Simpson Mason and Christian Shalgian,  
Director, ACS Division of Advocacy & Health Policy

Dr. Turner noted that the College secured a grant from the National Institutes of Health to determine how the nation can address disparities in healthcare.

In addition, 2020–2021 ACS President J. Wayne Meredith, MD, FACS, formed a Regental Anti-Racism Task Force. This body offered recommendations on how the College can improve DEI in the surgical workforce and within the ACS, Dr. Turner noted. Subsequently, the Regents Committee on Anti-Racism was appointed to ensure the recommendations were implemented and woven into the fabric of the College's work.

For insights on how the College and other surgical societies could implement these recommendations, the ACS hosted a DEI and Anti-Racism Summit, established a new Pillar within the Board of Governors and other ACS committees to explore opportunities, and created the Office of DEI led by Dr. Mason and Cie Armstead, MPA, DBA.

### Congressional "Asks"

Advocacy Summit participants engaged in more than 150 virtual visits with lawmakers and their senior staff April 5. ACS DAHP staff briefed attendees on key congressional "asks" to discuss in these briefings:

- Immediately stabilize the Medicare payment system and hold hearings on long-term solutions to address ongoing issues with MACRA implementation and the Medicare physician fee schedule.
- Urge CMS to use the flexibility provided in MACRA to test the specialty-developed APMs that the PTAC has approved. Additionally, CMS should use the authority that MACRA provided to adopt quality metrics that provide more meaningful data to inform care decisions and improvement efforts.
- Cosponsor the Improving Seniors' Timely Access to Care Act, which would facilitate electronic prior authorization, improve transparency, and increase CMS oversight of how Medicare Advantage plans apply prior authorization requirements.
- Cosponsor the Ensuring Access to General Surgery Act, which would direct the Secretary of the Department of Health and Human Services (HHS) to study and define a general surgery workforce shortage area and collect data on the adequacy of access to surgical services, as well as grant the Secretary authority to designate general surgery shortage areas. Determining

where patients lack access to surgical services and designating a formal surgical shortage area will provide HHS with a valuable new tool for increasing access to the full spectrum of high-quality healthcare services.

- Ensure funding for ACS's appropriations priorities in fiscal year 2023 by supporting increased dollars for cancer research and public health research on firearm morbidity and mortality. Additionally, the ACS seeks full funding for the grant program established by the MISSION ZERO Act and urges Congress to remove legislative language that prohibits the federal government from spending money to study or adopt solutions aimed at improving patient identification across the continuum of care.
- Celebrate the centennials of the CoC and COT by cosponsoring S.R. 566/H.R. 997 and S.R. 532/H.R. 951, respectively.

The next Leadership & Advocacy Summit will take place April 15–18, 2023, in Washington, DC. ♦



# Report on ACSPA/ACS Activities, February 2022

by Danielle Saunders Walsh, MD, FACS, FAAP

The Board of Directors of the American College of Surgeons Professional Association (ACSPA) and the Board of Regents (B/R) of the American College of Surgeons (ACS) met virtually February 4–5. Following is a summary of key activities discussed. The information provided was current as of the date of the meeting.

## ACSPA

As of January 10, during the 2022 election cycle (January 1, 2021–December 31, 2022), the ACSPA Political Action Committee (ACSPA-SurgeonsPAC) had raised more than \$310,000 from more than 580 College members and staff and disbursed \$255,000 to more than 90 congressional candidates, political campaigns, and other PACs. SurgeonsPAC continues to prioritize a balanced, nonpartisan disbursement strategy, including support for Democrats and Republicans, particularly health professionals; key congressional leaders; and members of US House and Senate committees with jurisdiction over healthcare legislation.

## ACS

The Board of Regents reviewed reports from division directors, approved a policy statement on Physician Health Programs and

Surgeon Well-Being in support of the Federation of State Medical Boards Policy on Physician Illness and Impairment: Toward a Model that Optimizes Patient Safety and Physician Health, and accepted resignations from six Fellows and changed the status from Active or Senior to Retired for 137 Fellows.

## Office of Diversity, Equity, and Inclusion

The Board of Regents Anti-Racism Committee, ACS Office of Diversity, Equity, and Inclusion (DEI), and Board of Governors Diversity Pillar met in January to evaluate the progress made on the recommendations in the November 2020 Task Force on Racial Issues Report and the June 2021 DEI and Anti-Racism Retreat. The Task Force recommendations identified 12 critical enabling habits and reviewed the current status:

- Achieved: Creating a staff Office of DEI, establishing a Regental Anti-Racism Committee, and creating resources on the history of Black surgeons
- In process: Understanding underrepresented minorities baseline demographics, developing best practices and training programs, leveraging research and funding to improve URiM

(underrepresented in medicine) access to care, and creating a business plan for action

- Near future: Defining new demographics goals and timelines on progress, promoting and disseminating a DEI plan, and catalyzing advocacy and legislative reform
- Longer term: Reassessing and amending bylaws and processes, forming private/public partnerships

## Division of Education

The Division of Education reported on key activities.

### Committee on Ethics

The Committee on Ethics is sponsoring several sessions at Clinical Congress 2022, including the John J. Conley Ethics and Philosophy Lecture with Martin Makary, MD, MPH, author of *Unaccountable—What Hospitals Won't Tell You and How Transparency Can Revolutionize Health Care*. The Ethics Colloquium will be Can I Fire My Patient?...The Duty to Care and Limits of Accommodation.

The committee is sponsoring three panel sessions: Coping with Conflicted Commitment to Surgeon Health, Ethical Implications of Structured

Racism, and Ethical and Moral Dilemmas in the Disclosure of Surgical Error. Meet-the-Expert sessions also are in development on Updates in Informed Consent, and the Value of Training in Surgical Ethics.

The committee also is sponsoring a Fellowship in Surgical Ethics through the MacLean Center for Clinical Medical Ethics at The University of Chicago, IL, for the 2022–2023 academic year.

#### SESAP

The Surgical Education and Self-Assessment Program® (SESAP®) remains the premier self-assessment and guided cognitive skills education program for practicing surgeons. SESAP 18 is scheduled for release October 2022 and SESAP 18 Advanced is set to release in 2023.

#### Division of Research and Optimal Patient Care

The Division of Research and Optimal Patient Care (DROPC) encompasses the areas of Continuous Quality Improvement (CQI), including ACS research and the accreditation programs. In addition to a status report on current activities, a strategic analysis of the quality programs (registries, programs, policy,

and research and development) was conducted in January 2022. The ACS has 19 hospital-based quality programs, along with the Surgeon Specific Registry (SSR). More than 4,000 participants in 2,500 hospitals participate in ACS Quality Programs, 100 countries participate in the Quality and Safety Conference, and 83 countries conduct Advanced Trauma Life Support® (ATLS®) courses.

#### Quality and Safety Conference

The 2022 ACS Quality and Safety Conference (QSC) will take place July 15–18 in Chicago, with limited in-person capacity because of ongoing COVID-19 safety concerns. Select sessions will be recorded during the in-person meeting and available on-demand a few weeks after the meeting. The program will encompass content from several ACS Quality Programs and feature an increased emphasis on enhancing the attendee experience with innovative engagement and networking experiences.

#### ACS Quality Improvement

##### Course: The Basics

The ACS Quality Improvement Course: The Basics launched in November 2021 and is intended for surgeons and other QI staff

interested in improving quality at their hospitals. The self-paced online course consists of six modules and an exam. Each module includes text, videos, interactive e-learning components, knowledge-check questions, and workbook activities. After completing the course, participants will understand the basic principles of surgical quality and safety. Attendees also will be able to apply a collection of tools and strategies to ensure success.

#### *Optimal Resources for Surgical Quality and Safety*

In 2017, the College released *Optimal Resources for Surgical Quality and Safety*, also known as the Red Book. More than 10,000 manuals have been distributed since its release. Additional marketing efforts are under way to broaden its reach and to better inform the national audience of its instructional and educational content.

The manual served as source material to develop new standards and the ACS Quality Verification Program (ACS QVP). The ACS QVP formally launched in July 2021, and multiple participation options are available to interested hospitals, with additional participation options for hospital systems and ACS

National Surgical Quality Improvement Program (ACS NSQIP®) participants available in the future. The ACS QVP provides a proven, standardized method for establishing, measuring, and improving a hospital's quality infrastructure across all surgical departments.

#### ACS NSQIP

A total of 850 hospitals participate in ACS NSQIP—699 in the adult option. The pediatric option represents 18% of overall participation. At present, 152 hospitals outside of the US participate in ACS NSQIP—approximately 18% of all participating facilities.

#### MBSAQIP

The Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) is collaborating with the Centers for Medicare & Medicaid Services (CMS), having been selected by the Centers for Medicare and Medicaid Innovation (CMMI)'s Bundled Payment Care Initiative (BPCI) as the sole ACS registry to participate in this program. Along with four other medical and surgical associations, ACS MBSAQIP is the only registry among the five associations to introduce a novel verification measure in addition

to clinical measures that are collected in the data registry.

#### Children's Surgery Verification Program

The Children's Surgery Verification (CSV) Quality Improvement Program launched in 2017 with the goal of ensuring that pediatric surgery patients have access to quality care.

A total of 151 centers participate in CSV. Approximately 35 of these centers are in various stages of verification; 41 of the active sites are fully verified as Level I children's surgery centers. All 151 centers participate in ACS NSQIP Pediatric.

#### Geriatric Surgery Verification Program

The Geriatric Surgery Verification (GSV) Quality Improvement Program launched in 2019 to ensure that older surgical patients have access to high-quality care. At present, 52 hospitals have applied for one of the three levels of participation: Level 1 Verification—Comprehensive Excellence; Level 2 Verification—Focused Excellence; and Commitment Level. Hospitals seeking Level 1 or Level 2 Verification must demonstrate all 30 GSV Program standards are in place through a comprehensive site visit. These visits confirm

that hospitals comply with the required structure, processes, and standards of care as outlined by the program. In all, 31 hospitals are enrolled at the verification level and are expected to demonstrate standards compliance within the first year of enrollment.

#### ISCR Program

The Agency for Healthcare Research and Quality (AHRQ) Improving Surgical Care and Recovery (ISCR) Program, a collaborative effort between the ACS and the Johns Hopkins Armstrong Institute for Patient Safety and Quality in Baltimore, MD, continues to attract hospitals interested in implementing enhanced recovery practices. Hospitals participating in ISCR receive a ready-to-use pathway, access to education materials on implementing the pathway, access to experts in performance improvement and education to help with troubleshooting, and inclusion in a community of professionals rolling out the same pathway. Approximately 60% of enrolled hospitals participate in ACS NSQIP. More than 350 hospitals have participated in the program. Enrollment in ISCR is now closed to new sites, but the program will continue until December 2022.

### Strong for Surgery

Strong for Surgery (S4S), a joint program of the ACS and the University of Washington, Seattle, is a quality initiative aimed at identifying and evaluating evidence-based practices to optimize the health of patients before surgery. The program empowers hospitals and clinics to integrate checklists into the preoperative phase of clinical practice for elective procedures. Since its release in 2017, S4S has more than 700 participating sites. The goal is to move the patient-facing version to an online platform for patients to complete before meeting with their surgeon.

### SSR

The SSR allows surgeons to track their cases, measure outcomes, and comply with changing regulatory requirements. The SSR can be used to meet the requirements of CMS's Quality Payment Program Merit-based Incentive Payment System, as well as the American Board of Surgery's Continuous Certification Program requirements. The SSR has an active user base of approximately 7,000 surgeons, and more than 12.6 million case records have been entered in the SSR system since its release in 2017. The SSR now offers the SSR Practice

Improvement Initiative (SSR PII) 2022—Quality Case Data Review and Reflection 2022 to allow surgeons to perform quality data assessment and CME.

### ACS COVID-19 Registry

The ACS COVID-19 Registry launched in April 2020 in response to requests from ACS NSQIP participating sites to track COVID-19 patients. Participation in the registry is free to any hospital.

Hospitals participating in the ACS COVID-19 Registry enter data variables covering demographics, severity predictors, admission information, hospitalization information, therapies used, and discharge information. Participating hospitals capture data on all patients ages 18 and older and are tracked from hospital admission through discharge. Approximately 70 hospitals participate and have submitted more than 19,000 cases. Participating sites can download their data at any time to look for trends or areas for quality improvement.

### Cancer Programs

The overarching mission of the College's seven Cancer Programs is to improve care for cancer patients. Cancer Programs work together to achieve this mission by setting standards, monitoring

compliance, accrediting sites, collecting and reporting vital statistics, and using vital statistics to drive quality improvement, research, optimization of staging, operative standards, and best practices. Integration plays an important role in ensuring that all Cancer Programs, the College, and member organization assets are engaged and deployed to improve the care of cancer patients and multiply the relative contribution of the ACS Cancer Programs to the larger cancer community.

In 2021, the Cancer Programs met the following strategic goals:

- Developed and introduced point-of-care synoptic operative reports
- Deployed the Rapid Cancer Reporting System to facilitate real-time cancer
- Improved abstraction/reporting
- Revised criteria for quality measure development and created a 30-measure portfolio
- Created and completed a national return to screening QI project
- Created and distributed cancer quality improvement educational material
- Reduced registry abstraction burden by reducing follow-up



from lifetime to 15 years based on analytic value assessments

- Restructured American Joint Committee on Cancer (AJCC) cancer staging editorial processes to adapt away from print books to online protocols
- Introduced data-driven AJCC cancer staging categories by incorporating National Cancer Database (NCDB) statistics and analytics
- Created diverse content to support the 100-year anniversary of the Commission on Cancer (CoC)
- Adapted to fluctuating work conditions resulting from the pandemic

2022 Key Performance Indicators for the Cancer Programs include accrediting 2,200 programs, reporting on 1.5 million new cancer cases, and developing 6–10 new cancer staging and synoptic operative report protocols.

The CoC is commemorating its 100-year anniversary this year, and several events are planned to celebrate its history and accomplishments.

#### Trauma Programs

The Committee on Trauma (COT) launched its centennial

celebration in 2022 with a series of activities highlighting its accomplishments, along with a new vision for the future. The Spring Meeting included a day of celebration, and additional programming will occur at ACS meetings throughout the year. To commemorate its history and accomplishments, representatives for the COT have authored a book, *Looking to the Future through the Lens of Legacy*, and are publishing a series of articles in the *Bulletin*.

In March 2022, the COT transitioned its leadership, with Jeffrey D. Kerby, MD, PhD, FACS, assuming the role of COT Chair for a 4-year term. Warren C. Dorlac, MD, FACS, COL USAF (Ret.), is now COT Vice-Chair and Chair of the Regional Committees on Trauma. Eileen M. Bulger, MD, FACS, transitioned from the COT Chair into the role of ACS Trauma Medical Director. Dr. Bulger replaces Ronald M. Stewart, MD, FACS, in this position.

The ATLS program continues to recover from the impact of the pandemic and is launching the 11th edition revision process this year and developing a new mobile application strategy for ATLS supporting all the trauma education programs. New

editions of Advanced Trauma Operative Management and Advanced Surgical Skills for Exposure in Trauma have been completed and the College's disaster management courses are in revision.

Launched at Clinical Congress 2019, the Future Trauma Leaders fundraising campaign (FTL100) was established to generate financial support for an initiative to coincide with the 100th anniversary of the COT in 2022. The FTL aims to recruit, mentor, provide program support, and reimburse travel expenses for eight future trauma leaders annually. The official fundraising campaign ended with the COT's 2022 Spring Meeting, surpassing the initial fundraising target of \$1 million.

The 2021 TQIP Annual Conference took place virtually November 15–17, with more than 3,600 registrants. The meeting platform offered attendees an integrated experience where they could view content, network with others, visit exhibitors, claim educational credit, and more, all in one place. The *Spine Injury Guidelines* were presented at the conference and were officially released earlier this year. The 2022 TQIP Annual Conference





will take place December 11–13 in Phoenix, AZ.

The STOP THE BLEED® (STB) program continues to focus on empowering, educating, and informing individuals in bleeding control techniques. The STB program provides training, both virtually and in-person, on the importance of learning the lifesaving skills to deploy in a bleeding emergency.

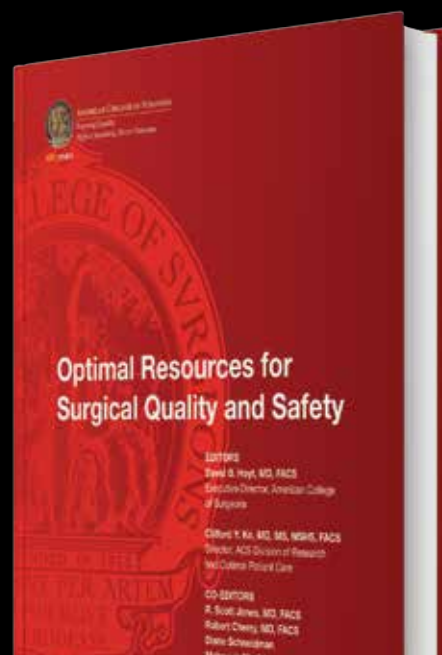
The STB program continues to promulgate the initiative globally, creating awareness throughout communities worldwide. As of January 2022, the STB program has a new vendor, North American Rescue, to help reduce the cost of the equipment and support ACS branding. In addition, STB will offer an ACS-branded Combat Application Tourniquet in all the kits and

provide a link to the new STB Interactive Course. The Working for Equity STOP THE BLEED® has been developed to create a basis for community support that can be adapted to multiple areas of need and connect individuals through STB training. As of December 31, 2021, the STB program has trained 1.8 million individuals with 99,048 global instructors. ♦

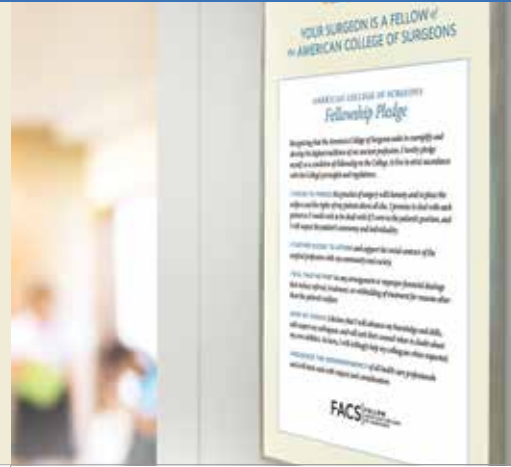
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# Associate Fellows: Apply Now for ACS Fellowship



Associate Fellows of the American College of Surgeons (ACS) interested in pursuing the next level of membership and who meet the criteria for Fellowship are encouraged to start the application process now.

Applications for induction into Fellowship at the ACS Clinical Congress 2023 in Boston, MA, are due **December 1, 2022**.

More than 100 years ago, the ACS was founded on the principle “To Heal All with Skill and Trust,” and this motto continues to guide the House of Surgery. Central to this motto is the College’s commitment to supporting practicing surgeons, surgical residents, medical students, and other members of the surgical care team across practice settings, specialties, and employment. Regardless of age, racial and gender identification, and geography, an inclusive ACS membership best serves our patients and promotes trust among the public. The ACS welcomes surgeons to our Fellowship who maintain the highest standards of care for their patients and value service to patients.

Surgeons voluntarily submit applications for Fellowship, thereby inviting an evaluation of their practice. In evaluating

the eligibility of Fellowship applicants, the College investigates each applicant’s entire surgical practice. Applicants for Fellowship are required to provide all necessary information for the evaluation of their surgical practice.

## Criteria for Fellowship

Associate Fellows are encouraged to apply for Fellowship within the first 6 years of their surgical practice. To encourage that transition, Associate Fellowship is limited to surgeons who have been Associates for 6 years or less.

The basic requirements for Fellowship include:

- Certification by an appropriate American Board of Medical Specialties surgical specialty board, an American Osteopathic Association surgical specialty board, or the Royal College of Surgeons in Canada; or certification by the surgical board in your country for international applicants.
- *For the US and Canadian applicants:* You will need 1 year of surgical practice at one location after completing all formal training (including fellowships).

- *For international applicants:* You will need 3 years of practice after completing all formal training.
- A current appointment as surgical staff at a primary hospital with no reportable actions pending.

A complete list of the requirements for US and Canada applicants can be accessed at: [facs.org/member-services/join/fellows](https://facs.org/member-services/join/fellows). The list of requirements for the International Fellowship is online at [facs.org/member-services/join/international](https://facs.org/member-services/join/international).

## Application Process

You will need your login information to access the application. The Fellowship application requests basic information regarding licensure, certification, education, and hospital affiliations. Applicants also are asked to provide the names of three Fellows of the College, preferably from their current practice location, to serve as references.

All Fellowship applicants must participate in a personal interview by an ACS committee in their local area. Exceptions are made for military applicants.

For more information about the application process, contact [facsapplications@facs.org](mailto:facsapplications@facs.org). ♦



SAVE A LIFE

## More than 2 Million People Prepared to STOP THE BLEED®

Whether at home or out in public, knowing how to control bleeding can make a life-or-death difference when the need arises. As the American College of Surgeons (ACS) and the trauma community celebrated May's national STOP THE BLEED® Month and the May 19 STOP THE BLEED® Day, the program reached a significant milestone—more than 2 million individuals have learned the essentials of bleeding control through in-person courses, online sessions, and the STOP THE BLEED® interactive course.

The ACS worked to increase these numbers significantly during STOP THE BLEED® Month, with increased outreach and more training sessions across the country.

“Every day, we are showing how STOP THE BLEED® can save lives across the globe. From Chicago to Ukraine, anyone who is equipped with this knowledge can jump into action when needed,” said ACS Executive Director Patricia L. Turner, MD, MBA, FACS.

A new online interactive course, available at [stopthebleed.org/training/online-course/](http://stopthebleed.org/training/online-course/), gives participants the knowledge they need to complete the lecture portion of the course.

Participants still are required to complete the skills portion of the training prior to receiving their certificate of completion.

In addition to new training opportunities, more people from a variety of backgrounds and training are able to become STOP THE BLEED® course instructors. Now, many categories of nonmedical professionals are eligible to become STOP THE BLEED® instructors and share this vital information with their communities.

### Efforts for Ukraine

STOP THE BLEED® has taken on particular importance recently since the start of the war in Ukraine. The ACS is supporting education efforts to ensure citizens of Ukraine know the basics of bleeding control so that they can implement these lifesaving techniques when needed.

Roxolana Horbowyj, MD, FACS, is conducting frequent online courses in Ukrainian via Zoom to educate people on the ground. Additionally, actors who play physicians on *New Amsterdam* and *Good Sam* promoted STOP THE BLEED® in a public service announcement (PSA), featuring Ukrainian subtitles, to bring

this important information to the people of Ukraine. View the PSA at [bit.ly/3Nk60jd](http://bit.ly/3Nk60jd).

### At the City Level

In early March, the City of Chicago announced, as part of the Safe Chicago initiative, the installation of more than 550 STOP THE BLEED® kits around the city, along with new training opportunities for municipal employees and the public. Initiatives such as this will help provide city-wide access to these skills and materials so that lives can be saved in a bleeding emergency.

“Our partnership with the City of Chicago is a model for other communities,” Dr. Turner said. “We want to expand these efforts in cities and towns across the country so that these life-saving kits are easily accessible in more public places.”

Learn more on the STOP THE BLEED® website at [stopthebleed.org](http://stopthebleed.org). ♦

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