

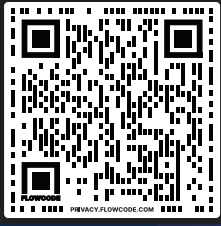
Bulletin

ACS / AMERICAN COLLEGE
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“We Suffer in Silence”

**Surgeons as
Second Victims**





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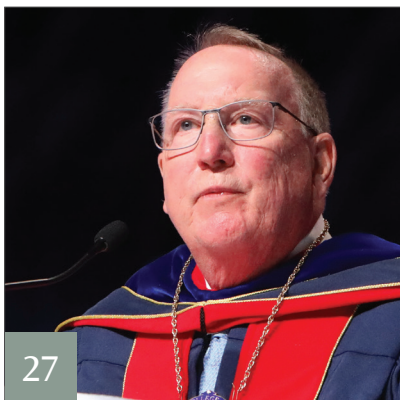
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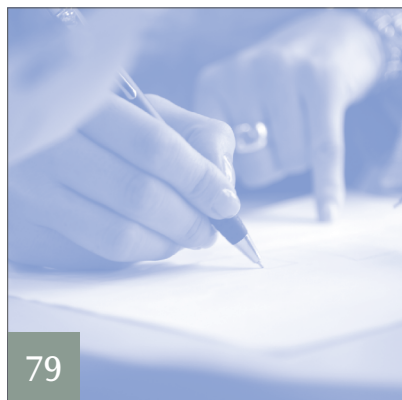
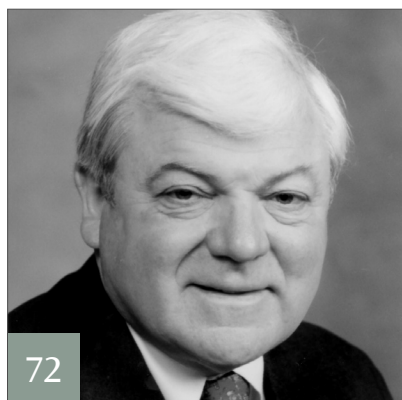
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Charting Our Course for the Year Ahead

by Patricia L. Turner, MD, MBA, FACS

It is hard to believe that 2022 is almost in the rear-view mirror. As I near the end of my first year as Executive Director and CEO, I want to take a moment to celebrate our accomplishments and outline the road ahead as we continue to move our specialty forward and strengthen the House of Surgery together.

First, I want to thank everyone who participated in our recent Clinical Congress in San Diego. It was amazing to be back together for the first time in 3 years, and the camaraderie, enthusiasm, and energy were extraordinary.

We welcomed world-renowned experts, featured cutting-edge innovations, and presented exciting new research and educational programming. Thank you, sincerely, to the dedicated staff, leaders, surgeon faculty, and subject matter experts—you made it possible!

More than 9,600 people joined us in person, with more than 2,000 others taking advantage of the virtual option. Altogether, registrants represented individuals from all surgical specialties, from all career levels, and from 116 countries.

You can read more about the sessions, learn how to access the on-demand content, see an assortment of photos, and get additional factoids about the meeting in a special Clinical Congress recap on pages 18–42.

Shifting Gears

For nearly 3 years, surgeons, frontline workers, and their teams made remarkable sacrifices to treat patients during the COVID-19 pandemic. Many experienced stress and burnout, while at the same time realizing just how resilient and resourceful we can be.

As we emerge from the pandemic, individuals and organizations—including the ACS—are refining their priorities and recalibrating tactics.

Moving into 2023, the ACS is being particularly strategic with program development and more innovative with technology. For example, we recognize that not every member can attend the full Clinical Congress, we would all benefit from a more individualized approach to specialty content, and we know that everyone wants to be able to access high-quality and innovative education close to home and when convenient.

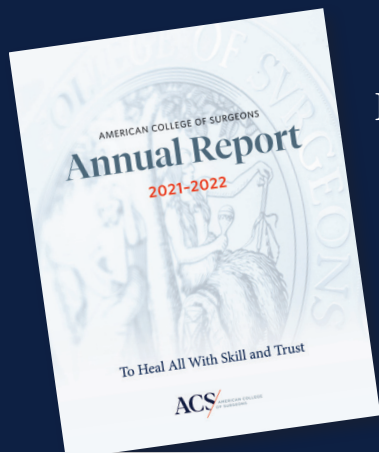
Your ACS staff and surgeon leaders have been working diligently to bring best in class to you. Webinars, toolkits, virtual seminars, in-person lectures, and skills-based courses are all part of what the ACS offers. Education in every format for all career stages is designed to help you excel, advance, and grow.

Additional developments will occur over the next few years, and they will deepen the value proposition for surgeons of all specialties. We currently have more than 84,000 members around the world, and our ACS chapters continue to grow in number and strength. We now have 119 chapters, including our newest chapters in the UK, Costa Rica, Bahrain, and the Kurdistan Region of Iraq.

Through a new pilot launched this year to waive resident dues for the 2022–2023 academic year, we also expect to increase resident participation in the ACS—and we are confident that residents of every surgical specialty, who are exposed to the career development resources, education, quality programs, and scholarship and grants opportunities that we offer—will become ACS members for life.

Helping our members provide the highest quality patient care has been the top priority for the ACS for the past 110 years, and it will continue to be the top priority.

This past year, we celebrated the centennials and outstanding accomplishments of the Committee on Trauma and the Commission on Cancer. They have both helped transform clinical care and significantly improved outcomes for trauma and cancer patients around the world.



Learn more about the numerous and impressive accomplishments of the ACS staff and volunteers on behalf of the House of Surgery in the ACS 2021–2022 Annual Report. Access the report at facs.org/about-acsgovernance/annual-report or scan the QR code on this page.

Productive Partnerships

One key to the strength, durability, and success of the ACS is our partnerships with other organizations.

In September, the ACS welcomed professionals from 47 multidisciplinary medical societies and health organizations for a Medical Summit on Firearm Injury Prevention (see the October *Bulletin*). In October, through our long-term collaboration with the military, we launched a Military Clinical Readiness Curriculum, which is a free online resource that provides valuable education for all surgeons who treat trauma victims (see page 74); and in November, the ACS, American Academy of Family Physicians, and American College of Physicians jointly authored an opinion piece in *Modern Healthcare* about the urgent need for Congress to halt Medicare payment cuts that take effect on January 1 and fix the broken Medicare payment system.

If you practice in the US and haven't yet contacted your lawmakers on this issue that affects our patients' access to care, please do so today at facs.org/surgeons-voice.

We know activism works. We know that our voices matter.

As I wrote in my October column, surgeon advocacy led to recent wins in two states. Based on the ACS STOP THE BLEED® program, California became the first state in the nation to require installation of trauma bleeding control kits in new buildings where people congregate; in New York, fellows and residents who initially did not qualify for that state's \$1.2 billion healthcare worker bonus program related to care of COVID patients now can collect the bonus.

The Power of Quality

Together, we accomplished a lot in 2022, and I am confident that we can achieve even more in 2023, including increasing awareness about the power of

quality among hospitals, lawmakers, regulatory agencies, payers, and the public.

An integrated, multiyear campaign launches early next year aimed at increasing participation in our Quality Programs and leading to inclusion of quality measures in healthcare reform legislation, a greater adoption of ACS quality metrics in CMS and private payer formulas, and a greater demand from the public to be cared for by a quality verified facility. More details about the campaign are on page 73 and forthcoming.

You can read more about the numerous and impressive accomplishments of the ACS staff and volunteers on behalf of the House of Surgery in my annual report to the membership (see sidebar).

As always, I look forward to hearing from you, and I hope to see you at upcoming events, including the Leadership & Advocacy Summit (April 15–18) in Washington, DC, the Quality & Safety Conference (July 7–13) in Minneapolis, MN, and Clinical Congress 2023 (October 22–26) in Boston, MA. A new hotel just opened adjacent to the Boston meeting space, which will lead to a fantastic experience in the city.

Thank you for your membership in the ACS. I wish you, your colleagues, and your family happy holidays and a healthy, safe, and productive new year. Please look for a fresh and redesigned *Bulletin* in January and engage with us on all of the new fronts in store for our organization. ♦



If you have comments or suggestions, please send them to Dr. Turner at executivedirector@facs.org.

“We Suffer in Silence”

**Surgeons as
Second Victims**

by Matthew Fox, MSHC



HIGHLIGHTS

- Explains the second victim phenomenon—feelings of guilt, sadness, and anxiety a surgeon may experience after an intraoperative adverse event
- Shares a story from a surgeon affected by treating patients early in the COVID-19 pandemic
- Describes how strong peer and institutional support can help surgeons recover

One December, early in his time as an attending trauma surgeon, Haytham M. Kaafarani, MD, MPH, FACS, treated a young man involved in a factory crash. The victim had been crushed by a forklift. He arrived to Dr. Kaafarani and the trauma bay in grave condition, and he was operated on over the following 72 hours to address pelvis, rectal, and bladder injuries, and the wound itself.

The patient had teenage children and his mother at the hospital, and each day, Dr. Kaafarani, associate professor of surgery at Harvard Medical School and Massachusetts General Hospital (MGH) in Boston, would talk with them to express that their loved one was in critical condition, and the surgical team was trying its best to save his life.

Shortly before Christmas, the major operations were completed, and the patient was in better condition, waking up when sedation was lightened and giving the thumbs up in the intensive care unit (ICU). Dr. Kaafarani went to the family and said, “We did it. He’s going to live. He’s going to be fine.” They were grateful, and the mother went home that day and made some Christmas cookies for Dr. Kaafarani and the care team.

But things changed that night. After Dr. Kaafarani had gone home for the first time in days, he received a call that the patient was deteriorating. The severe wounds had led to a massive infection, and he died because of them. It was Christmas Day. Dr. Kaafarani sat with the family and delivered the news. Dr. Kaafarani’s daughter kept the decorated cookie box in her room for years, serving as a reminder of the patient and his family every day.

As a trauma surgeon, Dr. Kaafarani is familiar with patient death. “I tell this story not because I can’t deal with difficult cases—I’ve experienced worse—but this one was different. In the back of my mind, I recalled that in the last surgery, the fat in his wound didn’t look as shiny as one expects it to be—it looked a little dull,” Dr. Kaafarani said. He struggled with the thoughts of self-doubt and guilt for potentially missing the sign of infection, and he internalized his pain. He wondered, if he had been more

experienced and less tired, would he have debrided the wound? Would the patient still be alive?

“It stayed with me for days, weeks, and maybe months. No one else doubted my heroic efforts to save the patient. It was in my own mind that I had failed,” Dr. Kaafarani said.

That internal struggle reveals an important truth for healthcare workers and, emphatically, for surgeons. When a patient experiences an intraoperative adverse event (iAE) during care and suffers a complication—or worse, death—the patient and his or her family are undoubtedly the victims. But the surgeons involved in the care, who experience the mental and emotional suffering of feeling that they made a mistake or could have done more, can be victims as well—the second victims.

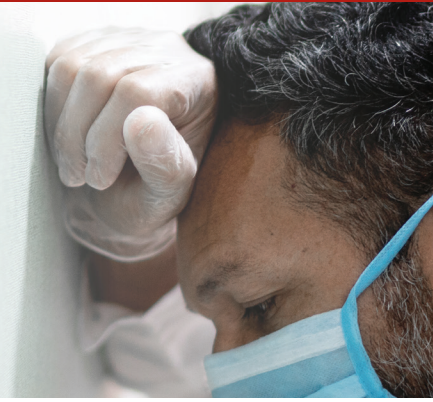
Surgeons as Second Victims

Dr. Kaafarani’s experience likely will ring familiar. As he points out, almost all surgeons will have their own stories. With the recent increased focus on physician and surgeon well-being, more attention now is being paid to this constellation of traumatic feelings and suffering, referred to as the second victim syndrome or phenomenon, which can manifest after a medical error or other significant adverse event occurs during patient care.¹

The second victim phenomenon has been a part of the wellness discussion in healthcare for more than 20 years and has received moderate academic attention, and research specifically focusing on surgeons’ experiences has been even less represented.

Dr. Kaafarani, who earlier in 2022 was appointed as The Joint Commission’s chief patient safety officer and medical director, spent years focusing on the impact of iAEs on patients. But after his experience and the prompting of a trainee, he transitioned his focus toward his colleagues.

In a 2017 study published in the *Journal of the American College of Surgeons*,² Dr. Kaafarani and colleagues



examined the effects of iAEs on surgeons from three major teaching hospitals in Boston, which revealed some staggering numbers. The study showed that 84% of respondents to a questionnaire who had experienced at least one iAE in the previous year reported a combination of anxiety, guilt, sadness, shame, and anger.

Some of the most impactful information came from the freeform comments, in which respondents could relay messages directly about their experiences. One surgeon wrote that, after experiencing an iAE, “We all hide our grief, suffer in silence. The pain can be close to debilitating.”

Beyond grappling with the reality of playing a part in a surgical error, blame was common, and sometimes debilitating mental and emotional anguish was the result of suboptimal institutional support mechanisms. Something needed to change.

“If this isn’t about surgeon well-being,” Dr. Kaafarani said, “then what is?”

A Core Well-Being Issue

There are commonly discussed determinants of a surgeon’s well-being, such as economic pressures, administrative burden, workplace discrimination, and structural bias in race or gender in the workplace. But the second victim syndrome speaks to what may be the defining burden that can weigh on a practitioner—feeling like they have failed to provide optimal care in a direct, one-to-one relationship with a patient. While each of these determinants can lead to burnout, responding to an iAE sometimes is ignored.

“When leadership talks about burnout, they rarely mention how adverse events are related,” said Ibrahim Khansa, MD, FACS, assistant professor of plastic surgery at The Ohio State University and a plastic and reconstructive surgeon at Nationwide Children’s Hospital, both in Columbus. “They talk about mindfulness, meditation, work hours, pay, how much call you take, which are all factors that are important. But we’re ignoring a big part about well-being, which is

anxiety about our patients. It’s normal. You should have some anxiety about your patients that drives you to do your best, but you need to be able to manage it.”

In fact, a second victim crisis can be the disease that causes the symptom of burnout, according to Gregory D. Pearson, MD, FACS, director, Center for Complex Craniofacial Disorders, associate professor of plastic surgery at Ohio State, and surgeon at Nationwide Children’s Hospital. An iAE, left unexamined and unresolved, can lead to burnout by affecting a surgeon’s connection to his or her work.

“Burnout is really about job satisfaction. You can work 10 hours or 100 hours. If you’re satisfied with your work and it has meaning, the hour differential doesn’t tend to matter,” Dr. Pearson said. “But second victim syndrome can lead to surgeons feeling like we’ve failed our patients and we’ve failed ourselves.”

Potential Long-Term Consequences for Residents

That feeling of failure can have lasting consequences for surgeons. Commonly, second victims experience increased anxiety about future errors, decreased job confidence, increased sleeplessness, worries about harm to professional reputation, and, most ubiquitously, the avoidance of similar patterns of care that precipitated the iAE.

“For a surgeon, that might mean they are now sending more cases to the interventional radiologist who seeks other ways of addressing an issue or looking for other medical solutions at the expense of surgery, so they don’t need to live with the fear of experiencing another error,” Dr. Kaafarani said.

And while the implications of shifted decision-making and in-surgery behavior can be significant at all levels of a surgical career, there are specific challenges for residents and trainees. Drs. Khansa and Pearson coauthored a survey-based study earlier in 2022 that looked at how surgical residents cope and recover after experiencing an iAE.³ For context, Dr. Pearson was the residency program director at Ohio State while Dr. Khansa was a resident, and

“It stayed with me for days, weeks, and maybe months. No one else doubted my heroic efforts to save the patient. It was in my own mind that I had failed.”

—Haytham Kaafarani, MD, MPH, FACS

he offered support when Dr. Khansa experienced a second victim event.

According to Dr. Khansa, “Published literature shows residents are especially vulnerable to second victim syndrome. Not only are they feeling anxious or guilty about the experience with patients, but they might feel anxious about their performance, their job, and their future.”

The findings were familiar—most respondents experienced guilt, anxiety, or insomnia, consistent with the second victim phenomenon. And, importantly, more than 15% of those residents said it affected their job performance. For a surgeon at the beginning of his or her career, these feelings can have long-lasting consequences that extend beyond a single patient.

“Not only does the adverse event affect the patient first and the resident second, it potentially affects future patients,” Dr. Pearson said. “If I experience an adverse event today, and I’m carrying it with me 3 months down the road and it’s still affecting my job performance, then it’s an issue. How is it affecting my patients or my interactions with my team and other faculty going forward? It’s a potential domino effect for residents who don’t recover early on.”

For residents or attending surgeons, recovery from experiencing an iAE can be difficult in the best of circumstances, and how does second victim syndrome manifest during a world-altering healthcare crisis, and what are the potential long-term effects?

Second Victims, COVID-19, and Post-Traumatic Stress

In March 2020, Brittany Bankhead, MD, FACS, assistant professor of surgery, trauma/acute surgical care at Texas Tech University Health Sciences Center in Lubbock, was practicing at MGH during her fellowship in surgical critical care.

As a trauma surgeon, she participated in the care of many gravely injured patients. As she said, “Every day, every shift, my work is fraught with high-acuity,

high-stress, intense pathophysiology, where patients had woken up that day thinking it would be normal.” Death and complicated treatment were a part of her professional life.

But nothing could prepare her for the COVID-19 pandemic. At MGH, Dr. Bankhead took on the role of ICU physician in the early crush of COVID-19 cases, which grew rapidly, all while she and her colleagues were struggling to learn more about the virus.

Dr. Bankhead described the strangeness of handling it firsthand and then learning about it through other channels.

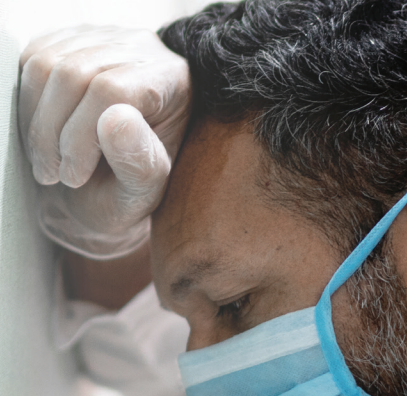
“Every night in that first week, I’d go to work and experience the surrealism of seeing this condition I’d only seen on the news before, and then I’d walk home and see new outlets reporting to all the world what my colleagues and I were dealing with on a minute-to-minute basis,” she said.

It was a much different experience than interacting with trauma victims, both in terms of treating the disease, as well as in watching extremely ill individuals face their death. “These patients were dying alone, terrified both of being there and not being there,” she said.

As surgeons and physicians around the world were grappling with patient care, they were living through fear, anxiety, and uncertainty in their own lives.

Dr. Bankhead, a mother of two, was confronted with the need to make difficult choices regarding interactions with her children. It was a profound struggle, Dr. Bankhead said, to cope with being a good parent while managing wildly increased work hours, sick patients, and uncertainty. She ultimately made the difficult decision to have her children stay with her parents for their safety, but it all took a severe toll on her mental health: “I felt like the ultimate failure as a mom, for not being able to take care of them and patients at the same time.”

All the while, she was afraid that a hole in her glove or an ill-fitting mask might lead her to the same fate as so many of her patients—on a ventilator, alone, leaving her children without a mother.



“We like to think as surgeons and scientists we can completely compartmentalize emotions from adverse or ongoing health events, but you inherently have a tie to them,” Dr. Bankhead said. “You always want the best for your patients, but this was different because you had the added component of wondering, ‘Am I going to spread this to my family? Am I going to get it myself? Can I take care of my patients while taking care of myself?’”

As with an iAE, the patients suffering and dying from COVID-19 were the primary victims. But like many of her colleagues on the frontlines of the pandemic in those early days, Dr. Bankhead was caught in a seemingly unending second victim cycle of fear, anxiety, sadness, and guilt, even though no one at the time would find fault with her for any potential error.

All the same, “I would have the feeling of guilt about decisions I made for patients and realizing it was wrong—not because I made a clinical mistake, but because no one knew better,” she said.

As her time treating COVID-19 during the initial waves wore on and eventually passed, and she moved with her family to practice in Texas, Dr. Bankhead could tell that she was not recovering as she expected from the many adverse patient events she faced. There were certain sensory experiences that would trigger flashbacks and familiar feelings of panic—news headlines from March 2020, the beeping of ventilators, the smell of an N95 mask.

“I knew these triggers bothered me and they weren’t normal, but I felt it was my job to power forward and, quite frankly, suppress it,” she said.

But it would not be simple, because Dr. Bankhead was experiencing post-traumatic stress disorder (PTSD) due to the barrage of illness and death she experienced, all associated with the ongoing event. Research has suggested that severe second victim syndrome can lead to a diagnosis of PTSD.⁴

Dr. Bankhead would struggle with sometimes disturbing thoughts stemming from her post-traumatic stress. Fortunately, she was able to recognize

how dangerous they could be to her health, family, and career. She needed time and space away from work, and she increased individual counseling sessions, which aided in her healing and return to a new normal. She continues to succeed as a trauma surgeon, researcher, and in her personal life. But without a clear definition of healing, recovery from her experience with PTSD is an ongoing story.

Supporting Second Victims

Second victim syndrome and PTSD—suffered by many healthcare practitioners throughout the acute phases of the COVID-19 pandemic—developed in unique, chaotic work circumstances. In a typical practice environment, research has found that healthcare workers involved in a second victim event are likely to progress through six stages in the aftermath, including chaos and accident response, intrusive reflections, fear of colleague and leadership perceptions, and enduring the internal and external investigations into the incident.⁵

But the final two stages take on particular importance for surgeons:

- Emotional first aid: Provider connects with colleague, mentor, or mental health professional for assistance in processing the event
- Final disposition: Provider may “drop out,” “survive,” or “thrive” after the event

Surgeons experiencing the second victim phenomenon can suffer in myriad ways—emotionally, mentally, and, potentially, in their careers. But, as surgeons have started to show in recent years, a strong institutional support system can make all the difference in getting to recovery, and a lack of such a system can be damaging.

“The problem is that we as surgeons are not taught how to support each other,” Dr. Khansa said. “Historically, we tend to beat each other down, which is what commonly happens during morbidity and mortality

“[During the pandemic] I would have the feeling of guilt about decisions I made for patients and realizing it was wrong—not because I made a clinical mistake, but because no one knew better.”

—Brittany Bankhead, MD, FACS

conferences. It’s an old school approach. But there’s a better way—support each other and build systems to encourage that support.”

The Power of Peer Support

Dr. Kaafarani and his team in Boston sought to establish a support system using the most empathetic group of individuals who could understand a surgeon’s complex relationship to managing an adverse event—their peers. Among the key data from his initial study on how surgeons responded to iAEs,² his team saw that it was a surgeon’s colleagues, above all other sources, who were a second victim’s most frequently used support system.

Based on these findings and other data showing the effectiveness of peer support, they designed a formal, surgery-specific peer support program at MGH for surgeons who experienced iAEs and catastrophic outcomes.⁶ The design of the program focused on identifying and training peer supporters, identifying iAEs quickly after they occurred, initiating follow-up to the affected surgeon, and starting a discussion between peers to help the individual work through the event.

Although the impetus was data-driven, Dr. Kaafarani had doubts about how effective such a program would be among surgeons, who are stereotypically seen as uninterested in engaging with the emotions of patient care.

“My expectation, understanding the culture of surgery, was that the program would be perceived as fluff and not meaningful. But I couldn’t have been more wrong,” he said. “As soon as I got the courage to establish it, to talk about second victim syndrome and the program in the open, and say, ‘This is what we need to do,’ the reception was unbelievable.”

The numbers from the study were highly positive. In the first year of the second victim program’s operations, the peer team performed nearly 50 outreach interventions after significant surgical mishaps or unexpected patient deaths. More than 80% of

participants in the program believed that it had a “positive impact on the department’s ‘safety and support’ culture by raising awareness of the need to support colleagues going through difficult patient situations.”⁶

The program design and its positive results could have implications for surgery programs that want to bolster intradepartmental support for surgeon well-being. Other surgeons have found in their own experiences, at all career levels and in all practice environments, that peer support matters and it works.

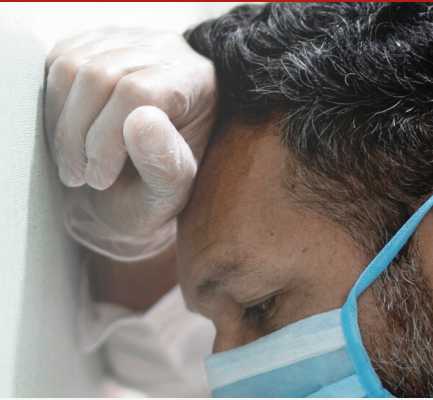
“What we found in our study is that support from peer residents should be stressed,” Dr. Pearson said. “It really can start a snowball effect, in a positive way, by building camaraderie, which encourages residents to use each other as resources, and improving teamwork. It gets residents talking to each other, about both patient-related matters and more personal ones, which has a positive spillover effect with communication.”

According to Dr. Bankhead, during the early days of the COVID-19 pandemic, when few institutional resources were available to aid physicians as they coped with the spike of patients, even informal peer support was critical.

“Unofficially, we were using peer support every day—at check in, at sign out. There was a built-in community of mutual understanding, and we were checking in on each other, asking how our families were,” she said. “It was a necessary release for anyone who took care of COVID-19 patients in the first waves.”

Ultimately, the goal of a peer support group for second victims is found in the final stage progression described previously. No hospital wants their surgeons to drop out due to an unresolved second victim event, and even simple “survival” falls short. It’s important to get surgeons into the stage where they thrive, become more interested in quality improvement, and can recognize issues in others, while promoting improved recovery processes for their colleagues and improved patient outcomes.

According to Dr. Khansa, “There’s a really good opportunity for growth after a surgeon experiences an



adverse event and for them to become safety advocates who work to prevent future occurrences.”

While second victim-specific support programs are only beginning to be implemented in hospitals, most institutions do offer support systems such as employee assistance programs. But these resources often struggle to build awareness.

“The challenge is that not enough people realize resources are available,” Dr. Pearson said. “For people interested in surgeon wellness, knowing what resources are available and knowing how to guide staff and residents, and for institutions to promote those resources, is a change that needs to happen.”

A Steadfast Focus

Nascent programs that are dedicated to addressing surgeons as second victims show promise, and health-care culture in the US is slowly adapting to meet the holistic well-being needs of practitioners. It is the hope that eventually all surgeons will have the support they need if, one day, they experience a complication, an outcome, or a patient death that they carry in their heads or hearts for longer, and more heavily, than expected.

But even as work toward that goal continues, surgeons will remain dedicated to patient care and compassionate in the face of difficulty. Second victims should not and cannot be ignored, but the focal point of surgical care will always be on the first victim of an adverse event.

“For better or worse, it is my job to ensure that the care that patients get—the high acuity needs, the technical skills, the follow-up—are top notch,” Dr. Bankhead said. “They deserve every bit of that, every bit of explanation, understanding, and empathy, and my hope is that is and always will be steadfast, no matter what happens to me as the second victim.” ♦

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Dr. Generoso Duremdes
(left) and Dr. Gene
Duremdes



Generations of Giving: Philanthropy Is a Family Affair for These Father-Son Surgeons

by Tony Peregrin

Dr. Gene Duremdes (left) and Dr. Generoso Duremdes (right) performing a laparoscopy



For nearly 3 decades, visitors to Princeton Community Hospital in West Virginia would likely hear a page for “Dr. Dad” or “Dr. Gene” summoning either Generoso Duremdes, MD, FACS, or his son, Gene Duremdes, MD, FACS, to care for a patient or, perhaps, participate in a meeting.

“These nicknames are terms of endearment,” said the junior Dr. Duremdes. “And I think they show the loyalty, love, and support that we’ve had all these years from our community and the people at our hospital.”

The father-son duo recently answered a different kind of call to action.

Together with their spouses—Janelle Duremdes, MD, and Mary Duremdes, RN—they are sponsoring the Duremdes Family Travel Award, an ACS fund that provides international physicians, specifically Filipino surgeons, with the opportunity to attend and participate in the annual Clinical Congress.

“My parents came from a very rural area in the Philippines, and they want to provide an opportunity for some of the young surgeons—who might not have the resources to make it to Clinical Congress—to be exposed to the latest research and trends in surgery,” explained Dr. Gene Duremdes.

“Karen Hope A. Dalmacio, MD, FACS, the inaugural recipient of the award, sent us this short letter describing her journey to Clinical Congress as not only a highlight of her career as a surgeon, gaining knowledge by attending the lectures, but also as something that helped her personally fight her own breast cancer,” said the senior Dr. Duremdes. “Dr. Dalmacio

continued her practice as a surgeon and became an inspiration, not only to her colleagues, but also to her patients.”

During the meeting, Dr. Dalmacio was able to see her mentor, ACS Past-President Patricia J. Numann, MD, FACS, honored with the ACS Lifetime Achievement Award. Their interactions during Clinical Congress were especially compelling as Dr. Numann was the spark that inspired the Duremdes family to create this traveling fellowship.

“When I was serving as the President of the ACS West Virginia Chapter in 2013—which was actually 20 years after dad served in that same position—we had the privilege of having Dr. Numann as the representative from the College to the chapter,” explained Dr. Gene Duremdes. “While we were sharing a wonderful evening of dinner and fellowship, we found out that Dr. Numann had spent a lot of time in the Philippines and that she loved her visits there. My parents were touched by her fondness for their birthplace and how she spoke about the need for the College to reach out to the international surgical community and share the wealth of information and resources that the ACS has to offer. So, from that brief encounter was born the idea of the traveling fellowship—it literally began just as a conversation during dinner.”

In the ACS Foundation 2019 Annual Report, Dr. Dalmacio described her experience observing Dr. Numann receive the College’s Lifetime Achievement Award: “It was through that recognition that I was inspired by her work, her persistence as a



Dr. Generoso Duremdes (left) and Dr. Gene Duremdes (right) in the OR doing an exploratory laparotomy

physician, her strength as a female surgeon, and, above all, her excellence. The experience of witnessing such a momentous event for her was more than enough to inspire me to strive more in doing my part as a member of my surgical community.”

Following Dr. Dalmacio, the second recipient of the Duremdes Family Travel Award was Leah Ruth Failagutan Porras, MD, in 2020. Due to the pandemic, Dr. Porras’s scholarship was deferred to Clinical Congress 2023.

Father-Son Surgeons

The Duremdes family arrived in the US in 1962 at St. Elizabeth Hospital in Elizabeth, NJ. Dr. Duremdes senior and his wife later trained in New York City—at Albert Einstein Medical Center and Fordham Hospital, respectively.

Dr. Duremdes senior took a job at Princeton Community Hospital in 1969 and is the longest-serving physician at that center. His son joined him in 1993 as a general surgeon, and for many years he performed traditional laparoscopy alongside his father.

“When I first started showing an interest in surgery, Dad said, ‘If you’re interested, you really need to see what it’s like to be a surgeon.’ So, I started scrubbing with him in high school, back in the days when you were allowed to do that. I learned so much, even by the time I was out of high school and college, from a surgical standpoint. It’s been a wonderful working relationship—and it’s almost not even father-son.

It’s almost like we’re friends. We know each other’s techniques to the point that we didn’t even talk to each other much in the operating room because we knew exactly what we were going to do. It’s almost like that sixth sense, that other unwritten language, that we knew each other so well.”

The senior Dr. Duremdes added, “I consider it a blessing and an honor to be able to work with and teach my son and to help him grow and develop into the surgeon that he has become today.”

Distinguished Philanthropist Award

Since 1989, the ACS has acknowledged individuals who have distinguished themselves through their exemplary investments in the mission of the College and in philanthropy with the Distinguished Philanthropist Award.

The Board of Directors of the ACS Foundation presented the 2020 and 2021 Distinguished Philanthropist Awards to the Duremdes Family and Charles E. Lucas, MD, FACS, at its annual donor recognition luncheon on Monday, October 17, at the Manchester Grand Hyatt in San Diego. The award recognizes the Duremdes Family and Dr. Lucas for their philanthropic endeavors, service to the surgical profession, and long-lasting contributions to the medical community and the ACS.

For Dr. Duremdes senior, looking back at his life experiences has made him realize the importance of giving back in order to support other surgeons’ opportunities for education and training.

From left: Mary Duremdes, RN, Dr. Gene Duremdes, Dr. Generoso Duremdes, and Janelle Duremdes, MD, at the 2022 ACS Foundation Donor Recognition Luncheon



“Pearl Harbor was bombed on December 7, 1941; Manila, in the Philippines, was bombed and destroyed the following day on December 8, along with the American and Filipino armed forces,” recalled Dr. Duremdes. “My parents were teachers, and we were all interred in the schools and forced to learn Japanese in order to teach the younger generation. My father, along with two other ROTC [Reserve Officers’ Training Corps] men, secretly built a boat, which took over a year. In the middle of the night our families escaped into the Davao Gulf only to be caught in a typhoon that capsized the boat. For 5 days and 4 nights, we were stranded on the capsized boat in shark-infested waters. We were all saved, praise the Lord, except my mother suffered from pneumonia and, without adequate antibiotics, she passed away. This experience inspired me to work hard, go to college and medical school, become a doctor, and to give back to my rural Philippine community.”

Dr. Gene Duremdes added: “Receiving the Distinguished Philanthropist Award is an honor for our family. With our traveling scholarship, we want to help rural surgeons in an underdeveloped country learn new information and technology and have the opportunity to meet and network with other surgeons at Clinical Congress who they never would have been able to meet otherwise.”

The Duremdes family has had its own remarkable experiences during Clinical Congress. In the fall of 1988, the senior Dr. Duremdes attended a lecture presented by Eddie J. Reddick, MD, FACS, and William B. Saye, MD, FACS, who were among the first to perform

laparoscopic cholecystectomy in the US. That lecture kindled his interest in the once controversial new procedure, and in June 1989, Dr. Duremdes senior became the first surgeon in southern West Virginia to operate using this new technology.

ACS Foundation

The Duremdes Family Travel Award is a recent example of the family’s long and generous contributions to the ACS Foundation, which began in 1992 with financial contributions to the College’s International Guest Scholarship fund.

“I think philanthropy starts locally,” said Dr. Gene Duremdes. “Working with your local community is a great way to start giving back. If you want to make a larger impact, use some of the resources provided by the College. The staff at the ACS Foundation were instrumental in developing the Duremdes Family Travel Award. From our standpoint, it was relatively easy—we just let the ACS Foundation guide us and show us what to do.”

“The ACS Foundation is there for the members at whatever capacity they need,” added Dr. Gene Duremdes. “They are very receptive to working with each individual surgeon at any level of engagement.”

To date, 387 international scholarships have been funded by the ACS Foundation to Fellows from more than 80 countries worldwide. ♦

TONY PEREGRIN is Managing Editor, Special Projects, Division of Integrated Communications, Chicago IL.



Surgeons
Sowing
Hope

Clinical Congress 2022 Highlights





Convocation: New Initiates recite the Fellowship Pledge

The ACS Clinical Congress 2022 in San Diego, CA, provided opportunities for surgeons, residents, medical students, and other health-care professionals from around the world to sharpen and test their surgical skills and interact with their peers and ACS leaders and staff. It was the first time in 3 years that Clinical Congress convened in person.

More than 9,600 individuals traveled to San Diego, and thousands more participated virtually and have accessed the conference's content on demand. All registrants can view on demand content through May 1, 2023, and registration remains open for new participants.

This article summarizes some of the conference highlights.

Convocation

A record 2,355 surgeons were initiated into ACS Fellowship this year, and following a joyful procession of ACS leaders, invited guests, and Initiates from 2020, 2021, and 2022, then-Secretary Tyler G. Hughes, MD, FACS, presented the Great Mace (see pages 30–32).

During the hour-long program, 12 international surgeons were conferred Honorary Fellowship, several of the College's most prestigious awards were presented, and 2021–2022 ACS President Julie A. Freischlag, MD, FACS, DFSVS, MAMSE, led the installation of new officers, including E. Christopher Ellison, MD, FACS, MAMSE, as President (see pages 25–28), Mary E. Fallat, MD, FACS, as First Vice-President, and Anne G. Rizzo, MD, FACS, as Second Vice-President.

The 2022 Honorary Fellows are:

- **Mohammad M. Al-Qattan**, Riyadh, Saudi Arabia
- **Ines Buccimazza**, MBChB, FCS(SA), FACS, Durban, South Africa
- **Reinhold Ganz**, MD, Gümliigen, Switzerland
- **Marco Montorsi**, MD, Milan, Italy
- **Graham L. Newstead**, MBBS, FACS, FRACS, FRCS, Randwick, Australia
- **Fernando Rodriguez Montalvo**, MD, PhD, FACS, Caracas, Venezuela
- **Paulina Salminen**, MD, PhD, Turku, Finland
- **Samuel Shuchleib Chaba**, MD, FACS, Mexico City, Mexico
- **Antonio Jose Torres**, MD, PhD, FACS, Madrid, Spain
- **Petr Tsarkov**, MD, PhD, Moscow, Russia
- **Laura G. Viani**, BA, BCh, BAO, DMMD, MSc, FRCSI, Dublin, Ireland
- **Peter-John Wormald**, MD, MBChB, FAHMS, FRACS, FCS(SA), FRCSEd, North Adelaide, Australia

See pages 38–41 for more information.

The 2022 Owen H. Wangenstein Scientific Forum Award was presented to Henri R. Ford, MD,



Convocation: Distinguished Service Award recipient Dr. Mark Malangoni delivers his acceptance speech via video



In the Convention Center: A giant ACS hashtag photo op

MHA, FACS, FRCS, FAAP, who is renowned for his groundbreaking research in necrotizing enterocolitis, significant history of extramural funding, and his reputation for mentorship and sponsorship.

Mark A. Malangoni, MD, FACS, received the 2022 Distinguished Service Award for his various leadership roles in the ACS and other medical organizations, including the American Board of Surgery (see September *Bulletin*), and Ernestine Hambrick, MD, FACS, an esteemed colon-rectal surgeon received the Dr. Mary Edwards Walker Inspiring Women in Surgery Award (see October *Bulletin*).

Named Lectures

Clinical Congress featured 12 Named Lectures, which provided attendees with opportunities to hear internationally renowned surgeons and healthcare experts share their insights on medicine and surgery.

Past ACS-Executive Director David B. Hoyt, MD, FACS, delivered the Martin Memorial Lecture and participated in a meet and greet after the presentation. In his talk, Dr. Hoyt provided an overview of how the ACS's historical commitment to patient care and quality has served as a pillar in the foundation of the modern organization, which has maintained significance and success in a rapidly evolving medical environment. At all times, he said, the ACS uses data, science, and surgeon experiences to move the College and field forward.

"We need to use outcomes and science to determine how we treat patients going forward, and we need to be transparent with the public," Dr. Hoyt said.

In the Excelsior Surgical Society/Edward D. Churchill Lecture, The Extraordinary Evolution of Surgery for Abdominal Trauma, lecturer David V. Feliciano, MD, FACS, MAMSE, discussed how the high quality of modern civilian and military trauma surgery is built on the foundation of

significant advances during the past 100 years. In this comprehensive talk, Dr. Feliciano described the evolution of trauma surgery for liver, spleen, duodenum, pancreas, and abdominal vascular injuries.

In the inaugural Metabolic and Bariatric Surgery Lecture, Don't Stop Now, Bruce D. Schirmer, MD, FACS, MAMSE, discussed the long road that the field of bariatric surgery has taken toward mainstream practice, and he urged surgeons to learn about obesity.

"Our biggest challenge is that we're only now beginning to understand the disease of obesity and how to work in conjunction with medical colleagues to provide lifelong ways for patients to keep the weight off," Dr. Schirmer said. "More importantly, there are still only 1% of patients each year who elect to have metabolic and bariatric surgery. What we really need to do is figure out what is wrong with our marketing and public education."

Noteworthy Academic Programming

Each year, Clinical Congress is anchored by expansive academic, scientific, and educational programming.

In addition to Didactic and Skills Postgraduate Courses, Clinical Congress 2022 provided attendees access to more than 100 expert-led Panel Sessions. These included well-attended sessions such as the 10 Hot Topics in General Surgery, hosted by Dr. Ellison and ACS Regent Kenneth W. Sharp, MD, FACS, MAMSE; Diverticulitis 2022: What's New, What's Old and What You Need to Know!; Structural Racism: What It Is and What It Means for Surgeons and Their Patients; and much more.

Three Special Sessions once again were offered at Clinical Congress. These sessions provided attendees with an in-depth look at important ACS topics in surgery, including reports from US surgeons who have provided care and education in Ukraine since



2021–2022 ACS Board of Regents

the war started. In a moving talk, Ukrainian surgeon Hnat Herych, MD, PhD, provided a firsthand account of how a surgeon in Ukraine is responding to the war injured.

Other Special Sessions featured a discussion on how educational accomplishments relate to promotion of surgery faculty and how the American Society of Anesthesiologists and the ACS can partner to address challenges such as Medicare payment and other reimbursement.

The Named Lectures, Panel Sessions, and Special Sessions are available to view via the on-demand platform.

Hands-On Events

Hundreds of attendees at all stages of a surgical career have been part of the Surgical Metrics Project since it debuted in 2019. Approximately 120 surgeons participated this year, performing laparoscopic ventral hernia repairs while using wearable technologies to measure surgical decision-making and techniques. Each person spent 1.5–2 hours completing the procedure.

According to Carla M. Pugh, MD, PhD, MAMSE, FACS, who leads the project, she and her colleagues will conduct a large-scale, deep dive into the data and draw some conclusions that can be used for feedback, quality improvement, operative efficiency, and patient safety.

The first ACS Surgical Ergonomics Hands-On Clinic for practicing surgeons and surgery residents generated significant interest and attendance, showcasing the importance of health and well-being in a physically demanding field. Ergonomic coaches helped participating surgeons learn about recently established ACS Surgical Ergonomics Recommendations, while applying them in a simulated environment at three simulation stations with open, laparoscopic, and robotic surgery equipment.

Awards and Honors

Practicing surgeons, residents, and medical students were recognized for their contributions to advancing the art and science of surgery, domestic and international volunteerism, leadership in residency, and much more at Clinical Congress. Visit the *Clinical Congress News* website (acsccnews.org) for a complete listing of the awards, honors, and dedications provided at this year's conference.

Annual Business Meeting

The Annual Business Meeting of Members convened October 19, with Dr. Ellison presiding. Following a series of reports from the Board of Regents (BoR), Board of Governors (BoG), ACS Foundation, and the ACS Professional Association Political Action Committee, new ACS Officers and other officials were elected for 2022–2023.

The President-Elect is Dr. Henri Ford, dean and chief academic officer of the University of Miami Miller School of Medicine in Florida. “We must affirm our relevance and exert our influence by taking the lead on issues that affect the national healthcare agenda, fighting for health equity, and promoting a more diverse surgical workforce,” Dr. Ford said. “My job is to empower and inspire others to achieve their best.”

The First Vice-President-Elect is Dr. Hughes, a clinical professor of surgery and director of medical education at the Kansas University School of Medicine, Salina. The Second Vice-President-Elect is Deborah A. Kuhls, MD, FACS, assistant dean for research and professor of surgery at the Kirk Kerkorian School of Medicine at the University of Nevada, Las Vegas.

See pages 34–36 for more information on the new Officers-Elect.

The new Secretary is Sherry M. Wren, MD, FACS, FCS(ECSA), professor of surgery (general



International Guest Scholars and Travelers

surgery) at Stanford Health Care in Palo Alto, CA. See page 29 for more information.

One surgeon was elected to the ACS BoR: Sarwat Salim, MD, FACS, professor of ophthalmology, vice-chair of clinical and academic affairs, and director of the glaucoma service at New England Eye Center and Tufts University in Medford, MA.

In addition, four surgeons were reelected to the BoR: Anthony Atala, MD, FACS, MAMSE, Diana L. Farmer, MD, FACS, FRCS, Fabrizio Michelassi, MD, FACS, and Steven C. Stain, MD, FACS.

The following Officers of the BoG Executive Committee were elected:

- **Chair:** Ross F. Goldberg, MD, FACS, district medical group vice-chair of surgery, specialty ambulatory medical director, chief of the Division of General Surgery, director of the robotic surgery program, and director of minimally invasive and hepatic surgery for Valleywise Health in Phoenix, AZ
- **Vice-Chair, and re-elected Optimal Patient Care Pillar Lead:** Lillian S. Kao, MD, FACS, professor in the Department of Surgery and chief of the Division of Acute Care Surgery at the McGovern Medical School, The University of Texas Health Science Center in Houston
- **Secretary:** Marion C. W. Henry, MD, MPH, FACS, professor of surgery at UChicago Medicine in Illinois

The following surgeons have been elected to the BoG Executive Committee:

- **Education Pillar Lead:** Amit R. Joshi, MD, FACS, professor of surgery and associate dean for graduate medical education at Cooper Medical School of Rowan University in Camden, NJ

- **Advocacy Pillar Lead:** Don J. Selzer, MD, FACS, Willis D. Gatch Professor of Surgery, program director of the fellowship for advanced gastrointestinal and bariatric surgery, chief of the Division of General Surgery, and associate chair of the Department of Surgery at the Indiana University School of Medicine in Indianapolis

In addition to Dr. Kao, three other Pillar Leaders were reappointed:

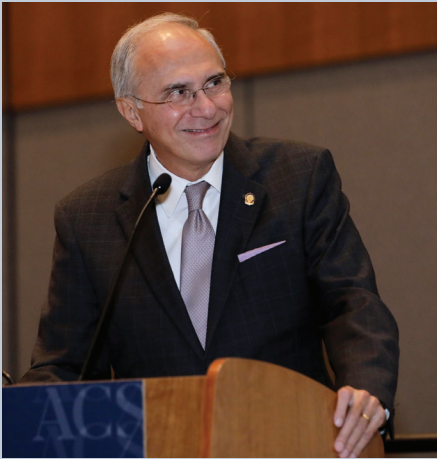
- **Diversity Pillar Lead:** Cherisse D. Berry, MD, FACS
- **Communications Pillar Lead:** Shannon M. Foster, MD, FACS
- **Member Services Pillar Lead:** Maie A. St. John, MD, PhD, FACS

Member Engagement Activities

Clinical Congress 2022 provided attendees and their guests with opportunities to participate in wellness activities, including 5K running tours, yoga, a steps challenge, and a scavenger hunt. The annual Taste of the City on the last night of the conference offered an informal venue for attendees, their families, and guests to experience San Diego's unique dining and cultural scene.

Clinical Congress 2023

The next Clinical Congress will take place October 22–26, 2023, in Boston, MA. Abstract submission begins mid-December, and housing reservations are under way. For more information, go to facs.org/clincon2023. ♦



CLINICAL CONGRESS 2022

By the Numbers

11,773
REGISTRANTS

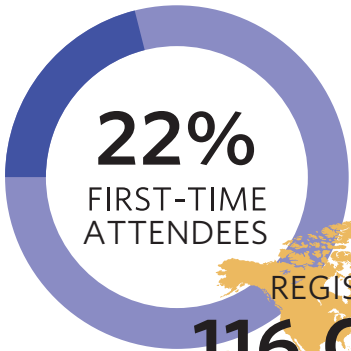
9,621 IN-PERSON
2,152 VIRTUAL



2,276
Total speakers
for 360+
sessions



2,355
INITIATES



243.25
CME CREDITS
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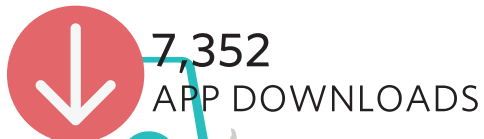


51
LIVESTREAM
SESSIONS



REGISTRANTS CAME FROM
116 COUNTRIES

- 13,600** Hours of on-demand sessions watched from 10/16 to 11/21
- 820** Scientific Forum abstracts presented
- 506** Scientific Forum ePosters presented
- 205** Videos presented



7,352
APP DOWNLOADS

109 MILLION
IMPRESSIONS FOR
#ACSCC22



400+
HEADSHOTS TAKEN
IN ACS CENTRAL

E. Christopher Ellison, MD, FACS, Is Installed as ACS President



Clinical Congress 2022 Convocation: Outgoing ACS President Julie A. Freishlag, MD, FACS (right), passes the Presidential Medallion to Dr. Ellison

E Christopher Ellison, MD, FACS, an esteemed general surgeon from Columbus, OH, was installed as the 103rd President of the ACS during Clinical Congress 2022 Convocation in San Diego, CA.

Dr. Ellison is the Robert M. Zollinger Professor of Surgery Emeritus at The Ohio State University College of Medicine (OSU COM), Columbus. He previously served as chair of the Department of Surgery, interim dean of the OSU COM, and president and CEO of The Ohio State University Physicians Practice Plan. He recently served as the George W. Paulson, MD, Scholar-in-Residence (Medical Heritage Center), for a 2-year term.

With a theme of “Surgeons United” for his year of service as ACS President, Dr. Ellison said he will work to unify all surgical specialties. “The ACS is a perfect place to bring our specialties together for a common purpose. The ACS appeals to surgeons of all specialties and strives for gender and racial equality throughout the College,” he said. (See the Presidential Address recap on pages 27–28.)

Career Highlights

Dr. Ellison is a 1976 graduate of the Medical College of Wisconsin, Milwaukee, and has spent nearly his entire career at The Ohio State University (OSU), beginning with a general surgery residency, which he completed in 1983. He entered community practice in Columbus between 1987 and 1993 before returning to OSU. He led the Division of General Surgery and served for 6 years as director of the General Surgery Residency Program. He was named chair of the Department of Surgery in 2000. For 13 years, he led the expansion of the department



Dr. Mary Fallat



Dr. Anne Rizzo

and the creation of multidisciplinary basic science and clinical research programs.

While serving as program director in general surgery, Dr. Ellison fostered a culture committed to diversity and inclusion in the program, which remains a hallmark of diversity at OSU. With the help of key faculty, he co-led the re-establishment of the master of medical science program, which was originally conceived by Robert M. Zollinger Sr., MD, FACS, in the 1950s. This program has provided a foundation for Ohio State to successfully prepare the next generation of surgeon scientists.

As Practice Plan CEO and interim dean of the College of Medicine (COM) at Ohio State, Dr. Ellison worked with the admissions team to help make The OSU COM a leading institution for opportunities for underrepresented minority students in medical education. He also helped build the research portfolio and provide a sound economic foundation for the COM.

ACS Service

Dr. Ellison became an ACS Fellow in 1986, and his service to the College has been exemplary throughout his multifaceted career. He was a member of the ACS Board of Governors (1997–2003); President of the ACS Ohio Chapter (2003–2004); Chair of the Advisory Council for General Surgery (2013–2015); Chair, Advisory Council Chairs (2013–2015); and most recently, Chair of the ACS Foundation Board of Directors (2019–2021). He also has been a member of many other ACS committees and workgroups. Dr. Ellison is a member of the ACS Academy of Master Surgeon Educators[®], and his current professional focus is on the education and operative coaching of surgical residents.

While serving as ACS Ohio Chapter President (2003–2004), Dr. Ellison contributed to advocacy efforts in the state to achieve tort reform and, in collaboration

with the leadership of Robert E. Falcone, MD, FACS, helped establish a state trauma system. Dr. Ellison has said one of the most rewarding experiences of his career was when he was elected as an ACS representative to the American Board of Surgery in 2003.

Honors and Awards

Dr. Ellison has served as president of the American Surgical Association (2018–2019) in addition to other leadership positions within other organizations and professional societies. Among his many awards and recognitions are the OSU Distinguished Service Award (2020), the OSU COM Professor of the Year (1999), and The Ohio State University College of Medicine Landacre Society Honorary Award (1998). In addition, he was awarded the Distinguished Service Award (2021) from the Medical College of Wisconsin.

Vice-Presidents

In addition to Dr. Ellison, Mary E. Fallat, MD, FACS, was installed during the Convocation as ACS First Vice-President; and Anne G. Rizzo, MD, FACS, as ACS Second Vice-President.

Dr. Fallat, who has a long history of service and leadership in pediatric surgery and trauma, is professor of surgery at the University of Louisville and director of surgical quality at Norton Children's Hospital, Louisville, KY, where she has been in practice for more than 35 years.

Dr. Rizzo, whose military service spans 27 years in the US Air Force and US Air Force Reserve, is a trauma, critical care, and general surgeon, in Sayre, PA, at the Guthrie Clinic. ♦

Dr. E. Christopher Ellison Urges Surgeons to Unite for the Profession, Patients



“It is apparent to me that the profession of surgery must be more united than ever before. As we take our professional journey, we as a College must be united across generations anchored by the ideals of our founders for the good of our patients and society.”

—E. Christopher Ellison, MD, FACS, MAMSE

The annual Convocation Ceremony during Clinical Congress has been described as transformative, not only for new initiates, but also for their family members, surgeon leaders, and other attendees who experience the pomp and circumstance and celebrate the admirable achievements of surgeons around the world.

Newly installed ACS President E. Christopher Ellison, MD, FACS, MAMSE, dedicated his Presidential Address to the 2022 initiates—all 2,355 of them who can now proudly add FACS to their credentials.

“Those in attendance have come from many different places, by many different means and roads. Likewise, our journey in our careers has begun at a thousand different points, both literally and figuratively. We have taken many different paths to get where we are today. Tonight, all of these roads intersect here in San Diego at the 103rd ACS Clinical Congress,” he said.

Dr. Ellison described being a surgeon as the most honorable and professionally rewarding among the many specialties in medicine and acknowledged that the past few years—because of COVID-19 and political turmoil—have been difficult. “It is apparent to me that the profession of surgery must be more united than ever before. As we take our professional journey, we as a College must be united across generations anchored by the ideals of our founders for the good of our patients and society,” he said.

Those ideals include quality, integrity, and professionalism.

Opposite, top photo: Dr. Ellison delivers the Presidential Address during the Clinical Congress 2022 Convocation Ceremony. Bottom: The full Convocation stage with Dr. Ellison and ACS leadership.

He went on to describe the spiritual and medical symbolism behind the ACS seal, which features Asclepius, the Greek god of healing, and a Native American medicine man sitting under the Tree of Knowledge. The words, *Omnibus per artem fidemque prodesse* are inscribed at the bottom of the seal as the College motto; it translates as “To Heal All with Skill and Trust.”

Among the ways that Dr. Ellison said he hopes to further the ACS motto are by promoting excellence in surgical care, bringing the House of Surgery closer together, and expanding diversity in the workforce to eliminate social disparities in access, and solve the rural surgeon shortage.

He also said it’s important that surgeons learn the Platinum Rule—treating patients how they wish to be treated, taking into account their unique ethnicity, culture, gender, background, and experiences.

You can learn more about Dr. Ellison and why he chose the presidential theme, Surgeons United, in a short video that kicked off the Opening Ceremony during Clinical Congress. Access the video at youtu.be/PJHylmS-yoM or by scanning the QR code.

You also can access the full text of Dr. Ellison’s Presidential Address in the *Journal of the American College of Surgeons* at journals.lww.com/journalacs. Search for the title, “Our Professional Journey: Surgeons United.”

The full Convocation Ceremony, including the procession, awards, and Presidential Address, is available at facs.org/for-medical-professionals/conferences-and-meetings/clinical-congress-2022/events/convocation or by scanning the QR code. ♦



Sherry M. Wren, MD, FACS, FCS(ESCA), Is Elected ACS Secretary



Dr. Sherry Wren

At the October 19 ACS Annual Business Meeting of Members in San Diego, CA, Sherry M. Wren, MD, FACS, FCS(ESCA), a general surgeon in Palo Alto, CA, was elected as ACS Secretary. She replaces Tyler G. Hughes, MD, FACS, who served as Secretary from 2019 to 2022. Dr. Wren is the second woman to hold this position, following Kathryn Anderson, MD, FACS, who served as Secretary from 1992 to 2001.

Dr. Wren is a professor of surgery (general surgery) at Stanford Health Care, part of the adult healthcare delivery system of Stanford Medicine, CA. She specializes in the surgical treatment of gastrointestinal cancer, including stomach, pancreas, intestinal, and colon and rectal cancers.

In addition, Dr. Wren is intimately involved with humanitarian and global surgery, managing educational partnerships in Sub-Saharan Africa and serving as faculty fellow of the Stanford Center for Innovation and Global Health. In 2017, Dr. Wren received the ACS/Pfizer International Surgical Volunteerism Award for her work providing surgery services and preparing surgeons to deliver international humanitarian aid.

An ACS Fellow since 1997, Dr. Wren has held several roles within the College. She was an ACS Governor from 2008 to 2014, wherein she served on the Board of Governors Committee on Socioeconomic Issues, the Committee on Surgical Practices, and the Committee to Study the Fiscal Affairs of the College. In addition, she was Vice-Chair of the ACS Women in Surgery Committee from 2005 to 2011 and a specialty society representative to the ACS Advisory Council for General Surgery.

At the local level, Dr. Wren served as President of the ACS Northern California Chapter (2008–2009), in addition to other roles within the chapter. ♦

One Mace to Rule Them All



by Tyler G. Hughes, MD, FACS

Yes, it is heavy. All the Secretaries of the American College of Surgeons will tell you that. Its weight is physical and metaphysical. The longer one carries it, the stronger the effect upon the bearer.

The ACS and fate granted me the honor of carrying the Great Mace one time. Up until the night I first held this talisman of surgeons, I was unaware of the power it holds over us and the person honored to carry it. I held this inspiring piece of art during the 2022 Convocation for less than 40 minutes all told; yet I felt a real effect that will last the rest of my life. This essay is for those who wonder what that experience is like and why I now feel so strongly about this symbol, which was presented as a gift of goodwill to the ACS in 1920 from British surgeons who worked alongside American surgeons during World War I.

Like Tolkien's ring, it has taken a certain power over me.



For the months prior to the event, one is reminded with a smile and a laugh by others that the main and only important job of the Secretary is to not drop the Mace. One responds typically with a smile and a laugh in return, but deep down there is the tug of worry that maybe you will be the one who drops it. Your laugh has just a tinge of nervous quality.

For many years, the person orchestrating the dance of Convocation has been Donna Coulombe, Senior Special Projects Manager, ACS Executive Services. A woman of incomparable competence, Donna reassures the Secretary that all will be well. She makes sure all the locks lock and the gears mesh so that the Secretary looks the part appropriately during the ceremony. Without Donna and her predecessors, the Mace likely would have been dropped metaphorically many times. When an email from Donna arrives, one reads it immediately and follows her directions precisely—especially the date, time, and place of rehearsal, which is the time one finds out the heft and magic of the Mace. It is the first time one actually touches it.

The personnel charged with transporting and protecting the Mace during those days it travels from Chicago to Convocation are friendly, serious, semi-secret

service types. They have “eyes” on the Mace at all times. During rehearsal, the Secretary is taught how to hold the object, how its cradle works, and how one should walk with it. Suddenly, one realizes this is serious and meaningful. Convocation and the Mace must be treated with respect.

Rehearsal over, the Mace is carefully placed back in its protective container and continues to be guarded against harm. As I surrendered it to its caretakers, I was reluctant to give it up for a reason I couldn't articulate at the time.

The time before Convocation passes much more quickly than one imagines. Initiates, Governors, Regents, Officers soon descend upon the robing area. The air is crackling with anticipation. One can feel the pride and sense of accomplishment of the Initiates, the sense of duty of the College officials. All are bathed in a rare bonhomie that comes with such celebrations of excellence in scholarship and principle.

For those leading the procession, there are signs with our names taped to the floor to assure we proceed in the proper order. During the 30 minutes or so before the Mace is handed to the Secretary, the weight of it begins to have an effect. ACS Executive Director



Dr. Hughes carries The Great Mace, fronting the procession of ACS leaders in the 2022 Convocation ceremony



The excitement from Dr. Hughes is unmistakable as then-ACS President Julie Frieschlag, MD, FACS, expresses, "It's wonderful to be back in person!"

and CEO Patricia L. Turner, MD, MBA, FACS, comes over and gives the Secretary encouragement that all will go smoothly. One knows that in a few minutes it will again be placed in one's hands and that this is no drill, no rehearsal. The Mace will be presented to 2,000 people and 1,100 or more new Initiates will become Fellows of the ACS, which has been an adventure of at least 13 years of study, joy, tears, and sacrifice. That is what Convocation represents. For many, they have traveled from all corners of the globe to have this almost sacred moment.

The music starts and the Initiates begin their procession. The entry of 1,100 people takes a bit of time. All the while, the Secretary is holding what is probably only 20 or 25 pounds of gleaming metal, but as the minutes pass, one realizes that weight is going to be with one for a while, and the minutes begin to become long.

Both too quickly and too slowly the moment comes when the Mace is visible to the audience. Nothing prepares one for that moment. The instant before, the Secretary is just an honorific person and, in the next instant, becomes the bearer of the symbol representing all the effort of the surgeons, their parents, significant loved ones, children, and their teachers.

It seems everyone in the enormous hall has a camera. They take picture after picture as the Mace proceeds up the aisle, and they don't stop anytime the Mace is in motion. The longest moment is when the national anthems of Canada and the US are played. The Secretary stands there at center stage holding the Mace. The weight grows heavier, and the Secretary feels

almost invisible knowing that the eyes of the multitude are on the Mace, not the person holding it.

The proceedings move on. Great words are spoken. Initiates become Fellows. Fine surgeons are recognized. The great moment for the person who is becoming President arrives, and the inspiring words of the speech are spoken. The closing music begins to play. The Mace moves again. Just as before—more pictures. The Secretary begins to feel the weight lifting. The Mace was not dropped. Happiness is palpable throughout the crowd.

In the robing area, Regents, Officers, Past Presidents press forward to view the Mace and touch it for a moment. Kathryn D. Anderson, MD, FACS, FRCS, who was both a previous Secretary and President of the ACS, asks to hold it one more time. Of course. Even more pictures are taken; then all too soon the guardians come forward to place the Mace back into its private realm until next year. This time I really don't want to let go. Like Tolkien's ring, it has taken a certain power over me. It was my precious for a short time. The feeling is too visceral to truly describe. I take joy that others will soon have the same experience, and now I share something with all the past Secretaries of the ACS. I will never look at the Mace in the same way again. I now know the power of so profound a symbol and am grateful to have been its keeper for a few moments. ♦

Note: See related video at youtu.be/2J_rfg9nqI4 or scan the QR code.





Henri R. Ford, MD, MHA, FACS, FRCS, FAAP, Is ACS President-Elect



Dr. Henri Ford

World-renowned pediatric surgeon and prolific physician-scientist Henri R. Ford, MD, MHA, FACS, FRCS, FAAP, is the 2022–2023 President-Elect of the ACS. His election was announced at Clinical Congress 2022 during the Annual Business Meeting of Members, where the First Vice-President-Elect and Second Vice-President-Elect also were announced.

Dr. Ford—an international authority on necrotizing enterocolitis, a lethal disease that causes inflammation of intestinal tissue in premature infants—is dean and chief academic officer at the University of Miami Leonard M. Miller School of Medicine, FL. He previously served as senior vice-president and chief of surgery at Children’s Hospital Los Angeles (CHLA), CA, and vice-dean of medical education at the Keck School of Medicine of the University of Southern California (USC) in Los Angeles. Dr. Ford was a professor and surgeon-in-chief at the University of Pittsburgh School of Medicine and Children’s Hospital of Pittsburgh, PA, before joining CHLA.

An ACS Fellow since 1996 and the 2022 recipient of the Owen H. Wangensteen Scientific Forum Award, Dr. Ford has a long and distinguished history of service to the ACS. He was on the ACS Board of Regents (BoR) from 2012 to 2021. In addition to being an ACS Regent, he served 4 years (2017–2021) as Chair of the ACS Program Committee, which is responsible for planning and implementing ACS continuing educational offerings presented during the annual ACS Clinical Congress.

Dr. Ford also served as a liaison for the ACS Advisory Council for Pediatric Surgery, was Chair of the

“We must affirm our relevance and exert our influence by taking the lead on issues that affect the national healthcare agenda, fighting for health equity, and promoting a more diverse surgical workforce. My job is to empower and inspire others to achieve their best.”

—Henri Ford, MD, MHA, FACS, FRCS, FAAP

ACS Ethics Committee, as well as the Past-Chair of the Nominating Committee and Past-Vice-Chair of the ACS Board of Governors (BoG). During his tenure with the Ethics Committee, Dr. Ford co-drafted the “American College of Surgeons Call to Action on Racism as a Public Health Crisis: An Ethical Imperative” in response to the civil unrest that gripped the nation in the wake of the killings of Ahmaud Arbery, Breonna Taylor, and George Floyd in 2020. This call to action led to the establishment of the Anti-Racism Committee by the BoR.

“My extensive record of service to the ACS has given me a unique perspective on its critical importance as the unified and powerful voice representing more than 84,000 ACS members in the US and around the world,” Dr. Ford said. “It is a distinct privilege to serve our members and this wonderful organization as President-Elect.”

Career Highlights

Born in Port-au-Prince, Haiti, Dr. Ford moved with his parents to Brooklyn, NY, as a teenager. He excelled at school and received a full scholarship to Princeton University, NJ.

At Princeton, his interest in medicine burgeoned, and he graduated cum laude with a bachelor of arts degree in 1980. Dr. Ford then entered Harvard Medical School in Boston, MA, where he received his medical degree in 1984. He completed his surgical internship and residency at NewYork/Presbyterian-Weill Cornell Medical College in New York City.

Inspired to pursue a career in academic surgery, Dr. Ford also completed a research fellowship in immunology at the University of Pittsburgh School of Medicine and a clinical fellowship at the Children’s Hospital of Pittsburgh. In addition, he received a master of health administration from USC.

With a strong reputation for mentorship and sponsorship, Dr. Ford is passionate about training the next generation of physicians and physician-scientists. As a scientist, Dr. Ford has conducted groundbreaking research on the pathogenesis of necrotizing enterocolitis, which has led to new insights into the diagnosis, treatment, and prevention of the disease. He is the author of more than 300 publications, book chapters, invited manuscripts, abstracts, and presentations.

Dr. Ford also works to promote health equity and to ensure that diversity, equity, and inclusion are woven into the educational and clinical fabric of medicine. He led the College’s efforts to provide trauma care for children injured during the 2010 earthquake in Haiti, and in 2015, he performed the first successful separation of conjoined twins in Haiti, alongside surgeons he helped train.

Leadership Vision

As President, Dr. Ford will work collaboratively with ACS leadership, the BoR, and the BoG to set strategic priorities for the College, maintaining a cohesive and influential voice nationally and internationally.

“We must affirm our relevance and exert our influence by taking the lead on issues that affect



Dr. Tyler Hughes



Dr. Deborah Kuhls

the national healthcare agenda, fighting for health equity, and promoting a more diverse surgical workforce,” he said. “My job is to empower and inspire others to achieve their best.”

Vice-Presidents-Elect

Tyler G. Hughes, MD, FACS, a clinical professor of surgery and director of medical education at the Kansas University School of Medicine, Salina, is First Vice-President-Elect. A Fellow of the College since 1986, Dr. Hughes has served in several ACS leadership positions and at present is Editor of the ACS Communities. He was instrumental in establishing the Advisory Council for Rural Surgery and chaired the council (2012–2016). He also has served on the BoG (2009–2015) and was a member of the BoG Committee on Socioeconomic Issues, Communications Pillar, Continuing Education Workgroup, Newsletter Workgroup, and Surgical Volunteerism and Humanitarian Awards Workgroup. At the local level, Dr. Hughes is Past-President of the Kansas Chapter of the ACS (2006–2007) and Past-Chair of the Kansas Credentials Committee.

Deborah A. Kuhls, MD, FACS, FCCM, assistant dean for research and professor of surgery, Kirk Kerkorian School of Medicine, University of Nevada, Las Vegas, is the Second Vice-President-Elect. Dr. Kuhls is a trauma surgeon who is board-certified in general surgery and critical care. An ACS Fellow since 2003, she served as president of the Nevada Chapter and chair of the ACS Committee on

Trauma Injury Prevention and Control Committee. She recently co-authored “Mass Shootings in America: Consensus Recommendations for Healthcare Response,” published in the *Journal of the American College of Surgeons* in July 2022, on recommendations to assist healthcare facilities and communities responding to a mass shooting event. Dr. Kuhls is a dedicated researcher and expert on injury prevention whose research interests include injury prevention of all types, such as vehicular crash, firearm, and other violence-related injuries, as well as disaster management, medical education, and the clinical care and outcomes of injured patients. ♦



Honorary Fellowship Is Conferred on 12 Eminent International Surgeons

Honorary Fellowship in the ACS was awarded to 12 prominent surgeons from around the world during the October 16 Convocation at Clinical Congress 2022 in San Diego, CA. The granting of Honorary Fellowships is one of the highlights of Clinical Congress.

Following are summaries of the careers of this year's Honorary Fellows.

View the full citations and sponsors for the Honorary Fellows in the 2022 Convocation program at facs.org/media/lpfdqkx/22_cc_convocationprogram.pdf or scan the QR code.



Mohammad M. Al-Qattan, MD Riyadh, Saudi Arabia

Dr. Mohammad Al-Qattan is a professor of surgery and consultant plastic and reconstructive surgeon at King Saud University in Riyadh, Saudi Arabia, where he previously served as head of the College of Medicine Research Center and the Division of Plastic Surgery.

He also serves as a consultant to National Guard Hospital, King Faisal Hospital and Research Center, and National Care Industrial Hospital, all in Riyadh.

Dr. Al-Qattan has published more than 500 peer-reviewed articles and book chapters and has received more than 90 awards, mainly for presentations of his clinical work. He also owns a US patent for a device he invented to perform sutureless repair of nerve injury. He has served on editorial boards and held visiting professorships in the Middle East, Europe, Asia, and the US, and he is a member of numerous specialty organizations.

Ines Buccimazza, MBChB, FCS(SA), FACS Durban, South Africa

Dr. Ines Buccimazza is a senior specialist in the Department of Surgery at the Nelson R. Mandela School of Medicine at the University of KwaZulu-Natal in Durban, South Africa. She also heads the Clinical Unit of Breast and Endocrine Surgery at Inkosi Albert Luthuli Central Hospital in Durban, where she leads the Breast Multidisciplinary Team meetings. In addition, Dr. Buccimazza chairs the Durban Breast Cancer Forum, is a council member and past-president of The Surgical Research Society of Southern Africa, and a council member and past-treasurer of Breast Surgery International.



Dr. Mohammad Al-Qattan



Dr. Ines Buccimazza



Dr. Reinhold Ganz



Dr. Fernando Rodriguez Montalvo

Dr. Buccimazza is an ACS Fellow, a board examiner for the College of Surgeons of South Africa, and an ACS Advanced Trauma Life Support® course director for South Africa. Dr. Buccimazza recently was elected president of the Association of Surgeons of South Africa.

Reinhold Ganz, MD Gümligen, Switzerland

Dr. Reinhold Ganz is internationally recognized as an innovator and pioneer in hip preservation surgery. He has had a 34-year career in the Department of Orthopedic Surgery at the University of Bern in various positions, from resident to chief of staff to professor and chair.

Dr. Ganz has authored or coauthored approximately 550 peer-reviewed articles for scientific publications and is the recipient of many international awards, including membership in the Swiss Academy of Medical Sciences, the Arthur Steindler Award from the Orthopaedic Research Society, the John Charnley Medal, the King Faisal International Prize for Medicine, and the Lifetime Achievement Award of The Hip Society.

Fernando Rodriguez Montalvo, MD, PhD, FACS Caracas, Venezuela

Dr. Fernando Rodriguez Montalvo is a retired general surgeon who has dedicated much of his work to trauma surgery in Venezuela and has taught hundreds of residents in that country.

Over the years, Dr. Rodriguez Montalvo has held many positions at the Dr. Domingo Luciani Hospital in Caracas, including assistant professor of surgery, chief of staff, postgraduate director, and professor of

surgery. In 1990, he founded the trauma unit, which carries his name, and helped develop a fellowship in trauma surgery, the only one in Venezuela.

An ACS Fellow since 1983, Dr. Rodriguez Montalvo also is a member of the Venezuelan Surgical Society, Venezuelan Oncological Society, Panamerican Trauma Society, and International Hepato-Pancreato-Biliary Association.

Marco Montorsi, MD Milan, Italy

Dr. Marco Montorsi is a professor of surgery and rector of Humanitas University in Milan, Italy, and has served as president of the Italian Society of Surgery. He also has held leadership positions in European academic surgery. Dr. Montorsi has been appointed to Italy's National Observatory for Medical Residency Training by the Minister of University and Research and as a member of the Superior Council for Health by the Minister of Health.

Dr. Montorsi was head of the Hepatobiliary Surgery Unit at San Paolo Academic Hospital in Milan for 8 years and has served as the head of the General Surgery Unit at Humanitas Research Hospital in Milan since 2004. Since December 2011, he also has been the director of the Department of General Surgery at Humanitas.

Graham L. Newstead, MBBS, FACS, FRACS, FRCS Randwick, Australia

Dr. Graham Newstead is a retired colon and rectal surgeon in Sydney, Australia, who is commonly credited for helping launch colon and rectal surgery as a specialty in Australia.



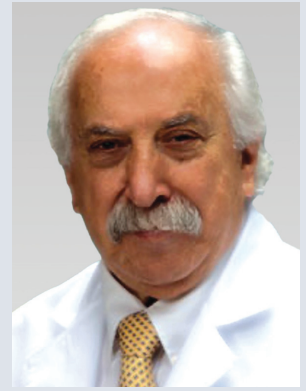
Dr. Marco Montorsi



Dr. Graham Newstead



Dr. Paulina Salminen



Dr. Samuel Shuchleib Chaba

A member of the teaching faculty at the University of New South Wales from 1975 through 2014, Dr. Newstead is now an adjunct associate professor of surgery at the university.

In Australia, he established the Bowel Cancer Foundation, Bowel Cancer Coalition, International Council of Coloproctology, and, jointly, the Colorectal Surgical Society of Australia and New Zealand. Dr. Newstead also founded the Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy. He was program chair for the 4th World Congress of Coloproctology Tripartite Colon and Rectal Meeting in Australia and the International Council of Coloproctology Training and Standards meeting in 2007 and 2008.

Paulina Salminen, MD, PhD Turku, Finland

Dr. Paulina Salminen has been a professor of surgery at the University of Turku, Finland, since 2019 and chief of surgery at Turku University Hospital since 2013.

Dr. Salminen has had a distinguished career as a clinical researcher. She is internationally recognized for serving as the principal investigator for six large, externally funded, multicenter randomized controlled trials, five of which address the optimal management of appendicitis and associated complications, and one which investigated the optimal surgical management of morbid obesity.

She has served as president of the Finnish Surgical Society, Finnish Society of Gastroenterology, and Finnish Digestive Surgeons. She is president of the Finnish Association of Bariatric and Metabolic Surgery, as well as a member of the executive board for the International Federation for the Surgery of Obesity and Metabolic Disorders.

Samuel Shuchleib Chaba, MD, FACS Mexico City, Mexico

Dr. Samuel Shuchleib Chaba is a general and endoscopic surgeon at the American British Cowdray Medical Center in Mexico City, Mexico.

Dr. Shuchleib Chaba often is credited with introducing and promoting laparoscopic and minimally invasive surgery in Mexico and throughout Latin America. He has served as a president and is one of the founding members of the Mexican Association of Endoscopic Surgery. He founded the *Mexican Journal of Endoscopic Surgery* in 2000. He was the executive director of the Latin American Federation of Surgery from 2005 to 2017 and presided over the scientific committee of two World Congresses of the International Federation of Societies of Endoscopic Surgeons.

An active ACS Fellow since 1981, Dr. Shuchleib founded the annual, well-attended Latin American Day at Clinical Congress, which features Spanish-language sessions.

Antonio Jose Torres, MD, PhD, FACS Madrid, Spain

Dr. Antonio Jose Torres is chief of the Department of Surgery at San Carlos Clinical Hospital in Madrid, Spain, and professor of surgery at the Complutense University of Madrid since 1995.

Dr. Torres has authored or coauthored approximately 300 peer-reviewed articles for scientific publications, 125 textbook chapters, and 29 books. He serves as principal investigator in numerous studies. He is a member of 28 national and international professional associations, including serving at present on the board of trustees for the International Federation for the Surgery of Obesity and Metabolic Disorders.



Dr. Antonio Jose Torres



Dr. Petr Tsarkov



Dr. Laura G. Viani



Dr. Peter-John Wormald

A Fellow of the ACS since 1998, he has served as President and Governor of the Spain Chapter of the ACS and was selected as an International Visiting Scholar to the College in 1994.

Petr Tsarkov, MD, PhD

Moscow, Russia

Dr. Petr Tsarkov is director of the Clinic of Colorectal and Minimally Invasive Surgery and chair of the Education Department of Surgery at Sechenov First Moscow State Medical University in Russia, a position he has held since 2013.

Dr. Tsarkov pioneered extended lymph node dissection for colorectal cancer in Russia, as well as extensive surgery for locally advanced and recurrent rectal cancer.

Dr. Tsarkov has been a visiting professor at multiple institutions around the world and is a winner of the Russian government award for developing innovative treatments for rectal cancer. He is the founding member and chair of the Russian Society of Colorectal Surgeons and director of the International Russian School of Colorectal Surgery conference, held annually in Moscow.

Laura G. Viani, BA, BCh, BAO,

DMMD, MSc, FRCSI

Dublin, Ireland

Dr. Laura Viani has been president of the Royal College of Surgeons in Ireland (RCSI) since June 2022. She is a consultant otolaryngologist and neurotologist to Beaumont Hospital and Temple Street University Children's Hospital in Dublin, Ireland.

She established the Republic of Ireland's first and only cochlear implant program in 1995, which has

grown to become the National Hearing Implant and Viani Research Centre. This standalone department at Beaumont Hospital cares for children and adults with severe-to-profound hearing loss from all over Ireland. She established the multi-institutional Hearing Research Centre, comprising professionals from Beaumont and Temple Street Hospitals, the RCSI, and Trinity College Dublin, each in Dublin. She also established research collaborations with Vanderbilt University in Nashville, TN.

To date, she has performed more than 2,000 cochlear implants in profoundly deaf children and adults.

Peter-John Wormald, MD, MBChB,

FAHMS, FRACS, FCS(SA), FRCS(Ed)

North Adelaide, Australia

Dr. Peter-John Wormald is a professor and chairman of the Department of Otolaryngology-Head and Neck Surgery at the University of Adelaide based at The Queen Elizabeth Hospital and the Royal Adelaide Hospital in Australia. He has held that position since 1998. He has worked as a consultant surgeon, professor, and fellow at medical institutions in the UK, Australia, and Hong Kong.

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Governors Survey Probes Telehealth, Microaggressions, Training, Private Practice



by

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Editor's note: The ACS Board of Governors (BoG) is the representative body of the ACS, and its members serve a critical role as liaisons between the Board of Regents and Fellows. The BoG conducts an annual survey of its domestic and international members in an effort to provide feedback to College leadership on matters of importance to surgeons.

This article provides an overview about matters related to current practice and training as a result of a 2021 survey. More in-depth results have been shared with ACS leadership, and discussions will continue on behalf of members to help shape the College's priorities and efforts. The 2022 ACS Leadership Survey is being conducted this fall. Results will be reported in 2023.

The 2021 ACS BoG survey was conducted in July and August 2021 and had a 95% (277/292) response rate. Respondents were predominantly male (78.7%), White (71.5%), based in the US (79.1%), between the ages of 51 and 65 years old (65.7%), and in full-time academic practice (63.2%).

Survey questions focused on the use of telehealth, experiences regarding microaggressions and harassment, opinions on the surgical training paradigm in the US, and the status of surgical private practice.

Telehealth

The use of telemedicine has increased significantly since the start of the COVID-19 pandemic. Approximately 79% of Governors reported that they have used telemedicine (both audio and video) since the start of the pandemic; this finding was similar across age groups. In the outpatient setting, telemedicine was used more commonly for routine follow-up of simple operations or with known patients. In all categories, telemedicine was used least often for complicated postoperative patients (see Table 1, page 44). It also was less commonly used for managing inpatients, including intensive care unit (ICU) patients and rehabilitation patients; for other clinical activities, such as responding to patient inquiries or staff providing home health services; or in responding to requests from a colleague in the operating room (OR) (see Table 2, page 44).

Approximately 28% of respondents said that they restricted and/or were planning to restrict telemedicine use for certain types of patients. Additionally, 35% of respondents reported that they currently had and/or were planning

TABLE 1.

During the previous 15 months, how often did you use telemedicine (both audio and video) for patient evaluation/management of outpatients?

Telemedicine use	Never	Rarely	Sometimes	Very often	Always
Follow-up of known patients	2.29%	16.06%	47.71%	32.57%	1.38%
Simple, straightforward postop patients	8.72%	18.81%	43.58%	25.69%	3.21%
New outpatient referrals	28.44%	27.06%	32.57%	11.47%	0.46%
Complicated postop patients	53.67%	26.15%	16.51%	2.75%	0.92%

TABLE 2.

During the previous 15 months, how often did you use telemedicine (meaning both audio and video) for patient evaluation/management of other clinical activities?

Telemedicine use	Never	Rarely	Sometimes	Very often	Always
Requests from the OR from a colleague	81.65%	12.39%	5.96%	0%	0%
ICU patients (including using an eICU model)	90.37%	4.13%	3.67%	1.38%	0.46%
Patient inquiries via your office telephone	46.79%	16.06%	29.82%	6.88%	0.46%
Patients receiving/staff providing home health services	61.47%	22.02%	14.68%	1.83%	0%
Extended care patients, inpatient rehab facility patients (either to see the patient or from their staff asking queries)	72.94%	15.60%	9.63%	1.83%	0%

Percentages may not total 100% due to rounding.

to have a facet of their practices routinely conducted through telemedicine.

When asked which patients would be challenging to evaluate or communicate with using telemedicine, respondents identified new patients, those with complex and urgent/emergent needs, patients requiring a physical exam (especially anorectal, genital, breast, ear, or ophthalmologic), elderly individuals, and those who have language barriers.

Responses to questions about telehealth did not seem to differ significantly by age or gender; however, international respondents reported using telemedicine slightly more than their US and Canadian counterparts for patients in the inpatient, emergency department, ICU, and OR settings, as well as for patients in extended care and rehab

facilities. Telehealth also was used for patient telephone calls to the office and patients receiving/staff providing home health services (see Figure 1, page 45).

A majority (58.8%) of Governors asserted that reimbursement should be the same for both in-person and telemedicine visits, while 35.4% noted reimbursement for in-person visits should be higher than for telemedicine visits, and 5.8% noted reimbursement for telemedicine visits should be higher than for in-person visits.

Respondents indicated strong support for the ACS to lobby for telemedicine coverage for established and new patient encounters by all public and private payer sources in the future. Additionally, many Governors said it was important for the ACS

FIGURE 1.
Telemedicine Used for Extended Care, Inpatient Facility Rehab

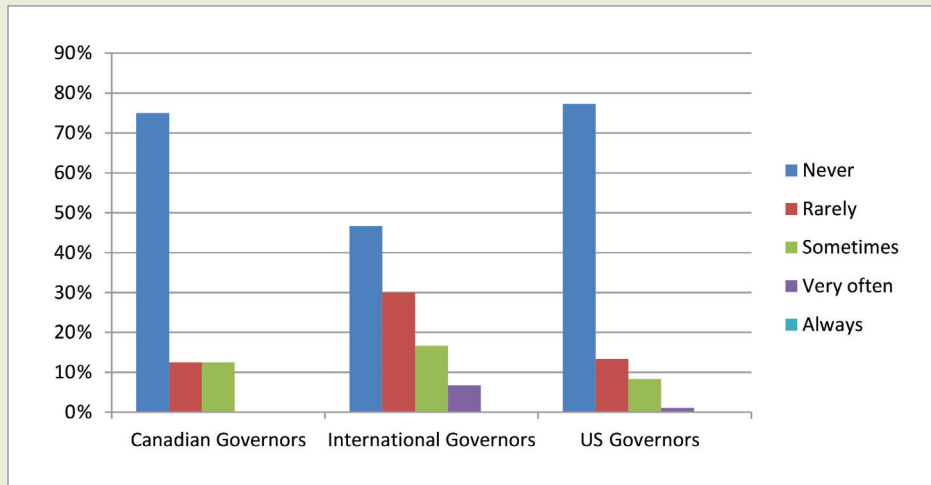


TABLE 3.
Indicate Level of Importance for Advocacy Efforts, Other Topics

	Not at all important	Slightly important	Moderately important	Quite important	Essential
How important is it for the ACS to lobby for telemedicine (audio and video) of established patient encounters to be covered by all public and private payer sources in the future?	3.25%	12.64%	21.30%	31.41%	31.41%
How important is it for the ACS to lobby for telemedicine (audio and video) involving new patient encounters to be covered by all public and private payer sources in the future?	8.66%	13.00%	27.80%	21.66%	28.88%
How important is it for the ACS to better define optimal methods for using telemedicine (including audio and video)?	2.89%	11.55%	31.41%	26.71%	27.44%
How important is it for the ACS to better clarify ethical concerns for using telemedicine (including audio and video)?	6.14%	13.00%	27.44%	24.19%	29.24%

to better define optimal methods and clarify ethical concerns for telemedicine use (see Table 3, this page).

DEI

The survey found that some of the more common challenges faced by surgeons related to diversity, equity, and inclusion (DEI) included harassment and

microaggressions. While many traits, behaviors, and actions can be the target of harassment and/or microaggressions, this survey focused on gender and race.

Gender-based harassment was defined explicitly as "...verbal and non-verbal behaviors that convey hostility, objectification, exclusion, or second-class status based on gender." The questions referred to the respondents' experiences over the past year.

TABLE 4. GENDER-BASED HARASSMENT

In the past year, how often have you experienced harassment due to your gender?

Gender	Never	Rarely	Sometimes	Very often	Always
Male	79.82%	15.14%	4.59%	0.46%	0%
Female	26.32%	28.07%	31.58%	10.53%	3.51%
Prefer not to answer	0%	100%	0%	0%	0%
Total	68.48%	18.12%	10.14%	2.54%	0.72%

In the past year, how often have you witnessed harassment based on gender?

Gender	Never	Rarely	Sometimes	Very often	Always
Male	41.28%	37.61%	19.72%	1.38%	0%
Female	21.05%	28.07%	35.09%	12.28%	3.51%
Prefer not to answer	0%	100%	0%	0%	0%
Total	36.96%	35.87%	22.83%	3.62%	0.72%

TABLE 5. GENDER-BASED MICROAGGRESSIONS

In the past year, how often have you experienced microaggressions due to your gender?

Gender	Never	Rarely	Sometimes	Very often	Always
Male	68.81%	19.27%	10.55%	1.38%	0%
Female	15.79%	15.79%	42.11%	21.05%	5.26%
Prefer not to answer	0%	0%	100%	0%	0%
Total	57.61%	18.48%	17.39%	5.43%	1.09%

In the past year, how often have you witnessed microaggressions based on gender?

Gender	Never	Rarely	Sometimes	Very often	Always
Male	31.19%	41.74%	23.85%	3.21%	0%
Female	10.53%	15.79%	42.11%	26.32%	5.26%
Prefer not to answer	0%	0%	100%	0%	0%
Total	26.81%	36.23%	27.90%	7.97%	1.09%

Percentages may not total 100% due to rounding.

TABLE 6. RACE-BASED MICROAGGRESSIONS

In the past year, how often have you experienced microaggressions due to your race?

Race	Never	Rarely	Sometimes	Very often	Always
American Indian or Alaska Native	50.00%	50.00%	0%	0%	0%
Asian	34.04%	29.79%	29.79%	6.38%	0%
Black or African American	14.29%	21.43%	28.57%	35.71%	0%
Native Hawaiian or other Pacific Islander	0%	100%	0%	0%	0%
White	72.73%	18.18%	9.09%	0%	0%
Prefer not to answer	52.94%	23.53%	17.65%	5.88%	0%
Total	62.09%	20.94%	13.72%	3.25%	0%

In the past year, how often have you witnessed microaggressions due to race?

Race	Never	Rarely	Sometimes	Very often	Always
American Indian or Alaska Native	50.00%	50.00%	0.00%	0.00%	0%
Asian	21.28%	27.66%	40.43%	10.64%	0%
Black or African American	7.14%	21.43%	28.57%	42.86%	0%
Native Hawaiian or other Pacific Islander	0%	100%	0%	0%	0%
White	38.38%	32.83%	25.76%	2.02%	1.01%
Prefer not to answer	17.65%	29.41%	47.06%	5.88%	0%
Total	32.85%	31.77%	28.88%	5.78%	0.72%

Men were more likely to report having witnessed harassment based on gender than having experienced it, but women reported very similar rates of experiencing and witnessing gender-based harassment. A majority of men (79.8%) reported “never” experiencing harassment based on their gender compared to only 26.3% of women, and approximately 14% of women reported experiencing gender-based harassment “very often” or “always” compared to only 0.5% of men (see Table 4, page 46).

In this survey, microaggressions were defined explicitly as “...subtle snubs, slights, and insults directed towards minorities, women, and other stigmatized groups that implicitly communicate hostility.”

Men were more likely to have witnessed microaggressions based on gender than experienced them, but women reported very similar rates of experiencing and witnessing microaggressions (see Table 5, page 46). A majority of men (68.8%) reported “never” experiencing microaggressions based on their gender, whereas only

TABLE 7. GENDER-BASED MICROAGGRESSIONS, BREAKDOWN BY RACE

In the past year, how often have you experienced microaggressions due to your gender?

Race	Never	Rarely	Sometimes	Very often	Always
American Indian or Alaska Native	50.00%	50.00%	0%	0%	0%
Asian	48.94%	23.40%	17.02%	10.64%	0%
Black or African American	28.57%	14.29%	42.86%	14.29%	0%
Native Hawaiian or other Pacific Islander	100%	0%	0%	0%	0%
White	61.62%	18.18%	14.65%	4.04%	1.52%
Prefer not to answer	47.06%	11.76%	35.29%	5.88%	0.00%
Total	57.40%	18.41%	17.69%	5.42%	1.08%

In the past year, how often have you witnessed microaggressions based on gender?

Race	Never	Rarely	Sometimes	Very often	Always
American Indian or Alaska Native	50.00%	50.00%	0.00%	0.00%	0.00%
Asian	23.40%	21.28%	42.55%	12.77%	0.00%
Black or African American	0%	35.71%	28.57%	35.71%	0.00%
Native Hawaiian or other Pacific Islander	100%	0%	0%	0%	0%
White	28.79%	39.90%	24.24%	5.56%	1.52%
Prefer not to answer	23.53%	35.29%	35.29%	5.88%	0.00%
Total	26.71%	36.46%	27.80%	7.94%	1.08%

Percentages may not total 100% due to rounding.

15.8% of women reported never experiencing them. Approximately 26.3% of women reported experiencing microaggressions “very often” or “always” compared to only 1.4% of men.

Both genders were more likely to have witnessed than experienced racism (defined in this study as “...prejudice against someone because of their race, when those views are reinforced by systems of power”) and microaggressions due to race. With most respondents identifying as White, this result is not unexpected.

A majority of men (65.6%) reported “never” experiencing microaggressions based on their race, whereas only 17.5% of women did. A similar percentage of men

(3.2%) and women (3.5%) reported experiencing microaggressions due to their race “very often” or “always.”

When analyzing by race, however, only 14.3% of Black Governors reported “never” experiencing microaggressions based on their race, and 35.7% reported experiencing microaggressions based on race “very often” or “always.” A higher rate of Black respondents reported experiencing microaggressions based on race “very often” or “always” in the past year (see Table 6, page 47).

In fact, 42.9% of Black respondents reported that over the past year they had witnessed microaggressions based on race “very often” and only 7.1% indicated that they “never” did (see Table 6, page 47). Similar

TABLE 8.
What Should a Surgical Readiness Rotation Include?

Starting IVs	76.32%
Placing NG tubes	82.89%
Placing Foley catheters	80.92%
Identification and initial treatment of shock	89.47%
Identification and initial treatment of pulmonary embolus	69.08%
Identification and initial treatment of sepsis	82.89%
Identification and initial treatment of ACS/MI	65.13%
Knot tying	89.47%
Suturing	90.13%
Sterile technique	94.08%
Other (please specify)	26.32%

responses were given for those regarding microaggressions based on race.

Importantly, Asian and Black respondents were more likely to report having “very often” experienced or witnessed microaggressions based on gender than did other racial groups (see Table 7, page 48). An attempt to further analyze the responses in the context of intersectionality was limited by the very small numbers of respondents in some of the intersections of gender and race.

Age did not seem to have a significant correlation with experience or witnessing of racism, gender-based harassment, or microaggressions based on gender or race.

Overall, microaggressions based on gender and race, gender-based harassment, and racism were reported as being witnessed more often than experienced, but all of these behaviors are occurring at rates higher than desired. Respondents indicated the ACS could reduce gender-based inequities and racism in surgery by promoting increased awareness and education, as well as transparency.

Surgical Training

Over the past several years, a resurgence in discussion about surgical training paradigms in the US has occurred. Concerns have included:

- Depth and breadth of experiences in medical school (especially in the fourth year)
- Impact of duty-hour restrictions on surgical residents
- Decrease in resident autonomy during training
- Best incorporation of new techniques and technologies into practice once surgeons have completed their formal training

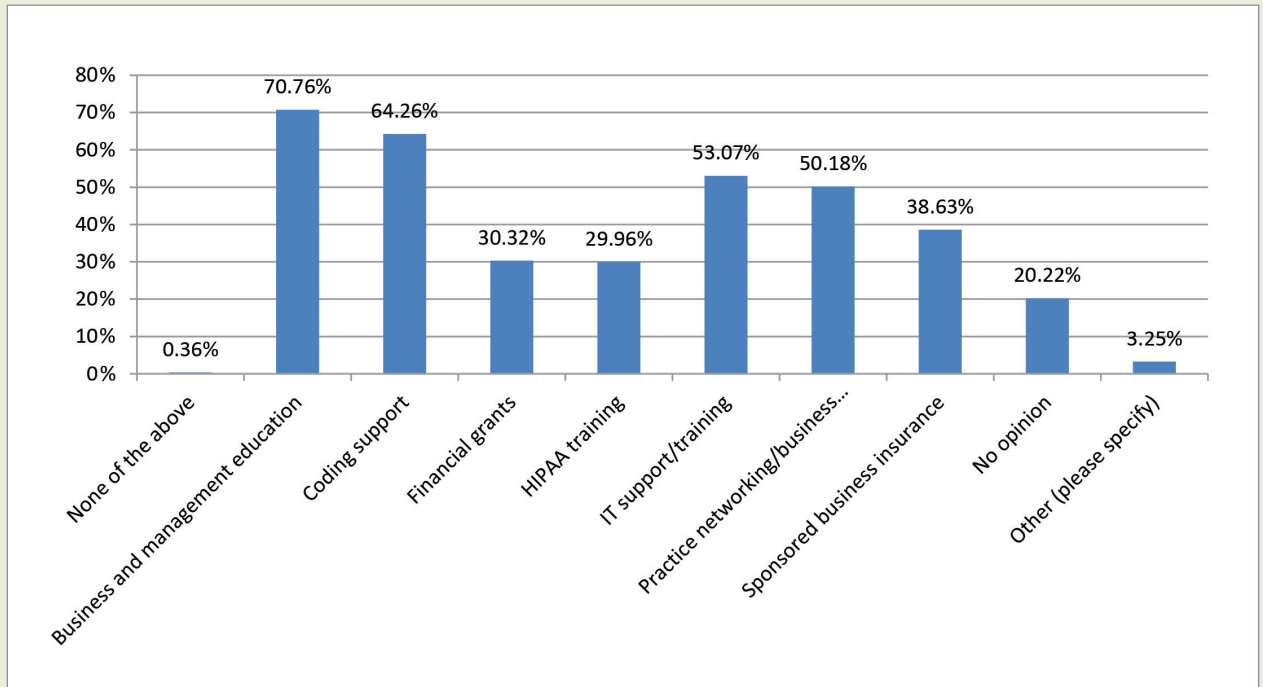
As a result, the survey included questions about surgical training in medical schools, residency, and practice. Approximately 55% of Governors indicated that medical schools should require a surgical readiness rotation before advancing to a surgical residency. Approximately 18% “disagreed,” and approximately 27% were “unsure.”

Respondents younger than 51 years old were more likely to support such a requirement than those aged 51 and older. Of the 54 respondents younger than age 51, 36 (67%) favored such a requirement, seven (13%) opposed it, and 11 (20%) were unsure. Among the 223 respondents ages 51 and older, 116 (52%) reported being in favor of such a requirement, 42 (19%) were opposed, and 65 (29%) were unsure.

The survey included questions regarding which areas should be covered in a “surgical readiness

FIGURE 2.

Which of the following ACS programs/resources do you think would be valuable to those in private practice?



rotation” (see Table 8, page 49) and made an open-ended inquiry as to what other topics should be included in the rotation. The areas that most respondents noted should be part of this educational experience included sterile technique (94%), suturing (90%), knot tying (89%), and identification and initial treatment of shock (89%).

When asked about the ACS, the Association of Program Directors in Surgery, and the Association for Surgical Education Resident Prep Curriculum, most (67%) reported that they were unaware of it:

- 38% were unaware but interested in knowing more
- 29% were unaware and not interested in knowing more
- 17% were aware of the program and had used it
- 13% were aware of the program and indicated that they may use it in the future
- 4% were aware of the program but had no plans to use it

Surgical training is a process of lifelong learning that starts in medical school and continues

throughout a physician’s practice. The surgical training paradigms change and evolve over time, and responses in this survey are consistent with much of the current literature.

Ongoing discussions regarding surgical residency training, the optimal degree of flexibility, and the idea of competency-based education and promotion undoubtedly will continue. This BoG survey reflects a broad spectrum of opinions and, at this time, it is recommended that the ACS act as a facilitator for these ongoing discussions rather than advocating for a single approach.

Private Practice

As the healthcare environment has evolved with time, the models for physician employment also have evolved. A large percentage (41%) of respondents were currently or had previously been in private practice, and most (71%) of them indicated that they would choose private practice again. A significantly lower percentage (14.9%) currently in full-time academic practice responded that they would choose private practice again.

ACS PRACTICE PROTECTION COMMITTEE RESOURCES

The ACS Practice Protection Committee (www.facs.org/advocacy/practice-protection-committee) is dedicated to the success of practicing Fellows, whether in independent surgical practice or employed practice. The committee directs its efforts toward providing timely information, practical suggestions, and other educational resources to assist Fellows in making well-informed business, professional, and financial decisions. Resources include the following, as well as:

- ACS Employed Surgeon Handbook
- ACS Private Practice Surgeon Handbook
- Commercial Insurance Coverage for Telehealth Services
- Economic Survival Strategies in the COVID World
- Financial Resources Available to Assist Surgeons
- Interviews
- Resource Library
- Webinars

A wide variety of barriers were reported for starting or joining a private practice, including specialty or practice focus, needed business skills, the challenge of building a reputation and developing referral sources, and the overall financial risks.

Nearly half (47.3%) of respondents indicated that the ACS should advocate for a revision of the Stark Law* to allow for more support of private practices, while 13.4% didn't agree, and 39.4% were unsure. The distribution of responses to this question changed somewhat when analyzed by practice type; fewer full-time academic surgeons supporting ACS advocacy for the Stark Law revision.

Respondents indicated that if the Stark Law were revised, hospital-provided electronic health record (EHR) systems would be the most beneficial to sustaining a private practice. It is important to note that in 2020, the Centers for Medicare & Medicaid Services and the Office of Inspector General released final rules amending the regulations to the Stark Law and the Medicare and State Health Care Programs: Fraud and Abuse; Revisions to Safe Harbors Under

the Anti-Kickback Statute and Civil Monetary Penalty Rules Regarding Beneficiary Inducements that facilitated the donations of EHR and cybersecurity technology.

More than 78% of respondents said that it was moderately important to essential for the ACS to develop programs/resources to help sustain surgical private practices. They indicated that the ACS programs/resources related to business and management education and coding support were the most valuable to those in private practice (see Figure 2, page 50).

Survey respondents indicated that it is critical for the ACS to continue assessing and understanding the models of surgical practice and support surgeons in the type of practice best suited to meet their needs and the needs of their patients. The ACS offers many resources across several specialties and is receptive to feedback from Fellows regarding strategies to optimize the utility of these efforts. ♦

*The Stark Law (42 USC 1395nn) is the physician self-referral law which (1) prohibits a physician from making referrals for designated health services payable by Medicare to an entity with which they have a financial relationship; (2) prohibits the entity from presenting claims to Medicare (or billing another individual, entity, or third party payer) for those referred services; and (3) establishes specific exceptions and grants the authority to create regulatory exceptions for financial relationships that do not pose a risk of program or patient abuse.

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ACS Quality and Safety Case Studies

Reduction in PONV Leads to Decrease in Emesis, Length of Stay, and Opioid Use in Bariatric Surgery Patients

by Ginny Ledbetter, MSN, APRN, ACNS-BC, CBN, Kaitlin O'Brien, DNP, RN, Hilliary Goode, BS, MSN, CRNA, Patrick D. Walker, PharmD, BCCCP, Alison Partridge, PhD, RN, CPAN, Charles K. Mitchell Jr., MD, FACS, FASMBS, and Bryan K. Thomas, MD

Editor's Note: In early 2021, a workgroup of representatives from the ACS Quality Programs was formed to understand the limitations and barriers to the performance of quality improvement (QI) projects. The workgroup created the QI Framework to facilitate more comprehensive and effective projects. The framework includes eight components and 40 specific criteria to guide a project team through the execution and documentation of QI projects. To help familiarize hospitals with the components and criteria of the QI Framework, it has been retroactively applied to the 2022 Best Practices Case Studies featured in the following case study. While this example does not include all 40 criteria of the QI Framework, it demonstrates how eight components compose a successful QI project. For more information on the ACS Quality Framework, contact ACSQualityFramework@facs.org.

Bariatric surgery inherently is associated with an increased risk of postoperative nausea and vomiting (PONV) compared with other surgical disciplines. In bariatric surgery patients, PONV is cited as one of the most common causes for prolonged lengths of stay (LOS) and unplanned readmissions.¹ A recent position statement published by the American Society for Metabolic and Bariatric Surgery (ASMBS) stated that “there is an urgent need for more research to address the significant problem of PONV in this special population.”² According to the statement, a lack of bariatric specific screening, established management guidelines, and appropriate measurement tools are among the greatest needs.² This situation highlights the need for more research.

After being involved with the Employing New Enhanced Recovery Goals for Bariatric Surgery (ENERGY) Project in 2017, and with the implementation of enhanced recovery after surgery (ERAS)

protocol at Bon Secours St. Francis Hospital in Charleston, SC, the program observed significant improvement in LOS and drastically decreased use of opioids in inpatient and outpatient settings. As the QI team continued to follow the quality data, there was a noted rise in the incidence of PONV in bariatric surgery patients who were experiencing more of these occurrences than the rest of the hospital's surgical population.

A further review of the 2020 data demonstrated a higher rate of PONV and documented emesis in bariatric patients. Patients were having more PONV in the post-anesthesia care unit (PACU) and surgical progressive care unit (SPCU) than other surgery patients.

The goal of this project was to work toward improving the patient experience and decrease PONV and LOS in the bariatric surgery patient in the PACU and SPCU.

Bon Secours St. Francis Hospital is one of four hospitals in the Roper St. Francis Healthcare system. It is licensed for 190 beds and was

The goal of this project was to work toward improving the patient experience and decrease PONV and LOS in the bariatric surgery patient in the PACU and SPCU.

the Lowcountry region's first magnet hospital, designated in 2010 and redesignated in 2015 and 2020. The hospital specializes in neurosurgery, bariatrics, maternity care, and cancer care. Bon Secours St. Francis Hospital is a leader in image-guided, minimally invasive surgeries.

Goal Specification

SMART Goals

Specific: The goal of this project was to decrease PONV in the bariatric surgery patient, both within the PACU and SPCU by December 2021.

Measurable: Data were extracted from a combination of the electronic health records (EHRs) and the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) database.

Achievable: The necessary staff were available to implement this project.

Relevant: Eliminating nausea and vomiting should increase patient satisfaction. Decreasing LOS and readmissions would be a cost savings for both patients and the hospital.

Timely: Project timeline was January 26 through December 31, 2021.

Strategic Planning

Plan Do Check Act (PDCA)

Plan: We identified a subgroup of key stakeholders from the Metabolic and Bariatric Surgery (MBS) committee members and developed a team to evaluate baseline PONV data, review literature, identify opportunities for improvement, and make recommendations for change in our current process. Our team consisted of:

- One general and bariatric surgeon, who was the chief of the Department of Surgery at Bon Secours St. Francis Hospital and medical director of Roper St. Francis Bariatric Surgery and Metabolic Weight Loss Division
- One bariatric surgeon from Bon Secours St. Francis Hospital
- One lead certified registered nurse anesthetist (CRNA) of bariatric and metabolic surgery, Bon Secours St. Francis Hospital
- One bariatric coordinator from Bon Secours St. Francis Hospital
- One pharmacy clinical specialist from Bon Secours St. Francis Hospital
- One quality specialist and metabolic and bariatric surgery

clinical reviewer from Bon Secours St. Francis Hospital

- One quality specialist and research nurse scientist from the Department of Nursing Excellence

In addition to our project team, we have an interdisciplinary MBS committee that meets monthly.

The MBS committee consists of two bariatric surgeons; two obesity medicine physicians; four advanced practice providers; one program coordinator; five dietitians; four representatives from the quality department; four representatives from administration; five anesthesia providers; one pharmacist; one clinical psychologist; representatives from endoscopy, imaging, physical therapy, respiratory therapy, infusion center, physician office, preoperative area, PACU, and the inpatient nursing unit; two representatives from the OR; and four clinical educators.

Do: The CRNA reviewed all charts for patients undergoing bariatric surgery from October to December 2020 who had PONV in the PACU and SPCU. The presence of the PONV was determined by chart review of rescue antiemetics received (ondansetron or promethazine). A literature review also was completed.

The Fourth Consensus Guidelines for Management of PONV, published by the ASER and SAMBA, highlights the importance of a multimodal approach.

The Fourth Consensus Guidelines for the Management of PONV, published by the American Society of Enhanced Recovery and Perioperative Medicine (ASER) and Society for Ambulatory Anesthesia (SAMBA), highlights the importance of a multimodal approach.³ Several therapies with various mechanisms of action are cited but there is a significant lack of evidence highlighting the single best approach.⁴

Fosaprepitant and aprepitant are Neurokinin-1 (NK-1) receptor antagonists and carry a Category A Level 1 recommendation for PONV prophylaxis.³ The decision to trial fosaprepitant over alternative antiemetics with similar quality of evidence stemmed from NK-1 receptor antagonists' proven ability to reduce acute and delayed emesis. In a prospective, double-blind placebo-controlled study of 125 patients undergoing bariatric surgery with Apfel scores ≥ 2 , use of aprepitant was associated with an absolute risk reduction in incidence of vomiting of 11.9%.⁵

In a retrospective chart review of 338 female patients undergoing bariatric surgery, aprepitant was associated with a cumulative reduction in vomiting episodes at 48 hours ($p = 0.04$).⁶ In a retrospective database analysis of four identically designed, double-blind, randomized controlled studies of 171 female patients with Apfel scores ≥ 2 , use

of fosaprepitant demonstrated statistically significant reductions in vomiting episodes at 0–2 hours ($p = 0.002$), 0–24 hours ($p < 0.001$), and 0–48 hours ($p < 0.001$) after surgery.⁷ The ASER/SAMBA guidelines suggest “NK-1 receptor antagonists may be useful when postoperative emesis is highly undesirable, such as in gastric surgery.”³

Findings: All bariatric surgical patients are high risk for PONV as several variables—such as surgical site, mechanical manipulation of stomach, length of surgery, female predominance, and preoperative smoking cessation requirement—make up this risk category.^{8,9}

Process Evaluation

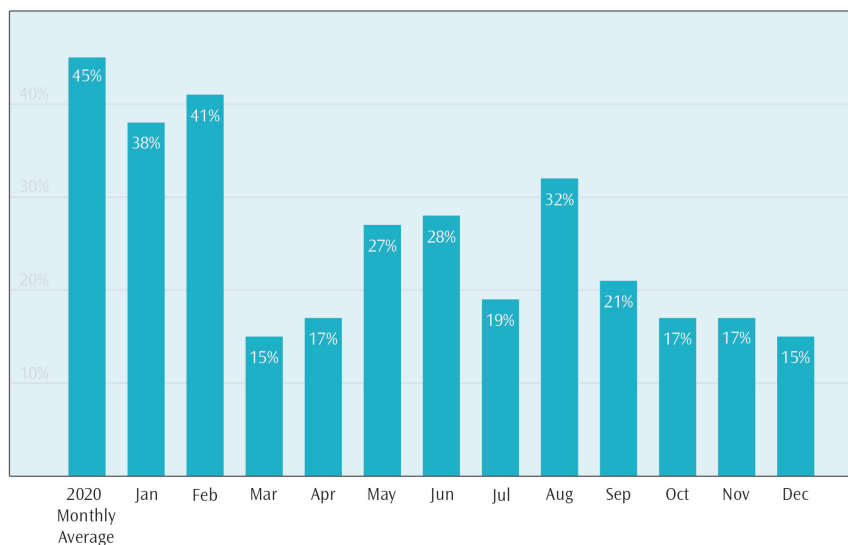
Proposal: Anesthesia proposed the addition of fosaprepitant to our established ERAS PONV prophylaxis protocol. This consisted of preoperative application of a scopolamine patch, IV dexamethasone 8 mg prior to induction of anesthesia, and IV ondansetron 4 mg within 30 minutes of emergence. After literature review and discussion with pharmacy leadership, fosaprepitant use for bariatric cases was implemented in January 2021 with plans for formal review and approval by the pharmacy and therapeutics (P&T) committee after a 3-month trial period. The PONV subgroup met biweekly to review data in

preparation for an April 6, 2021, P&T committee meeting, where key stakeholders were granted formal approval to continue use of fosaprepitant. It was added to the preoperative medication order set and given to all bariatric surgery patients. On December 7, 2021, fosaprepitant was brought back to the P&T committee as a follow-up item to review 6 months of internal data since its implementation as part of the bariatric surgery ERAS protocol.

The QI team created an Excel spreadsheet for data collection. Metrics included postoperative nausea in the PACU and/or SPCU, documented emesis, and drinking within 8 hours of surgery.

- An encounter form was developed to interview each patient. Starting on postoperative day (POD) 1, a PACU nurse would evaluate the patient's PACU experience via interview. On POD 2, an anesthesia provider would perform a follow-up interview to assess for any painful or noxious stimuli throughout the perioperative period.
- Additional follow-up interviews were performed by phone, typically 24 to 48 hours after discharge, to assess the patient's oral intake tolerance.
- All data collected were maintained in an Excel spreadsheet and updated periodically. Members

FIGURE 1. PACU RESCUE ANTIEMETIC PERCENTAGE



of the PONV project team developed a handout highlighting key components within our ERAS protocol and in-services were provided in May 2021 to the ambulatory surgery unit, PACU, and SPCU staff on the overall goals and performance improvement (PI) initiatives.

Several changes were made throughout the project period that could influence outcomes. Effective June 1, 2021, use of a preoperative scopolamine patch was discontinued. This decision stemmed from concerns that scopolamine's anticholinergic effects could pose as a barrier to early ambulation, thus contributing more risk than benefit considering fosaprepitant's implementation. Additional changes included use of an 8 mg dose of ondansetron in the OR rather than 4 mg.

In the early stages of data collection, the team noted that several patients were receiving an additional 4 mg dose in the

PACU and decided to optimize initial ondansetron dose and provide a different drug class in the PACU as a rescue antiemetic. Other changes effective June 1, 2021, included implementation of QueaseEASE aromatherapy in the PACU and SPCU, and adjustment of goal time for postoperative ambulation and oral fluid intake from 8 to 6 hours.

Nurses documented the time that patients left the PACU on the SPCU whiteboard as a visual cue to optimize achievement of time-dependent goals. The QI team worked with pharmacy to develop a bariatric-specific Anesthesia Phase 1 order set for the PACU. It provided guidance for first- and second-line treatment of postoperative pain to decrease opioid use and treatment of postoperative nausea. Components included ketorolac 15 mg IV for pain management, as well as QueaseEASE, promethazine 6.25 mg IV,

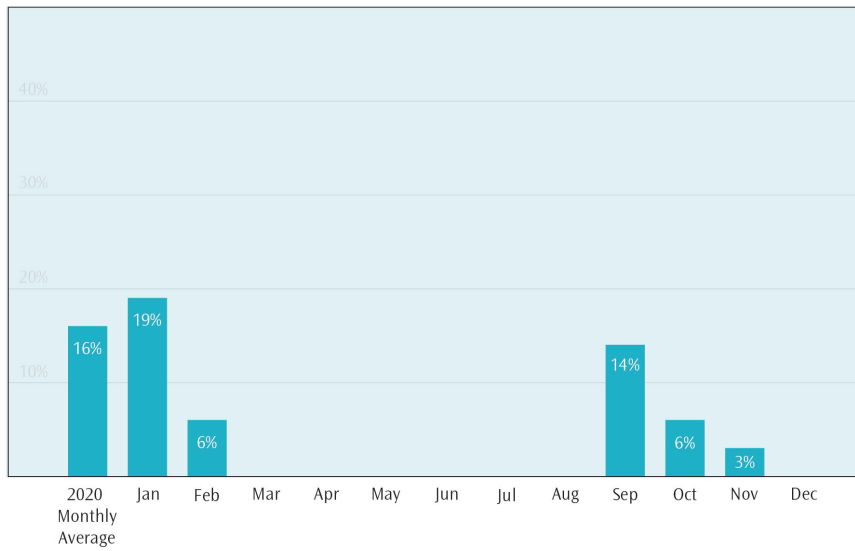
and lorazepam 0.5 mg IV for nausea management.

Outcome Evaluation

Check: PONV was measured using the documented administration of a rescue antiemetic in the PACU or on the inpatient unit in the EHR. Emesis was measured based on documented emesis volume or occurrences in the EHR. Percentage was calculated based on the number of patients that received a rescue antiemetic or had emesis documented divided by the overall bariatric surgical cases each month multiplied by 100.

PONV data were reviewed at the monthly MBS committee meetings. With the implementation of these process changes, the QI team observed a decrease in PONV in the patient population from an average of 45% in 2020 to an average of 24% in 2021, and a decrease in documented emesis from an average of 16% in 2020 to an average of

FIGURE 2. EMESIS DOCUMENTED PERCENTAGE



4% in 2021 (see Figure 1, page 55, and Figure 2, this page).

One surgeon scheduled postoperative ondansetron on the SPCU instead of as needed, which affected the data; as of December 2021, both surgeons prescribed scheduled postoperative ondansetron, and only promethazine was considered a rescue medication.

The addition of fosaprepitant and other interventions described has positively contributed to improved patient outcomes.

Act: We continued to review monthly PONV data at the MBS committee meetings in 2022 and assess for improvement opportunities. We shared data with the units, posting results and showing the success of our interventions.

Setbacks

One anesthesiologist was resistant to the strategy to minimize opioids and continued

to pursue use. All providers are tracked on an Excel spreadsheet. It was decided to exclude this provider from the analysis.

Two physicians prescribed promethazine as PRN. We will perform further analyses to determine which orders were given as needed and given to treat breakthrough.

Throughout this PI project, reeducation was performed to address noncompliance with the PONV protocol. One PACU nurse was providing aromatherapy and administering IV rescue antiemetics concomitantly. Some staff members also did not retrieve preoperative orders, which prompted repeat education.

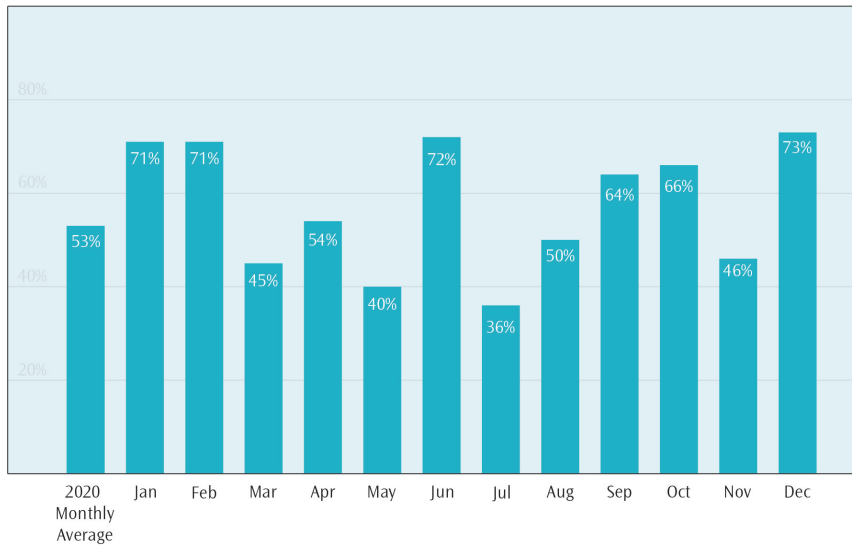
There was a delay to updating the order sets in our EHRs. This potentially served as a barrier since our order sets were not reflective of our PONV protocol when we began our intervention. To prevent a delay in our go-live, we provided education to the PACU nurses and anesthesia on the protocol. This allowed

us to begin implementation before the official order set was established in the system.

Gold standard assessment of postoperative pain or nausea relies on direct patient communication.³ Assessing pain and nausea can be challenging due to its subjective nature as well as the varying degrees of sedation seen in the perioperative period. In review of the baseline data, most patients reported high numeric scores on the pain rating scale and the documentation of an antiemetic to track PONV, which prompted us to evaluate the process. However, the reliability of these data does serve as a limitation.

The timing of our PONV PI project and the implementation of the da Vinci robotic cases also could have served as a limitation, as this procedure can be associated with increased nausea, vomiting, intraoperative time, and anesthesia requirements. Use of da Vinci technology for robotic-assisted surgery began in January. Patients did not

FIGURE 3. FLOOR RESCUE ANTIEMETIC PERCENTAGE



experience increased vomiting despite the longer cases and the implementation of robotic surgery, so there was no observed change in the data.

It cannot be confidently stated that fosaprepitant caused the change or if it was one of the other variables implemented during the project. The use of aromatherapy also was implemented in June 2021. In review, it would have been better if the project was organized differently, with consistent gaps between each intervention.

Cost Evaluation

With an average cost of an RSFH general acute care inpatient day at \$880, by cutting LOS from 2 days to 1 day, there was a potential cost savings in 2021 (332 patients) of \$292,160—or \$880 per patient. While LOS was not reduced to the 1-day goal, LOS was reduced from 2020 to 2021. Using the same volume of patients from 2020

to 2021 (332) with actual LOS data, the potential cost savings from 2020 to 2021 is as follows:

- Roux-en-Y gastric bypass cases: \$20,451.20
- Sleeve cases: \$90,569.60
- The total potential cost savings: \$111,020.80

Cost of Fosaprepitant Implementation

Financial summary:

Annual medication cost with implementation of fosaprepitant is approximately \$15,000 annually.

In selecting a NK-1 receptor antagonist for the Bariatric PONV prophylaxis protocol, the parenteral prodrug formulation, fosaprepitant, was chosen over the active oral formulation, aprepitant, to optimize adherence and avoid potential cost constraints that would be incurred directly by the patient. Since administration

recommendations for PONV prophylaxis is 3 hours prior to induction, aprepitant would require the patient to purchase as an outpatient and self-administer before presenting to the facility for their procedure.

The additional costs associated with PONV were up to 100 times more expensive compared with prophylaxis with generic antiemetic. The cost of treating vomiting was three times more than the cost of treating nausea.

There was no additional funding for this project.

Knowledge Acquisition

Lessons Learned

It is beneficial to have a committed team. For example, the anesthesia team was very involved; they spoke with patients and physically went to the PACU and talked to the nurses. One of the team members previously worked in the PACU and was helpful

Monitoring data is important for continuous improvement. If an issue is found, dig further to determine the cause.

as she knew many of the staff members. The team worked directly with a PharmD, who was integral to the success of this project, a key stakeholder, and part of the committee.

It is important to have a consistent care team. A core set of floor nurses took care of the bariatric patients. While they did not experience any issues on this project, the cohesiveness of the team was addressed early on to make sure the project was being implemented across the board in the same way.

Monitoring data is important for continuous improvement. If an issue is found, dig further to determine the cause. For example, did an anesthesia provider go off protocol? Is it a one-off or a trend?

This project was unique because the team already was involved in bariatric patient care and available, so they did not need to pull in outside resources. The stakeholders were engaged and monthly interdisciplinary meetings were well attended. The data and committee feedback helped inform the process. It is always encouraging when you are trying to make a change and you have interest in and support for the change.

End of Project Decision-Making

The process still is under adjustment, and postoperative preventative pain medication was recently added, which may influence future data.

The research team is reviewing the project process, removing steps, and simplifying the data while ensuring the project is still on track.

The QI team plans to share its results with other service lines. Information about the program has been shared by word of mouth, and this has helped others with an interest in implementation in their programs. The team will continue to monitor and review data on a monthly basis and look for opportunities for improvement. ♦

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ACS Cancer Research Program

New Standards Offer Glimpse of Multidisciplinary Care through the “Lens of the Breast Cancer Patient”

by Jill R. Dietz, MD, MHCM, FACS, Scott H. Kurtzman, MD, FACS, Kathy Yao, MD, FACS, and Judy C. Boughey, MD, FACS

In order to help hospitals and healthcare facilities manage multiple accreditation programs, ACS Quality Programs restructured the standards and procedures to fit into the newly created “Nine Domains” (see Figure 1, page 60). Leaders of the National Accreditation Program for Breast Centers (NAPBC) saw this as an opportunity to rewrite the standards focusing on the patients’ perspectives—an approach that previously had not been considered.

“Standards and guidelines were developed to improve patient outcomes, and were written by physicians, for physicians. While standards do improve patient care, individual patient concerns and goals may not be addressed by physician-focused standards,” said Scott H. Kurtzman, MD, FACS, NAPBC Chair.* “We want each NAPBC center to think about the multidisciplinary care their team provides through the lens of the breast cancer

patient rather than focusing only on the treatment from each provider’s perspective.”

Jill R. Dietz, MD, MHCM, FACS, Chair of the Standards and Accreditation (SA) Committee and lead author of the new standards explains, “Chapter 5, Patient Care: Expectations and Protocols’ has been restructured to focus on the patient journey: diagnosis, evaluation and decision-making, treatment, and post-treatment survivorship and surveillance. Our goal was to remove tedious, check-the-box standards, and instead, emphasize each center’s focus on patient-centric care. Some of the standards are unchanged and relocated to the appropriate chapters in the new Nine Domains format. We also developed additional standards that specifically focus on patient experience.”

The standards rewrite team was composed of multidisciplinary members of the SA Committee, patient advocates, site reviewers, members of the Education and Quality committees, NAPBC leadership, and ACS staff. The rewrite was approached by gathering patient experience data and surveying what centers value from their accreditation status.

This team of multidisciplinary experts met weekly to lay out an ideal patient journey, supplying many examples of exemplary patient care. The group and leadership chose the critical metrics that would be achievable by most accredited sites. The standards went through a public comment period from February 14 through March 7, 2022, and then a revision process, taking into consideration feedback from the accredited centers. The new standards were approved by NAPBC leadership and the board.

By setting standards that were achievable by all centers regardless of center size or resources, the NAPBC standards have successfully raised the bar for care. Early on, the use of image-guided biopsy, case presentation at multidisciplinary tumor boards, and even the use of breast-conserving procedures was inconsistent. Through standard setting, significant progress has been made in multidisciplinary cancer care.

The 2018 Standards are now met by the majority of accredited sites and are no longer serving the original purpose of “raising the bar.” NAPBC leadership

*Miller M, Bleicher R, Kaufman C, et al. Impact of Breast Center Accreditation on Compliance with Breast Quality Performance Measures at Commission on Cancer-Accredited Centers. *Ann Surg Oncol*. 2019;26(5):1202-1211.

FIGURE 1. STANDARDIZED NINE DOMAINS OF THE ACS QUALITY PROGRAMS

- | | |
|--|---|
| 1: Institutional and Administrative Commitment | 6: Data Surveillance and Systems |
| 2: Program Scope and Governance | 7: Quality Improvement |
| 3: Facilities and Equipment Resources | 8: Education: Professional and Community Outreach |
| 4: Personnel and Services Resources | 9: Research |
| 5: Patient Care: Expectations and Protocols | |

felt that it was time to change direction and focus on the patient journey and value-based care, and the improvement aims of the Institute of Medicine *Crossing the Quality Chasm* report.[†] The 2018 standards addressing surgical care are excellent examples of the shift to more contemporary patient-centered measures. Previous surgical standards focused on procedures and thresholds such as percentage of breast conservation versus mastectomy and sentinel node biopsy rates. Recent data have shown high compliance rates with these threshold standards, which suggests mastery of the concepts, making the need to keep those standards outdated.

The surgical section in the new standards asks centers to ensure that patients are involved in the decision-making process and have the education to make the best decisions for their situation.

Additionally, the new surgical standards suggest surgeons should assess preoperative or postoperative patient and environmental factors that could lead to functional or

complicating issues that may require intervention such as lymphedema or mobility concerns. To improve recovery and lessen the chance of patients getting addicted to opioids, the new surgical standards encourage surgeons to use enhanced recovery after surgery (ERAS) protocols and prehabilitation as well as consider alternatives to narcotics for postoperative pain management.

Dr. Kurtzman suggests, “It is easier for centers and site reviewers to have objective, threshold metrics to check off; however, while these metrics previously were useful, many of them do little to improve care today. Implementation of the new standards will require a shift in philosophy. Are programs embracing the spirit of the standard or just checking a box to pass accreditation?”

Randy E. Stevens, MD, a radiation oncologist and NAPBC lead site reviewer explains, “Using this new approach and philosophy rather than being the ‘breast center police,’ the standards and site reviewers have the shared purpose of helping each center provide the best possible care for their patients. Both centers and site reviewers will need education,

bidirectional interaction and feedback, and a prolonged rollout phase to ensure the successful implementation of the new standards.”

ACS senior leadership has supported the development and rollout of the new standards because the approach aligns with many other value-based programs initiated through the College. The new standards were released November 7 but NAPBC centers will not be required to follow them until 2024. Change is difficult, so hopefully centers that embrace the new standards will be at the forefront and ready to transition to value-based reimbursement models. Most importantly, the patient’s journey will be improved. ♦

[†]Institute of Medicine (US) Committee on Quality of Health Care in America. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington (DC): National Academies Press (US); 2001.

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Coding and Practice Management

Coming in 2023:

Extensive Changes for Reporting Anterior Abdominal Hernia Repair

by Megan McNally, MD, FACS, Jayme Lieberman, MD, FACS, and Jan Nagle, MS

Over the years, the Centers for Medicare & Medicaid Services (CMS) and the American Medical Association (AMA) Specialty Society RVS Update Committee (RUC) have identified Current Procedural Terminology* (CPT) codes that are performed less than 50% of the time in the inpatient setting and that include inpatient hospital evaluation and management (E/M) services codes in the CMS physician time and visit database. The intent of this site-of-service anomaly screen was to determine if the work relative value units (wRVUs) for procedures were potentially misvalued because the codes included inpatient E/M visit codes even though the procedures typically were performed in an outpatient setting. The concern was that the payment should reflect the typical patient, and if the typical patient has a facility status of outpatient, then the wRVUs and time/visit database may not include inpatient E/M services codes. The most recent review

*All specific references to CPT codes and descriptions are © 2022 American Medical Association. All rights reserved. CPT is a registered trademark of the AMA.

of codes using the site-of-service anomaly screen identified codes for reporting abdominal hernia repair. The ACS and other stakeholder societies took the following steps to avert potential underpayment for hernia repair procedures resulting from the CMS “typical patient” payment policy.

Site-of-Service Anomaly Screen

The first RUC and CMS review of codes identified by the site-of-service anomaly screen resulted in a 7% to 12% decrease in wRVUs for seven open and laparoscopic hernia repair codes for 2012. More recently, code 49565, Repair recurrent incisional or ventral hernia; reducible, was identified by the RUC as a service performed less than 50% of the time in the inpatient setting that included inpatient hospital E/M service codes and had Medicare utilization of more than 5,000 paid claims. Although only code 49565 was identified under the screen’s criteria, both the RUC and CMS currently require review of all family codes

when one or more codes are identified as potentially misvalued. This means that all open and laparoscopic hernia codes would need to be reviewed for physician work.

The ACS, Society of American Gastrointestinal and Endoscopic Surgeons, and American Society of Colon and Rectal Surgeons determined that payment for the typical hernia repair patient will result in all codes being under-reimbursed. Said another way, if 60% of patients were discharged the same day or the next day as outpatient, then all claims would be reimbursed as if all patients were outpatient because that was typical. Instead of submitting to a physician work review of code 49565 and related family codes, which likely would result in significant wRVU decreases based on the typical patient policy, the three societies recommended referring the codes to CPT to update the codes. This better describes hernia repair procedures as performed in current practice, taking into consideration the use of mesh, hybrid procedures, and length of stay.

Literature supports implantation of mesh as typical for both open and laparoscopic/robotic hernia repair procedures, along with other abdominal procedures.

Mesh Implantation or Excision

Literature supports implantation of mesh as typical for both open and laparoscopic/robotic hernia repair procedures, along with other abdominal procedures. Coders frequently ask how to report the significant work for mesh removal when performing an initial or recurrent abdominal hernia repair, because mesh implantation is not included in the current work value for these procedures. Mesh implantation and removal with stomal hernia repair also is a common coding question. Consequently, any changes to hernia repair coding required consideration of the use and removal of mesh.

Hybrid Procedures

The stakeholder societies and the AMA recently have received coding questions about correct reporting for “hybrid” abdominal hernia repair procedures where parts of the procedure are performed via

[†]Orangio G, Selzer D, Savarise M. Coding and practice management corner: Correct CPT coding of colectomy procedures: Open or laparoscopic? *Bull Am Coll Surg.* 2019;104(7):46-47.

an open approach and parts of the procedure use laparoscopy and/or a robot. These are not laparoscopic procedures converted to open procedures, but instead procedures that may start via an open approach and finish using a laparoscopic/robotic approach under pneumoperitoneum.

A column in the June 2019 issue of the *Bulletin* clarified questions regarding correct coding for hybrid procedures. This was in response to changes to the International Classification of Diseases Tenth Revision Procedure Coding System (ICD-10-PCS) codes that classify procedures for facility reporting that do not correspond to CPT coding (closed, percutaneous, open, laparoscopic).[†]

Consequently, any changes to hernia repair coding required consideration of the approach, including a hybrid approach.

Size, Number, and Type of Hernia Defect(s)

It is important to differentiate the total size of a hernia defect, as this affects the total physician work. For example, current coding for repair of a “Swiss cheese” incisional hernia that has

a large total defect is coded the same as a single small incisional hernia. In addition, the repair of anterior abdominal hernias (i.e., epigastric, incisional, ventral, umbilical, spigelian) and parastomal hernias is similar.

Global Period Consideration

A global period of 0 days was recommended and accepted for new primary anterior abdominal hernia repair codes, a change that will allow correct reporting of hospital and office E/M visit codes in the postoperative period. For example, if the patient stays overnight and is discharged the next day, CPT code 99238 or 99239 can be reported for discharge management on the day after the procedure. On the other hand, if the patient is admitted and stays 5 days in the hospital, the surgeon can report an inpatient E/M visit code for each hospital day that a visit occurs. If this family of codes retained a 90-day global assignment, only the reduced work for outpatient discharge management would be included in the 90-day global payment since the typical patient for most hernia repairs is an outpatient. In addition,

TABLE 1. 2023 ANTERIOR ABDOMINAL HERNIA REPAIR NEW AND RELATED CODES

2023 CPT Code	2023 Description	2023 Global
Initial		
•49591	Repair of anterior abdominal hernia(s) (i.e., epigastric incisional, ventral, umbilical, spigelian), any approach (i.e., open, laparoscopic, robotic), initial, including placement of mesh or other prosthesis, when performed, total length of defect(s); less than 3 cm, reducible	000
•49592	less than 3 cm, incarcerated or strangulated	000
•49593	3 cm to 10 cm, reducible	000
•49594	3 cm to 10 cm, incarcerated or strangulated	000
•49595	Greater than 10 cm, reducible	000
•49596	Greater than 10 cm, incarcerated or strangulated	000
Recurrent		
•49613	Repair of anterior abdominal hernia(s) (i.e., epigastric incisional, ventral, umbilical, spigelian), any approach (i.e., open, laparoscopic, robotic), recurrent, including placement of mesh or other prosthesis, when performed, total length of defect(s); less than 3 cm, reducible	000
•49614	less than 3 cm, incarcerated or strangulated	000
•49615	3 cm to 10 cm, reducible	000
•49616	3 cm to 10 cm, incarcerated or strangulated	000
•49617	Greater than 10 cm, reducible	000
•49618	Greater than 10 cm, incarcerated or strangulated	000
Parastomal		
•49621	Repair of parastomal hernia, any approach (i.e., open, laparoscopic, robotic), initial or recurrent, including placement of mesh or other prosthesis, when performed; reducible	000
•49622	incarcerated or strangulated	000
Mesh		
•+49623	Removal of total or near-total non-infected mesh or other prosthesis at the time of initial or recurrent anterior abdominal hernia repair or parastomal hernia repair, any approach (i.e., open, laparoscopic, robotic) (List separately in addition to code for primary procedure) (Use 49X15 in conjunction with 49X01–49X14)	ZZZ
Related Codes		
•15778	Implantation of absorbable mesh or other prosthesis for delayed closure of defect(s) (i.e., external genitalia, perineum, abdominal wall) due to soft tissue infection or trauma	000
•+15853	Removal of sutures or staples not requiring anesthesia (List separately in addition to E/M code)	ZZZ
•+15854	Removal of sutures and staples not requiring anesthesia (List separately in addition to E/M code)	ZZZ

The following codes will be deleted for CPT 2023: 49560, 49561, 49565, 49566, 49568, 49570, 49572, 49580, 49582, 49585, 49587, 49590, 49652, 49653, 49654, 49655, 49656, and 49657.

2023 CPT code numbers will be effective January 1, 2023. For procedures performed in 2022, continue to use 2022 CPT codes for hernia repair.

• New code for 2023

+ Add-on code

For parastomal hernia repair, it was determined that size and initial versus recurrent hernia were not key factors for work that required separate additional codes.

because the codes will have a 0-day global assignment, additional procedures (wound debridement, suture/staple removal) will be separately reportable even if the procedure does not require a return to the operating room (OR).

Summary of 2023 CPT Coding Changes

For 2023, CPT approved significant coding changes, as summarized in this column. The full 2023 CPT code descriptors are presented in Table 1, page 63.

- Delete codes 49560–49590, which describe open repair of anterior abdominal hernias
- Delete codes 49652–49657, which describe laparoscopic repair of anterior abdominal hernias
- Delete add-on code 49568, which describes implantation of mesh for open ventral/incisional hernias and defects resulting from necrotizing soft tissue infection

[‡]2023 CPT code numbers will be effective January 1, 2023. For procedures performed in 2022, continue to use 2022 CPT codes for hernia repair.

- Add 12 new codes (49591–49596 and 49613–49618)[‡] to report anterior abdominal hernia repair by any approach (i.e., open laparoscopic, robotic), further by initial or recurrent hernia, further by total defect size, and further by reducible or incarcerated/strangulated
- Add two new codes (49621–49622)[‡] to report parastomal hernia repair by any approach (i.e., open laparoscopic, robotic), further divided by reducible or incarcerated/strangulated
- Add one new add-on code (49623)[‡] for removal of mesh/prosthesis at the time of initial or recurrent anterior abdominal hernia repair or parastomal hernia repair
- Add one new code (15778)[‡] for implantation of absorbable mesh or other prosthesis for delayed closure of external genitalia, perineum, and/or abdominal wall defect(s) due to soft tissue infection or trauma
- Add two new add-on codes (15853–15854)[‡] for removal of sutures/staples not requiring anesthesia, to be reported separately in addition to an E/M code

Coding Guidance

Codes 49591–49596 and 49613–49618 describe repair of an anterior abdominal hernia(s) (epigastric, incisional, ventral, umbilical, spigelian) by any approach (open, laparoscopic, robotic). Codes 49591–49596 and 49613–49618 are reported only once, based on the total defect size for one or more anterior abdominal hernia(s). When both reducible and incarcerated/strangulated anterior abdominal hernias are repaired at the same operative session, all hernias are reported as incarcerated/strangulated. For example, one 2 cm reducible initial incisional hernia and one 4 cm incarcerated initial incisional hernias separated by 2 cm would be reported as an initial incarcerated hernia repair with a maximum craniocaudal distance of 8 cm and reported with code 49594. Inguinal, femoral, lumbar, omphalocele, and/or parastomal hernia repair may be separately reported when performed at the same operative session as anterior abdominal hernia repair by appending modifier 59, Distinct Procedural Service, as appropriate.

FIGURE 1.
MEASURING A SINGLE HERNIA

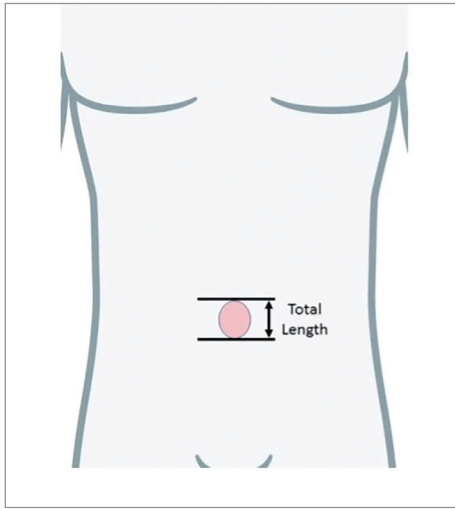
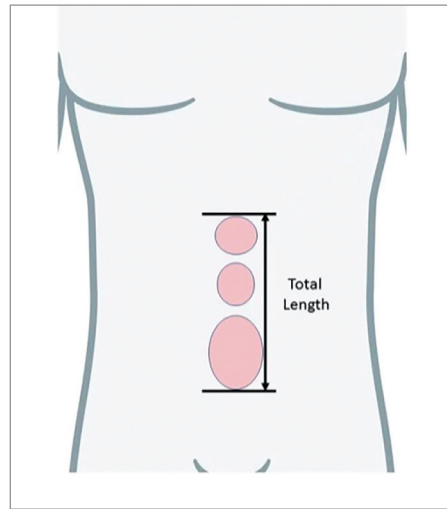


FIGURE 2.
MEASURING MULTIPLE HERNIAS



Codes 49621 and 49622 describe repair of a parastomal hernia (initial or recurrent) by any approach (open, laparoscopic, robotic). Code 49621 is reported for repair of a reducible parastomal hernia and code 49622 is reported for an incarcerated or strangulated parastomal hernia. For parastomal hernia repair, it was determined that size and initial versus recurrent hernia were not key factors for work that required separate additional codes.

Implantation of mesh or other prosthesis, when performed, is included in 49591–49596, 49613–49618, and 49621–49622 and may not be separately reported no matter the approach (open, laparoscopic, robotic). For total or near-total removal of noninfected mesh, report add-on code 49623 in conjunction with 49591–49596, 49613–49618, and 49621–49622. For removal of infected mesh, see codes 11004, 11005, 11006, and 11008.

Measuring Hernia Defect(s)

Codes 49591–49596 and 49613–49618 are reported only once, based on the total defect size for one or more anterior abdominal hernia(s). In addition, the total hernia defect size should be measured before opening the hernia defect(s) because during repair the fascia typically will retract, creating a falsely elevated measurement. Hernia measurements are performed either in the transverse or craniocaudal dimension. The total length of the defect(s) corresponds to the maximum width or height of an oval drawn to encircle the outer perimeter of all repaired defects. If the defects are not contiguous and are separated by greater than or equal to 10 cm of intact fascia, total defect size is the sum of each defect measured individually. Without a total size indicated, coders may be inclined to report the hernia repair code for the smallest defect. Therefore, it will be very important to

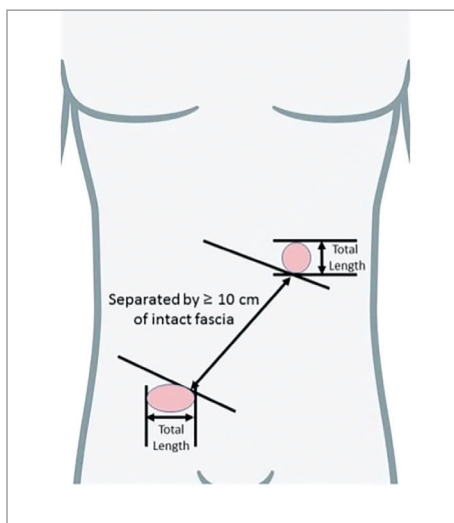
document the total defect size in the operative report so coders will know which code to select.

Figure 1, this page, depicts measuring a single anterior abdominal hernia defect, such as an umbilical hernia. Figure 2, this page, depicts measuring multiple anterior abdominal hernia defects. For example, Swiss cheese defects would be measured from the superior-most aspect of the upper defect to the inferior-most aspect of the lowest defect. Figure 3, page 66, depicts measuring remote abdominal hernia defects separated by 10 cm or more of intact fascia, such as a defect in the lower right quadrant from a prior open appendectomy and a separate hernia in the upper left quadrant from a previous laparoscopic port placement.

Reporting Postoperative Work

Assigning a 0-day global period to the new anterior abdominal family of codes requires the surgeon to separately report

FIGURE 3.
MEASURING REMOTE HERNIAS



all procedures and services performed beginning the day after the operation, including hospital visit E/M codes 99231–99233, discharge management codes 99238–99239, office visit E/M codes 99211–99215 (in-person or via telehealth, as allowed), and any other E/M services code, when appropriate, such as telephone E/M codes 99441–99443, online digital E/M codes 99421–99423, or principal care management codes 99424–99427.

In addition, codes for procedures performed after the day of surgery will be separately reportable even if they do not require a return to the OR—for example, wound debridement or wound repair including resuturing. When sutures/staples are removed during an office visit, new add-on codes 15853–15854 may be reported in addition to the E/M visit code. Codes 15853–15854 are practice-expense-only codes that include clinical staff time, supplies, and equipment related to suture/staple removal.

Although there will be more claims reported in the postoperative period, this increase should not be a burden to surgeons who already will be completing a chart for every patient encounter, whether in the hospital or the office. With respect to additional patient copays for each encounter, this situation is not different than patients being admitted for medical (nonsurgical) issues that include daily copays for the primary physician visits and all consultant visits, along with subsequent postdischarge follow-up office visits.

Learn More

The ACS collaborates with KarenZupko & Associates (KZA) to offer coding courses that provide the tools necessary to increase revenue and decrease compliance risk. These courses are an opportunity to sharpen your coding skills. You also will be provided online access to the KZA alumni website,

where you will find additional resources and frequently asked questions about correct coding. Information about the courses and registration can be accessed at karenzupko.com/general-surgery.

In addition, as part of the College's ongoing efforts to help Fellows and their practices submit clean claims and receive proper reimbursement, a coding consultation service—the ACS Coding Hotline—has been established for coding and billing questions. ACS Fellows are offered five free consultation units (CUs) per calendar year. One CU is a period of up to 10 minutes of coding services time. Access the ACS Coding Hotline website at prsnetwork.com/acshotline. ♦

DR. MEGAN McNALLY is a surgical oncologist in the St. Luke's Health System, Kansas City, MO, and assistant clinical professor at the Department of Surgery, University of Missouri-Kansas City School of Medicine. She also is a member of the ACS General Surgery Coding and Reimbursement Committee and ACS advisor to the AMA CPT Editorial Panel.



A Look at The Joint Commission

Joint Commission Changes Reviews of Hospitals

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

The end of 2022 brings with it some important news and exciting updates from The Joint Commission.

In September, The Joint Commission announced that it will review its “above and beyond” requirements—those that go beyond the Centers for Medicare & Medicaid Services (CMS) conditions of participation (CoPs) and are not on crosswalks to CoPs.

“During the COVID-19 public health emergency (PHE), CMS put many requirements on hold,” said Jonathan B. Perlin, MD, PhD, MSHA, MACP, FACMI, president and CEO of The Joint Commission. “As the PHE nears its end, CMS has been reviewing the waived requirements to determine whether some should be permanently retired. The Joint Commission will similarly address the necessity of our own unique requirements.”

The Joint Commission will review each requirement to answer:

- Does the requirement still address an important quality and safety issue?
- Is the requirement redundant?

- Are the time and resources needed to comply with the requirement commensurate with the estimated benefit to patient care and health outcomes?

Additionally, The Joint Commission will conduct quantitative analyses of scoring patterns and tests for redundancy. Where necessary, it also will conduct literature and field reviews and engage experts within the field.

“American healthcare still has a long way to go to fully recover from COVID-19 and to reach a new equilibrium, especially as we are now witnessing secondary effects from the pandemic,” Dr. Perlin stated. “At The Joint Commission, we are committed to working with you to help address the many challenges healthcare is facing, as well as to making our own requirements as efficient and impactful on patient safety and quality as possible.”

Dr. Perlin expanded on why The Joint Commission is conducting a comprehensive review of its “above and beyond” requirements in

“At The Joint Commission, we are committed to working with you to help address the many challenges healthcare is facing, as well as to making our own requirements as efficient and impactful on patient safety and quality as possible.”

—Dr. Jonathan Perlin

“Health equity is among The Joint Commission’s highest priorities. By standardizing the collection and sharing of SDOH data, clinicians can be better prepared to tailor a patient’s care to their environment, access, and abilities. The Joint Commission looks forward to collaborating with some of the leading healthcare organizations in the US to address the SDOH that contribute to food insecurity.”

—Dr. Jonathan Perlin

a September 14 interview with *Modern Healthcare* titled “Joint Commission Standards Under Review.”

Reducing Food Insecurities

In October, The Joint Commission announced that it joined the Sync for Social Needs coalition, which was part of the White House Conference on Hunger, Nutrition, and Health, committing to a role in ending hunger and reducing diet-related disease in the US by 2030.

As the standards-setting organization for more than 22,000 US healthcare organizations, The Joint Commission is committed to working with participants to scale implementation to lower clinician burden to screen for social needs. The Joint Commission recognizes that the social determinants of health (SDOH)—the conditions in the environments where people live, learn, work, and play—can limit an individual’s access to nutritious foods.

Americans who lack access to nutritious food are disproportionately low-

income, Black or Hispanic, or live in rural areas. Standardizing SDOH data collection and sharing is a crucial step in understanding and addressing the nature and extent of these issues.

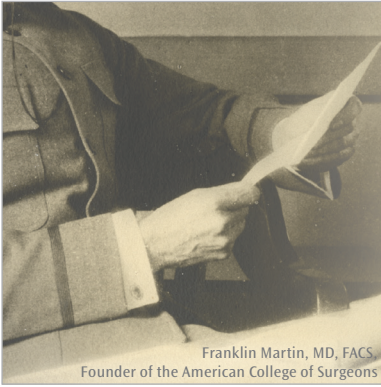
“Health equity is among The Joint Commission’s highest priorities,” said Dr. Perlin. “By standardizing the collection and sharing of SDOH data, clinicians can be better prepared to tailor a patient’s care to their environment, access, and abilities. The Joint Commission looks forward to collaborating with some of the leading healthcare organizations in the US to address the SDOH that contribute to food insecurity.”

Furthering its commitment to health equity, The Joint Commission recently released new and revised requirements to reduce healthcare disparities that will go into effect January 1, 2023, for hospitals, critical access hospitals, and some segments of ambulatory healthcare, behavioral healthcare, and human services organizations. ♦

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.

DR. LENWORTH JACOBS is a professor of surgery and professor of traumatology and emergency medicine at the University of Connecticut, and director of the Trauma Institute at Hartford Hospital, CT. He also is the Medical Director of the ACS STOP THE BLEED® program.



Franklin Martin, MD, FACS
Founder of the American College of Surgeons

From the Archives

Trepanation Reveals the Success of the Incas

by Tiffany R. Sanchez and Angel D. Chavez-Rivera

In 1865, Ephraim George Squier, an American archaeologist in Cuzco, Peru, found an Inca skull, dated 1400–1530, with signs of trepanation—a surgical intervention in which a hole is drilled or scraped into the skull. This discovery suggested neurosurgery was performed in the early Americas and ignited theories on brain size and intelligence among scientists.¹

Squier's finding sparked conversation with Paul Broca, a French physician, anatomist, and anthropologist best known for his research on Broca's area (a region of the frontal lobe that is named after him), and other leading researchers who sought to uncover the mystery behind trepanation.

The Peruvian Highlands in the 15th and 16th centuries was an area full of warfare. Weapons used during this period included sling stones and clubs. Bones from Huarochirí, Peru, in the Hrdlička skeleton collection at the Smithsonian National Museum of Natural History, and archeological crania studies from the south central and Cuzco regions confirm that head trauma was common in the Peruvian

Highlands.² Furthermore, early success from this procedure is evidenced by skulls found with multiple trepanations without fractures. Multiple trepanations may have been intended to treat headaches, convulsions, or other intracranial mass disorders.²

Today, trepanation is known as a craniotomy.³ The Incas performed trepanations using bifacial, obsidian tools to create incisions in patients' skulls.^{3,4} In later years, bronze and copper tools were used for these same procedures. The preferred surgical tool was the *tumi*, a curved metal knife that cut through skin and the pericranium. Natural materials like coca, datura, or yuca often were used as anesthesia in these procedures. Also, large amounts of alcoholic beverages such as *chicha*, a fermented corn drink, were given to patients to induce drowsiness.⁴

Although there were different methods of performing trepanation, the Incas most frequently practiced a circular grooving technique, which was the process of scoring an outline on the skull and removing the central plug.^{3,4} Some skulls were found with gold cranioplasties.⁴

Today, trepanation is known as a craniotomy. The Incas performed trepanations using bifacial, obsidian tools to create incisions in patients' skulls.



Artist Gladys R. Sanchez depicts Inca surgeons performing trepanation, along with tools, tumis, trepanned skulls, and gold cranioplasty

A 2018 study by Kushner and colleagues analyzed 800 trepanned crania and compared the degree of healing of the Peruvian trepanations with the trepanation practices during “other ancient, medieval, or American Civil War periods.”³ This study concluded that in ancient Peru (400–200 BC), the long-term survival rate was 40% and improved to a high of 91% (1000–1400 AD). The average survival rate was determined to be 75%–83% during the Inca period (1400–1500 AD).³ Kushner compared these findings to the American Civil War, when the average mortality rate was 46%–56% in cranial surgeries. The high survival rates during the Inca Empire may be attributed to procedures being performed in open-air environments, the use of herbal medication, and single-use tools.³

Although trepanation was a worldwide practice, archaeological evidence confirms that Peru has the most trepanned skulls in history.⁵ Without modern anesthesia and aseptic protocols, it is astonishing that the Incas had such tremendous success with trepanation. All in all, Squier’s skull finding revolutionized the knowledge of ancient surgery and continues to influence medical historians today. ♦

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In Memoriam

Dr. Sean Grondin, ACS Regent



Known for his humility and thoughtful leadership, ACS Regent Sean C. Grondin, MD, MPH, FACS, FRCS, passed away suddenly November 14, at the age of 56.

Dr. Grondin was a highly skilled cardiothoracic surgeon from Alberta Health Services and the Cumming School of Medicine at the University of Calgary in Canada, with expertise in thoracic oncology and minimally invasive thoracic surgery.

An ACS Fellow for more than 15 years and a Regent since 2020, Dr. Grondin shared much of his time and talents with the College, holding positions on several committees throughout the years. He also was inducted into the ACS Academy of Master Surgeon Educators® in 2020 after being recognized as a leader in surgery and surgical education. In addition, Dr. Grondin has held several senior leadership positions in other organizations, including the Canadian Association of Thoracic Surgeons, The Society of Thoracic Surgeons, the Western Thoracic Surgical Association, and the James IV Association of Surgeons.

ACS Regent Douglas E. Wood, MD, FACS, FRCSEd, a longtime friend and colleague of Dr. Grondin, said, “As I observed Sean take on leadership roles, he did so with humility and integrity. He often was ‘the adult in the room’ who helped take

difficult and controversial issues and distill them into a rational consensus that everyone could get behind. There are few who have this level of diplomacy and emotional intelligence.”

Born and raised in Canada, Dr. Grondin attended medical school at Dalhousie University in Halifax, Nova Scotia. After completing a general surgery residency at Dalhousie, he went on to finish a thoracic surgery residency at the University of Toronto and a thoracic oncology fellowship at the Brigham and Women’s Hospital in Boston, MA. In an effort to advance his understanding of research methodology and improve his scientific writing, Dr. Grondin earned a masters degree in clinical effectiveness from the Harvard School of Public Health. He then completed a second fellowship in minimally invasive thoracic surgery at the University of Pittsburgh, PA.

After starting his clinical practice at Evanston Northwestern Healthcare near Chicago, Dr. Grondin returned to his strong Canadian roots. He spent the next 20 years at the Foothills Medical Centre in Calgary, Alberta. He served in many leadership roles, including professor of surgery at the University of Calgary and a 4-year term as academic and clinical head of the Department of Surgery at

the University of Calgary and Alberta Health Services.

“Sean was remarkably accomplished, yet so down to earth, humble, and understated. He fulfilled all of what is important for a close friend and colleague—nonjudgmental, loyal, present, and a source of comfort and inspiration. And Sean was funny, incredibly funny. He could always make me laugh,” Dr. Wood shared.

Dr. Grondin was particularly passionate about the enhancement of leadership skills for faculty members and trainees, as well as surgical workforce planning and physician wellness. He authored or co-authored more than 100 peer-reviewed journal articles and abstracts and participated in many presentations on these topics. Dr. Grondin also received several honors, including the Mentor of the Year award from the Royal College of Physicians and Surgeons of Canada.

“I saw Sean inspire and mentor many students and residents, taking them under his wing and helping them gain the skill and confidence to be great thoracic surgeons like himself. He was a selfless leader of impeccable integrity,” said Dr. Wood. “Sean Grondin was a bright light, and our world is darker in losing him.”

Dr. Grondin is survived by his wife Cathy MacPherson and two children, Ben and Kate. ♦



In Memoriam

Dr. William Sasser, ACS Past-Second Vice-President

William F. Sasser, MD, FACS, a renowned cardiothoracic surgeon and ACS Past-Second Vice-President, passed away on September 25. He was 88 years old.

Dr. Sasser earned his undergraduate degree from Vanderbilt University in Nashville, TN, in 1956, and his medical degree from Emory University Medical School in Atlanta, GA, in 1960. From there, he went on to a surgical residency at Barnes Hospital (now Barnes-Jewish Hospital) in St. Louis, MO, where he began a 60+ year career as a surgeon, educator, and mentor.

A Mentor and Friend at St. Louis University

In 2004, toward the end of his active surgical career, Dr. Sasser left private practice and joined the teaching faculty at St. Louis University (SLU). According to his colleague, partner at SLU, and friend, Keith S. Naunheim, MD, FACS, when asked about this somewhat unusual career change, Dr. Sasser would answer, “Surgery has given me so much, so I just decided it was time to give back.”

During his decade at SLU, Dr. Sasser stayed true to his word and gave back by

becoming a beloved mentor. With his unique combination of surgical skill, upbeat demeanor, and Southern charm, Dr. Sasser quickly became a favorite teacher. “While it’s true he was an excellent teacher regarding the technical aspects of surgical procedures, he was more valued by faculty and trainees alike for his insights and accounts of the larger universe of cardiothoracic surgery,” Dr. Naunheim said.

Dr. Sasser’s regional and national leadership roles had led him to interact with the prominent figures in chest surgery, and he would regale students and residents with anecdotes describing those surgeons and their work.

According to Dr. Naunheim, “Some of these stories were technical, others were humorous or personal, but all were instructive regarding the realities of surgery—both good and bad.”

These accounts provided a rich portrait of general thoracic surgery and provided trainees a window into that world that was both instructive and entertaining. When he finally retired after a decade at SLU, Dr. Sasser was recognized as the GOM (Grand Old Man) in the surgery department.

Dedication to the ACS

A Fellow of the College since 1971, Dr. Sasser had a steadfast commitment to the ACS and took on several leadership roles later in his career, including serving as Second Vice-President, 2005–2006. He was a member of the Board of Governors (BoG), 1995–2001, during which time he was a member of the BoG Committee on Socioeconomic Issues, the Chair of the BoG Committee to Study the Fiscal Affairs of the College, and the BoG Secretary (1998–2000).

In line with his dedication to giving back to surgery, Dr. Sasser played an important part of developing the ACS Foundation—which obtains financial support for the charitable and educational work of the College—into the effective force it is today by serving as a board member and regular contributor. ♦



ACS Unveils New “Power of Quality” Campaign

During the Opening Ceremony at Clinical Congress, ACS Executive Director and CEO Patricia L. Turner, MD, MBA, FACS, previewed the College’s new quality campaign, which will build on ACS’s more than 100 years as the preeminent voice on surgical quality.

The ACS “Power of Quality” Campaign will reignite a conversation about surgical quality—the kind of quality that saves and improves lives.

“We want our surgeons to always feel empowered to do what’s right for our patients, and when we ground our work in quality improvement and push ourselves and our institutions to get better, then that’s the power of quality in action,” Dr. Turner said.

The dynamic, multiyear campaign will empower all stakeholders on the quality journey—driving greater adoption of ACS Quality Programs with more hospitals, increasing surgeon engagement, advocating for the use of ACS quality metrics in public policy, and ensuring that patients recognize the excellence of ACS

programs and seek care from its surgical quality partners (SQPs).

“Being a Fellow of the American College of Surgeons means something and being an ACS-verified or accredited hospital means something,” Dr. Turner said.

To help hospitals promote their participation in ACS Quality Programs, Dr. Turner unveiled the new Surgical Quality Partner diamond as an essential component of the campaign. The College created this visual symbol to represent the ACS standards of quality and drive recognition of the leadership role that the ACS plays in surgical quality.

Since Clinical Congress, 28 hospitals participating in the ACS Quality Verification Program—the College’s recently launched comprehensive, standardized program for establishing, measuring, and improving hospital-wide quality infrastructure—have received a toolkit to use in their promotional materials, emphasizing their involvement in the program.

The ACS will provide the diamond and a range of communications assets broadly in early 2023, enabling the 2,500+ hospitals that participate in at least one ACS Quality Program to highlight their participation in the ACS.

The SQP diamond has been tested and was received more favorably than the *U.S. World & News Report’s* ranking marks. As the public becomes more aware of the impact of the ACS’s role in surgical quality improvement, which is a key component of the campaign, the aim is for the diamond to act as an influential representation of a hospital’s commitment to patient outcomes.

“We want our campaign to inspire, energize, engage, and reestablish the ACS as the preeminent voice and expert for surgical quality,” Dr. Turner said.

The *Bulletin* will have more to share in the coming months as the Power of Quality campaign formally begins and evolves. Visit facs.org/quality to learn more. ♦

ACS Releases Free Clinical Readiness Curriculum for Military, Civilian Surgeons

The ongoing conflict in Ukraine has underscored the need for military surgeons in the US and abroad to maintain a state of readiness to meet the needs of the war injured. In response, the ACS, in coordination with the Military Health System Strategic Partnership ACS and the Uniformed Services University of the Health Sciences in Bethesda, MD, has developed a free resource: the Military Clinical Readiness Curriculum.

This curriculum is designed for a general surgeon deployed to a relatively far battlefield base who must be capable of providing initial trauma resuscitation and life- and limb-saving surgical procedures for those injured in combat. It also is relevant to all deployed surgeons, as well as all trauma and general surgeons caring for the injured, no matter their location. The curriculum can be used to correct an identified knowledge deficit or for just-in-time learning.

The curriculum is organized into seven domains of knowledge, including:

- Airway and Breathing
- Critical Care and Prevention
- Expeditionary Unique
- Head and Spine Injury
- Torso Trauma
- Transfusion and Resuscitation
- Wounds, Amputations, and Fractures

The first 12 video-based modules are available to view for free:

Expeditionary Unique

- Pediatric Trauma

Transfusion and Resuscitation

- Damage Control Resuscitation
- Emergency Resuscitation Thoracotomy

Wounds, Amputations, and Fractures

- Management of War Wounds
- Compartment Syndrome and Fasciotomy
- Amputation
- Burn Care

Torso Trauma

- Pelvic Fracture Care
- Blunt Abdominal Trauma
- Damage Control Surgery
- Thoracic Trauma
- Wartime Vascular Injury

Additional modules will be released soon. Access the curriculum today at facs.org/for-medical-professionals/education/



[programs/military-clinical-readiness-curriculum](https://facs.org/for-medical-professionals/education/programs/military-clinical-readiness-curriculum) or scan the QR code. ♦



ACS Launches Emergency General Surgery Verification Program

In September, the ACS and the American Association for the Surgery of Trauma (AAST) launched the Emergency General Surgery Verification Program (EGS-VP), a new surgical quality program that will help hospitals establish and maintain the highest standards in emergency general surgery.

“The ACS has been committed to ensuring the highest standards in quality surgical care for more than 100 years,” said ACS Executive Director and CEO Patricia L. Turner, MD, MBA, FACS. “This new quality program, developed in collaboration with AAST, will help hospitals ensure that they are delivering optimal care for every patient requiring emergency general surgery. We are confident that by introducing these standards and the new EGS-VP we will see improved patient care and better outcomes.”

The program standards manual, *Optimal Resources for Emergency General Surgery*, provides the resources, support, pathways, and multidisciplinary involvement necessary for

participation. EGS disease areas specified in the manual are acute abdomen/peritonitis, soft tissue infection, gallbladder disease, gastrointestinal obstruction, pancreatitis, diverticular disease, appendicitis, acute gastrointestinal bleed, perforated peptic ulcer disease, and incarcerated hernia.

“These 43 standards raise the bar of emergency general surgery. We are talking about hospital commitment, appropriate facilities and equipment, dedicated trained personnel and services, clinical care, continuity, robust data collection, quality improvement, education, and research,” said Raul Coimbra, MD, PhD, FACS, surgeon-in-chief, Riverside University Health System Medical Center, and professor of surgery, Loma Linda University School of Medicine. “All those components will be analyzed to achieve verification. Not just a hospital’s clinical care, but their institutional commitments, the data they collect, how they use the data to improve quality and care delivery, and how they use data for education and research.”

EGS-VP has been developed for the unique needs of emergency general surgery patients and providers. The program addresses:

- **Resources:** Standards specific to the diverse nature of EGS
- **Data:** A targeted registry within the ACS National Surgical Quality Improvement Program (NSQIP®) platform designed with EGS outcomes and variables in mind
- **Clinical care:** Development of standardized pathways of care utilizing a multidisciplinary approach
- **Value-added care:** Recognition that the right team, timeframe, and support provides the best opportunity to improve outcomes

Pilot sites that have participated in the program have commended EGS-VP for providing the resources to evaluate and improve emergency general surgery services.

A key aspect of EGS-VP is the role of data collection in improving care. Alongside the

“This new quality program, developed in collaboration with AAST, will help hospitals ensure that they are delivering optimal care for every patient requiring emergency general surgery.”

—Patricia L. Turner, MD, MBA, FACS

EGS-VP, the EGS Targeted Module of the ACS NSQIP registry has been developed to bring hospitals the data they need to advance their quality processes. The first registry of its kind to capture both operative and nonoperative cases, the module offers participating hospitals access to targeted EGS variables and reports designed specifically to support outcomes measurement and improvement. Leveraging the features of

the ACS NSQIP platform allows participants to capture clinically relevant, risk-adjusted data and benchmark their outcomes in a national registry.

“EGS-VP follows in the strong tradition of surgical quality improvement programs administered by the ACS. The program is built on the College’s quality principles to provide hospitals with a framework to create a culture of patient safety and develop

highly reliable care delivery,” said Clifford Y. Ko, MD, MS, MSHS, FACS, FASCRS, Director, ACS Division of Research and Optimal Patient Care.

Enrollment is now open for hospitals interested in participating in the EGS-VP. For more information, visit facs.org/quality-programs/accreditation-and-verification/emergency-general-surgery. ♦





Charm

Die Struck, 3 color enamel, hand polished. Available from Sterling Silver to 14K Solid Gold



Stud Earrings

Die-struck in sterling silver & inlaid with hard enamel. Hand polished & buffed to highlight the College logo. Earrings are sold in pairs.



Expandable Bracelet & Charm

Die-struck sterling silver miniature charm is hand polished & buffed to highlight the College logo. Charm is placed on a sterling silver expandable bracelet.



Black Bowtie Kit

100% silk, jacquard woven bowtie, pocket handkerchief & cummerbund. The ACS logo is elegantly woven into each with a black on black pattern.



Necktie

100% silk ties with woven ACS logo & contrasting diagonal stripes. Available in Dark Blue, Maroon, Light Blue, Gray & Black. Extra long ties available.



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ACS Fellow certificate is reproduced on a gold or silver plate; mounted on a solid walnut plaque; 3 sizes available



Floating Metal ACS Certificate Plaque

12" x 18" bottom panel showcases The American College of Surgeons logo. "Floating" above that panel is a smaller 8" x 10" plate with a replica ACS certificate.



Tie Tac/Lapel

Die Struck; 3 color enamel; hand polished; Available from Gold-Filled to 14K Solid Gold



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Your choice of 3 fine qualities. Single Gold-Filled, 14K Solid Gold & Sterling Silver emblem.



Tie Bar

Florentine front with Alligator clasp on back; Gold-Filled ACS emblem on 24K Gold-Plated bar



College Ring

ACS Fellowship ring available in 14K, 10K Solid Gold & Sterling Silver; College crest modeled in deep sharp relief



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Call for Nominations for ACS Officers-Elect and Board of Regents

The ACS 2023 Nominating Committee of the Fellows (NCF) and the Nominating Committee of the Board of Governors (NCBG) will accept nominations for leadership positions in the College.

Call for Nominations for ACS Officers-Elect

The 2023 NCF will select nominees for three Officer-Elect positions of the ACS:

- President-Elect
- First Vice-President-Elect
- Second Vice-President-Elect

The deadline for submitting nominations is **Friday, February 17, 2023**.

Criteria for consideration

The NCF will use the following guidelines when considering potential candidates:

- Loyal members of the College who have demonstrated outstanding integrity and an unquestioned devotion to the highest principles of surgical practice
- Demonstrated leadership qualities such as service and active

participation on ACS committees or in other areas of the College

The ACS encourages consideration of women and underrepresented minorities for all leadership positions.

All nominations must include:

- A letter of nomination
- A current curriculum vitae
- A maximum of three personal letters of support (optional)

In addition, nominations for President-Elect must include a personal statement from the candidate detailing their ACS service, interest in the position, and vision for the College's future.

Further Details

Entities such as surgical specialty societies, ACS Advisory Councils, ACS Committees, and ACS chapters that wish to provide a letter of nomination must provide a description of their selection process and the total list of applicants reviewed.

Any attempt to contact or influence members of the NCF

by a candidate or on behalf of a candidate will be viewed in a negative manner and may possibly result in disqualification. Applications submitted without the requested information will not be considered.

Learn more about the roles, duties, and time commitment involved for these Officer positions at facs.org/member-services/leadership/get-involved/officers.

The deadline for submitting nominations is **Friday, February 17, 2023**. Nominations must be submitted to officerandbrnominations@facs.org. For more information, contact Emily Kalata at 312-202-5360 or ekalata@facs.org.

Call for Nominations for ACS Board of Regents

The 2023 NCBG will select a nominee for one vacancy on the Board of Regents to be filled at Clinical Congress 2023. Please note this Regent vacancy is a Bylaws-designated Canadian seat, and therefore, only Canadian Fellows will be considered.

For information only, the current members of the Board of Regents who will be considered

for re-election to their second or third terms are (all MD, FACS) Françoise P. Chagnon, Annesley (AJ) W. Copeland, Gary L. Timmerman, David J. Welsh, and Douglas E. Wood.

Criteria for Consideration

The following guidelines are used by the NCBG when reviewing candidates for potential nomination to the Board of Regents:

- Loyal members of the College who have demonstrated outstanding integrity and an unquestioned devotion to the highest principles of surgical practice
- Demonstrated leadership qualities such as service and active participation on ACS committees or in other areas of the College

The ACS encourages consideration of women and underrepresented minorities for all leadership positions.

Only individuals who are currently, and are expected to remain, in active surgical practice for their entire term (up to three 3-year terms) may be nominated

for election or reelection to the Board of Regents.

The NCBG recognizes the importance of the Board of Regents representing all who practice surgery in both academic and community practice, regardless of practice location or configuration. Nominations are open to surgeons of all specialties. Note that in the event of an unexpected vacancy, the NCBG will accept nominations from Fellows regardless of country of practice.

All nominations must include:

- A letter of nomination
- A personal statement from the candidate detailing their ACS service and interest in the position
- A current curriculum vitae
- A maximum of three personal letters of support (optional)

Further Details

Entities such as surgical specialty societies, ACS Advisory Councils, ACS Committees, and ACS Chapters that wish to provide a letter of nomination

must provide at least two nominees, a description of their selection process, and the total list of applicants reviewed.

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

The deadline for submitting nominations is **Friday, February 17, 2023**. Nominations must be submitted to officerandbrnominations@facs.org. For more information, contact Emily Kalata at 312-202-5360 or ekalata@facs.org. ♦

Report on ACSPA/ACS Activities, October 2022

by Danielle Saunders Walsh, MD, FACS

The Board of Directors of the American College of Surgeons Professional Association (ACSPA) and the Board of Regents (BoR) of the ACS met October 15, 2022, at the Manchester Grand Hyatt Hotel in San Diego, CA. The following is a summary of key activities discussed. The information provided was current as of the date of the meeting.

ACSPA

As of November 7, during the 2022 election cycle (January 1, 2021–December 31, 2022), the ACSPA Political Action Committee (ACSPA-SurgeonsPAC) raised more than \$640,000 from more than 930 College members and staff and disbursed nearly \$575,000 to more than 120 congressional candidates, political campaigns, and other PACs. SurgeonsPAC continues to prioritize a balanced, nonpartisan disbursement strategy, including support for Democrats and Republicans. Distribution of funds is focused on health professionals, key congressional leaders, and members who serve on important US House and Senate committees with jurisdiction over various healthcare policies

and issues, including ACS-supported legislative priorities.

ACS

The BoR accepted resignations from 21 Fellows and changed the status from Active or Senior to Retired for 79 Fellows. The Regents also approved the formation of the Kurdistan Region Iraq Chapter and the revised Statement on Surgical Technology Training and Certification.

Division of Advocacy and Health Policy

A strategic analysis of the Division of Advocacy and Health Policy was conducted to review the division's programs and products, identify internal and external challenges, define future vision, and establish priorities for moving forward.

Reviewed topics included:

- Quality and tiering
- State affairs
- Value and payment

Recommendations presented and discussed included:

- Developing a comprehensive plan to assist Fellows with

ACS impact opportunities on the value of a surgeon

- Increasing state-based activity
- Participating in a campaign to promote ACS verification as a brand for future endorsement
- Prioritizing ACS impact opportunities on the value of the surgeon
- Promoting verification to patients, purchasers, and other stakeholders

Division of Education

The Division of Education reported on the following key activities:

Clinical Congress 2023

The Division of Education presented a proposed program for Clinical Congress 2023 for the Regents' comment and review.

Committee on Ethics

The Committee on Ethics, housed in the Division of Education, sponsored several sessions at the Clinical Congress 2022, including the John J. Conley Ethics and Philosophy Lecture given by Mary L. Brandt, MD, FACS, on The Ethics of Belonging. The Ethics Colloquium was titled Can I Fire My Patient?...



The Duty to Care and Limits of Accommodation. Panel sessions addressed the topics of Coping with Conflicted Commitment to Surgeon Health, Ethical Implications of Structural Racism, and Ethical and Moral Dilemmas in the Disclosure of Surgical Error. Meet the Expert Sessions included The Value of Training in Surgical Ethics and Updates in Informed Consent. Plans are underway for activities at upcoming Clinical Congresses.

Division of Research and Optimal Patient Care

The Division of Research and Optimal Patient Care encompasses the areas of Continuous Quality Improvement, including ACS research and the accreditation programs.

Trauma Programs

A strategic analysis of the Trauma Programs was conducted to review programs and products, identify internal and external challenges, define future vision, and establish priorities for moving forward.

Reviewed programs included:

- Education
- Injury prevention and advocacy

- International quality
- Trauma quality

Recommendations presented and discussed included:

- Developing an advocacy and public messaging campaign to support development of a National Trauma and Emergency Preparedness System
- Developing infrastructure for global promulgation of trauma quality programs
- Optimizing the trauma education learning experience
- Strengthening core trauma quality programs to increase impact and expand reach

Office of Diversity, Equity, and Inclusion

The Office of Diversity, Equity, and Inclusion (DEI) continues to develop its infrastructure and strategic framework. Major activities include: working with the 10 research teams that received the ACS Regental Innovative Grant for Diversity, Equity, Inclusion and Anti-Racism to ensure alignment of the research project with ACS strategic priorities; provide

resources for a midyear status report from each research team; and include the grant recipients in other relevant ACS DEI initiatives. This inaugural program has evolved into a 2-year program. To provide ongoing support of the grantees' research projects in the second year, the Office of DEI collaborated with the ACS Foundation to secure additional funding for each grantee.

The Office of DEI successfully launched and completed a 3-month pilot, the ACS DEI Educational and Alignment (E&A) Collaboratives, which are educational workshops comprised of ACS members and staff who are vested in the development and distribution of DEI efforts. Participants who completed the pilot E&A Collaborative series developed an understanding of DEI fundamentals, engaged in the use of a common DEI lexicon to be integrated College-wide, and sharpened a basic set of skills to develop and communicate DEI tools, programs, and curricula. ♦

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