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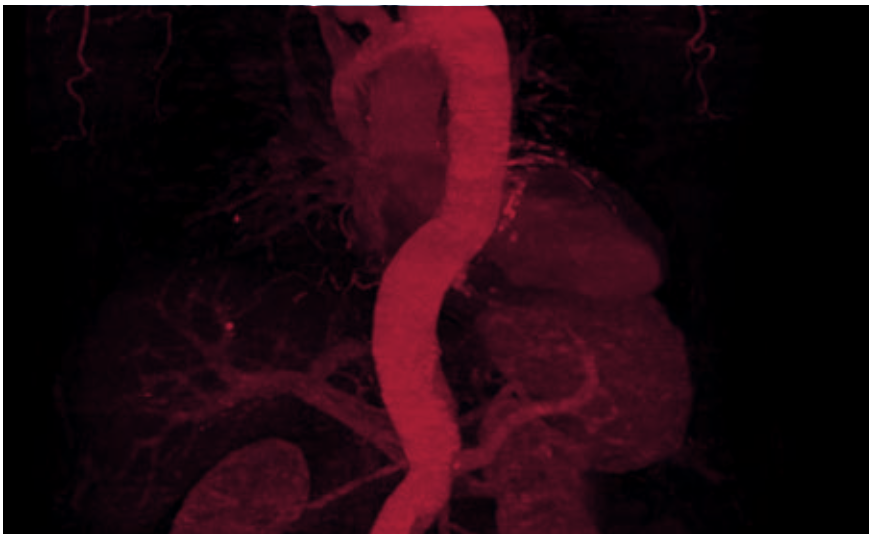

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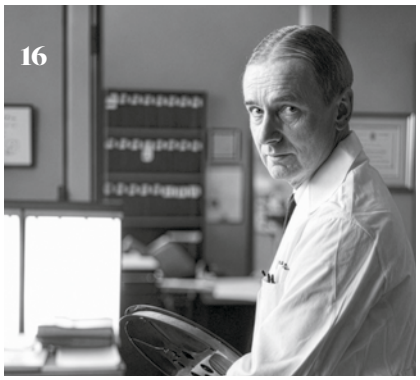

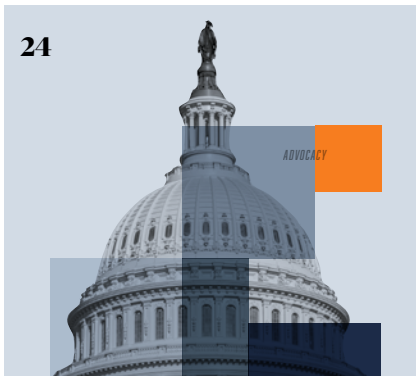

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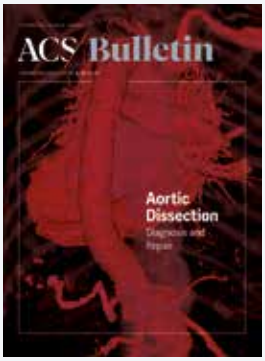

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Advocacy Under the Aegis of the ACS

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AS MANY OF YOU KNOW, I enjoy mythology. This summer, as a new film adaptation of *The Odyssey* appeared in theaters, I had a fresh opportunity to reflect on a philosophical concept that arose from Greek mythology and resonates strongly with the work of the ACS: *aegis*.

In one traditional use, the aegis was depicted as a shield or protective animal skin the goddess Athena carried; in other accounts, a thunderbolt wielded by Zeus. Thus, an aegis was classically defined as both a defensive object and a proactive one. In modern parlance, aegis has lost its literal forms but has retained its dual meanings. The word now connotes both protection and sponsorship, including by organizations or in governance.

Few words describe ACS advocacy efforts better. Since our founding, the ACS has served as both a shield and a champion, advancing policies that protect surgeons and strengthen surgical care. For more than 5 decades, we have built an increasingly strong federal and state advocacy infrastructure with two complementary goals: to advance beneficial laws and regulations and aggressively defend surgeons and patients against adverse policy changes.

Surgeons now face a convergence of challenges. Although we may not prevail in every battle, it is increasingly important to remain steadfast in ensuring surgeons' voices are amplified wherever healthcare policy is shaped.

Protecting Evidence-Based Science

One of our most recent advocacy successes has focused on defending scientific research.

In May, the federal Office of Management and Budget (OMB) published a proposed rule that would fundamentally alter the federal grantmaking process for scientific research. Among its most striking changes is a proposal to shift decision-making authority over discretionary grants from scientific experts to political appointees. If implemented, these appointees would be permitted to disregard scientific peer review but required to block funding to grants that do not reflect administration policy priorities. They would also have authority to terminate grants during the award period if they were deemed inconsistent with shifting priorities.

Recognizing that replacing expert judgment with political preference would jeopardize research, erode the evidence base that guides surgical practice, and damage the early-career investigator pipeline, we, along with dozens of other academic and specialty societies, submitted a letter to the OMB expressing vociferous opposition to the proposed rule. In August, the Senate passed a continuing resolution that would sustain government funding at current levels until December 11 and temporarily block the OMB proposal. That bill now moves to the House. We remain vigilant

about ensuring that appropriate rules remain in place for the rigorous science on which high-quality surgical care depends.

Fighting for Fair Compensation

The ACS also remains committed to opposing policies that would lower surgeon reimbursement.

In mid-2025, the Centers for Medicare & Medicaid Services (CMS) proposed a 2.5% reduction in work relative value unit payments, on the grounds of increased surgical efficiency. Research led by ACS Medical Director of Health Policy Research **Thomas C. Tsai**, MD, MPH, FACS, and lead author **Christopher P. Childers**, MD, PhD, showed that operative times had, in fact, increased. Despite this compelling evidence and our outspoken opposition, CMS finalized the policy, and it took effect January 1.

However, our work did not end there. More than 3,000 of you mobilized through SurgeonsVoice, and the ACS led a coalition of nearly 40 organizations to advocate on Capitol Hill for legislation reversing the reduction. As a result, US Representatives Ron Estes (R-KS) and Thomas Suozzi (D-NY) introduced the Efficiency Adjustment Delay Act (HR 7520), which would pause the payment cut.

Since the bill's introduction, nearly 3,000 additional surgeons have used SurgeonsVoice to urge Congress to support HR 7520. As we continue advocating for its passage, I urge all US members to participate.

Improving the MPFS

Long-term payment reform remains a priority for the ACS. Currently, we are advocating for substantive improvements to the Patients First Act of 2026 (HR 9693), which was introduced this July by three Congressional Doctors Caucus leaders (including **Greg Murphy**, MD, FACS).

The bill provides new and increased funding to primary care, leaving significant payment issues among surgeons and other specialists largely unaddressed. The bill also does not reverse the Medicare physician payment reductions scheduled to begin in 2027. Because the recent 2027 Medicare Physician Fee Schedule (MPFS) proposed rule would further erode reimbursement for surgical care, assertive advocacy is now critical if we are to make this bill acceptable for our surgical colleagues.

Since 1992, increases of as little as $20 million in the MPFS have triggered across-the-board budget cuts. This legislation would helpfully raise the Medicare budget neutrality threshold and create an annual inflationary payment update, helping reduce competition among specialties for limited Medicare resources.

To date, we have submitted official comments to the US House Committee on Energy and Commerce, published evidence-based analyses in *Health Affairs* and *STAT*, and engaged directly with lawmakers on Capitol Hill. We are also actively reviewing the proposed MPFS rule and will continue pressing lawmakers for changes that support high-quality surgical care. As with all our advocacy efforts, each of us has a voice, and our participation is essential.

Steps Forward

Advocacy is not solely about defending against harmful policies. Using our aegis is also about looking forward, strengthening our profession, and improving patient care.

This year's passage of the Consolidated Appropriations Act illustrates this. This law includes several decisions that align with ACS priorities, including increased funding for the Hospital Preparedness Program, military-civilian trauma training partnerships, the National Institutes of Health, and the US Centers for Disease Control and Prevention. It also sustains funding for firearm injury prevention and the Advanced Research Projects Agency for Health, extends the Dr. Lorna Breen Healthcare Provider Protection Act through 2030 and COVID-era Medicare telehealth flexibilities through 2027, and more.

Advancing Surgery Together

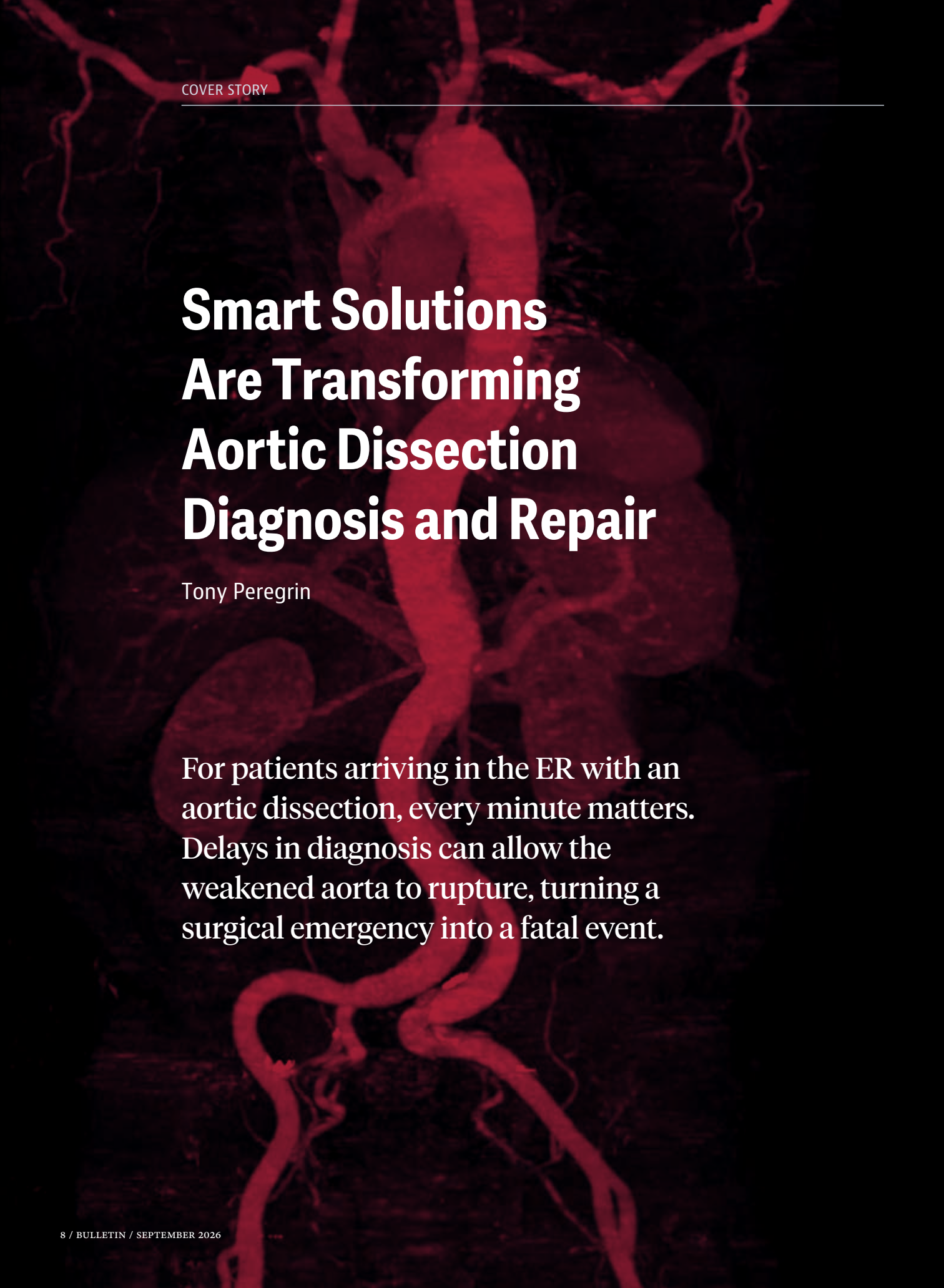
Surgeons, as leaders in the OR and a significant part of the engine that runs our hospitals, bring strategic leadership to patient care. The ACS strives to use a similarly principled approach to its advocacy for evidence-based policy, appropriate payment, and optimal care.

Just as we undertake aggressive surgical interventions when we must, so too must we speak out strongly to defend and serve our patients and our profession in these difficult times. Advocacy, strongly built on ancient principles, remains vital to our future.

Register for Clinical Congress

Clinical Congress is just weeks away. Learn more and register today: *facs.org/clincon2026.*

Dr. Patricia Turner *is the Executive Director & CEO of the American College of Surgeons. Contact her at* executivedirector@facs.org.



Smart Solutions Are Transforming Aortic Dissection Diagnosis and Repair

Tony Peregrin

For patients arriving in the ER with an aortic dissection, every minute matters. Delays in diagnosis can allow the weakened aorta to rupture, turning a surgical emergency into a fatal event.

ARTIFICIAL INTELLIGENCE (AI) platforms can rapidly analyze computed tomography angiography (CTA) scans, flag suspected aortic dissections, and alert care teams to prioritize urgent cases, helping reduce delays that can prove fatal.

Aortic dissection, the third-leading noncardiac cause of sudden unexpected death, carries a 1%–2% increase in mortality per hour in the first 48 hours if left untreated.[1,2] Because rapid detection and accurate diagnosis are so vital to ensuring patient survival, AI algorithms that recognize the features of an aortic dissection via imaging, such as dissection flaps and aneurysms, can generate real-time alerts that help mobilize surgical teams more quickly, mitigating risks of mortality.

A large-scale validation study that examined more than 1,300 chest and thoraco-abdominal CT angiography images revealed that an AI-powered software platform showed an 80.1% positive predictive value for aortic dissection.[3]

Another study reviewed an aortic dissection algorithm using the noncontrast-enhanced CT images of 170 patients.[4] Researchers found that the algorithm had an "area under the curve of 0.940 for detecting aortic dissection, with an accuracy of 90.0%, sensitivity of 91.8%, and specificity of 88.2%."[4] According to the researchers, the algorithm "showed comparable diagnostic performance to radiologists for detecting aortic dissection."

While AI-enhanced triage can lead to improved patient outcomes, it is essential to understand the specific pathology of the condition that is being assessed.

Whether identifying a tear algorithmically or interpreting a scan manually, physicians must accurately distinguish between the two types of aortic dissection: Type A begins in the ascending aorta and requires immediate treatment due to life-threatening complications; Type B, which originates in the descending aorta, generally is less immediately life-threatening than Type A, although Type B aortic tears can lead to mortality without medical intervention.

"If we look at how things were done historically, patients entering the ER received a 2D scan for aneurysmal disease, referrals were made, and surgery was performed based on that surgeon's 3D creation in their mind of a 2D image in terms of where to place stents," said Allan M. Conway, MD, FACS, a vascular surgeon and associate professor of surgery in the Division of Vascular and Endovascular Surgery at University of California San Francisco Health and MarinHealth.

Aortic dissection, the third-leading noncardiac cause of sudden unexpected death, carries a 1%–2% increase in mortality per hour in the first 48 hours if left untreated.

A digital subtraction angiography of the abdominal aorta with a stent graft featuring a Cydar image fusion overlay. Red rings identify the renal, visceral, and iliac vessel origins, as well as the proximal aortic landing zone.

Dr. Allan Conway and Tina Desai, MD, FACS, in the OR after completing their first case using Cydar Maps technology in 2024.

"While digital twinning is a fairly new concept in medicine, it's well known that engineers will stress jet engines to see how they will respond in real-world scenarios."

Dr. Allan Conway

Traditionally, assessment for aortic dissection has been a manual process that depends on individual expertise and interpretation. Emerging AI tools can help augment and streamline this approach.

"I think where AI has the potential to really change the game is by allowing us to recognize these pathologies much faster and, as a result, increase the efficiency of the referral process," he added. "In this scenario, when a patient comes into the ER with symptoms, the scan is done, AI recognizes the pathology and alerts the surgical team, helping get operating rooms ready and ultimately decreasing the time from presentation to the operation."

Digital Twins and Surgical Planning

As AI algorithms grow increasingly proficient at interpreting diagnostic images, researchers are exploring how those data can be used to generate patient-specific virtual models, also known as digital twinning, to explore potential treatment pathways before a procedure begins.

The concept of twinning originated in aerospace engineering, where virtual models are stress-tested under conditions too costly, or impossible, to reproduce physically.

"While digital twinning is a fairly new concept in medicine, it's well known that engineers will stress jet engines to see how they will respond in real-world scenarios," explained Dr. Conway. "We're starting to see this in the surgical world. Ideally, what we want to do is 'stress' the patient virtually. So, for aortic dissection repair, we would try

different stents and treatment types to see how the virtual patient responds."

While largely in the experimental phase in medicine, the intention behind twinning is to offer clinicians treatment pathways that are data-driven, adaptive, and personalized. A scientific article published in 2025, "Digital twins for the era of personalized surgery," describes this approach as follows: "A digital twin in surgery is a dynamic virtual replica of an individual's physical and physiological state, integrating both bodily systems and healthcare interactions."[5] This technology, which could be used in the preoperative, intraoperative, and postoperative stages, is an evolution of other advanced tools, including 3D modeling and virtual reality simulations.

"For aortic work, I think twinning has the ability to change the way in which we treat patients. For most aortic work, it's typically an individual surgeon making a plan," said Dr. Conway. "I think where twinning will help, and this will rely on good data, is I should be able to have a CT scan analyzed by AI software and it should be able to predict how that aneurysm or dissection is going to behave with different treatment models and whether that's a nonoperative approach versus an X, Y, or Z type of stent, and how that patient is going to respond 1 year, 2 years, and 5 years down the line."

A January 2026 study examined the accuracy of a thoracic endovascular aortic repair (TEVAR) digital twin for preoperative planning. TEVAR is considered the gold standard for complicated acute Type B aortic dissections depending on the location and acuity of the dissection. Researchers retrospectively analyzed pre- and postoperative CTA scans from patients treated with a specific stent graft. Using a computer simulation of 20 patients to determine how accurately it could predict the placement of the stent graft, researchers found the simulation closely matched what happened in the human patients.[6]

On average, the difference between the simulation and the actual outcome was only about 4%.[6] "The integration of such a validated methodology into routine clinical workflows within a very short simulation time could reduce procedural risks, enhance precision in device deployment, and ultimately improve patient outcomes," the study's authors noted.

The surgical team reviews the image fusion overlay before stent graft deployment. The live fluoroscopy image, highlighted by a yellow outline, is paired with red rings identifying critical vascular landmarks to support image-guided aortic surgery.

"I think we're going to start seeing this approach in the next wave of aortic care," said Dr. Conway. "In fact, surgeons are already doing it."

While widespread use of digital twinning, which can be thought of as a virtual dress rehearsal, is still on the horizon, this tool has demonstrated use in surgical specialties such as orthopaedics, neurosurgery, and plastic and reconstructive surgery—specifically for procedures where precision is essential and anatomical structures can vary greatly.

"I think one of the largest applications of AI will be in preoperative decision-making," added Jason T. Lee, MD, FACS, chief of the Division of Vascular Surgery in the Department of Surgery at Stanford Medicine in Palo Alto, California. Dr. Lee's focus is on minimally invasive diagnostics, aortic surgery, and complex endovascular aneurysm repair. "Now that hundreds of thousands of implants for TEVAR have been performed worldwide over the last 35 years, we have amassed a bank of outcomes data. Researchers are analyzing imaging findings, preoperative metrics, electronic health records, and other large datasets to determine which patients are the best candidates for these procedures."

Despite the promising ability of digital twinning and other preoperative assessments to test, predict, and optimize surgical approaches, barriers to universal adoption persist, including high costs, developing standardized validation models, and integrating vast amounts of patient data into these platforms.

> "With image fusion technology, there is less radiation time because you know where the vessels are. You also don't have to inject as much contrast dye to locate the vessels."
>
> Dr. Allan Conway

"As healthcare systems generate increasingly large and complex datasets, AI offers the computing power needed to analyze information that would otherwise be difficult to manage," said Dr. Lee. "Most surgeons are not concerned that AI will replace them in the OR. Instead, we see the value it brings by augmenting routine yet important tasks, such as preoperative risk assessment and postoperative follow-up. The more AI can support those efforts, the better care we can provide."

GPS for Complex Aortic Repairs

Once a treatment strategy has been determined—whether guided by conventional imaging, AI-enhanced analysis, or patient-specific digital simulations—the next challenge is executing that plan in the OR.

Just as AI can help surgeons interpret complex imaging data and identify optimal treatment approaches, this technology also can assist in translating those insights into precise intraoperative action. Specifically, advanced image-guidance platforms can assist surgeons performing complex, minimally invasive vascular surgeries, including aortic dissection repairs.

Using preoperative CT scans, this technology generates precise 3D anatomical models that are superimposed onto live x-ray screens (fluoroscopy) in the OR. This technique, referred to as image fusion technology, has evolved into an important tool used in complex endovascular interventions. Several image fusion platforms are available, including Philips VesselNavigator and Cydar Maps.

According to Dr. Conway, Cydar's distinguishing feature is its cloud-based structure, which uses AI to automatically map patient-specific aortic anatomies during surgery, including the location of the aneurysm and critical branch vessels, such as the renal, celiac, superior mesenteric, and left subclavian arteries.

"We have been using it for all our aortic cases since 2024," said Dr. Conway. "When patients ask us about this technology, we assure them that AI is not doing the surgery and that AI is not telling us where to place our stents and where to place our wires. We're still the decision-makers, and we're still the ones performing the surgery."

In addition to its "GPS-like" guidance overlays that enhance surgical precision, image fusion platforms also show measurable gains in efficiency, with some studies showing a reduction in procedure time by as much as 20%.[7]

"I think knowing where the vessels are where we need to put the x-ray machine in advance really speeds up a lot of the imaging that we have to acquire," said Dr. Conway, who also noted a reduction in radiation exposure for everyone in the OR (patient and staff) by as much as 50%.[7] "As soon as you put your foot on the pedal and start using fluoroscopy, radiation is being delivered. With image fusion technology, there is less radiation time because you know where the vessels are. You also don't have to inject as much contrast dye to locate the vessels."

Barriers to Wider Adoption

The precision of fusion mapping relies on high-quality preoperative imaging. "You need good-quality CT scans to be able to produce accurate fusion maps with thin slices that are 1 millimeter or less in thickness in order to capture intricate anatomical details," explained Dr. Conway.

While high-resolution imaging provides greater anatomical detail, processing and integrating hundreds of CT images requires substantial computational power. The costs associated with

processing these data are significant and typically based on an annual subscription model.

"I think one big hurdle with this technology is cost. Convincing hospital administrators to part with the dollars for a yearly recurring fee can be difficult, especially when a lot of these technologies are expensive and there isn't one technology that fits everybody. We are very grateful for our philanthropic support, which has been instrumental in helping us adopt and use this technology," said Dr. Conway.

For many institutions, decisions about investing in this technology are based on whether improvements in efficiency, radiation reduction, contrast savings, and workflow justify the recurring expense.

As hospital systems weigh the value of these platforms, surgeons must also consider how to integrate them into practice. "I think there is a risk associated with relying solely on the technology for clinical decision-making, and not using the other tools—fluoroscopy, angiography, anatomical expertise, and procedural experience—that we've trained on for years, which could lead to problems. AI technology is a guide," advised Dr. Conway.

ARISE II Results Highlight Clinical Promise

While advanced imaging and guidance help optimize surgical precision for complicated aortic repair cases, long-term outcomes for these patients will continue to depend on the performance of the endovascular devices themselves.

Although endovascular stent grafts are routinely used to treat descending aortic aneurysms and dissections, there are currently no approved devices for repair in the ascending aorta. The ARISE II trial is a multicenter, National Institutes of Health clinical study, which is following patients for 5 years

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"Developing devices for the ascending aorta is a natural progression as we continue expanding our ability to treat pathology closer to the heart."

Dr. Jason Lee

to evaluate the GORE ascending stent graft. The aim of this pivotal trial is to determine whether this catheter-delivered device can serve as a minimally invasive endovascular alternative to open-heart surgery for patients with ascending aortic disease who face a high risk of surgical complications.

"Stanford Medicine was one of the first sites on the West Coast to treat a patient with this device within the ARISE II trial," said Dr. Lee. "Surgeons from the Stanford Department of Cardiothoracic Surgery and Stanford's Division of Vascular & Endovascular Surgery worked in collaboration to test the safety and efficacy of the ascending aortic stent graft for the treatment of conditions such as dissection, pseudoaneurysm, or ulceration of the ascending aorta."

The 61-year-old patient who was the subject of the Stanford trial had a history of chronic Type B aortic dissection with aneurysmal degeneration. According to a press release issued by Stanford Medicine, the patient received the stent graft without complications and was discharged home after 3 days.[8] If the patient had received open-heart surgery, the hospital stay could have lasted as long as 1 week followed by 4–6 weeks of recovery at home.

"We were fortunate that we had a very good outcome for our patient that we submitted for the trial, and we look forward to the next trial to further learn about the appropriate patients and techniques to safely use this ascending stent graft," Dr. Lee said.

In December 2025, enrollment began in the ARISE III trial, which will assess the same ascending stent graft but in patients requiring emergency repair for Type A dissections. According to Dr. Lee, Stanford Medicine will again be a participant in the trial.

"Endovascular techniques have revolutionized a lot of aortic care during the last 25 years," said Dr. Lee. "It was natural that eventually we would have devices to potentially use in the ascending aorta, and participating in this trial is just another step in the evolution of us getting closer to the heart itself and expanding our ability to treat these pathologies."

For Dr. Lee, exploring repair options in the ascending aorta represents the next frontier in a decades-long endovascular revolution. "Developing devices for the ascending aorta is a natural progression as we continue expanding our ability to treat pathology closer to the heart."

Still, Dr. Lee stressed that open repair remains the gold standard for ascending aortic disease, backed by decades of innovation and excellent long-term outcomes. The promise of an endovascular approach, he said, lies in its potential to complement—not compromise—the durable outcomes achieved through traditional surgery, offering another option for carefully selected patients with challenging anatomy or elevated operative risk.

From AI-powered triage and digital twinning to image fusion guidance and next-generation endovascular devices, emerging technologies are reshaping every stage of aortic care. These innovations offer the potential to accelerate diagnosis, refine procedural planning, enhance intraoperative precision, and expand treatment options for patients once considered too high risk for intervention.

Yet as these tools become more sophisticated, their greatest value will continue to be their ability to augment the surgeon's clinical judgment. The future of aortic care lies in harnessing data-driven insights while maintaining the human expertise needed to interpret complex anatomy and deliver personalized treatment.

Tony Peregrin *is the Managing Editor of Special Projects in the ACS Division of Integrated Communications in Chicago, IL.*

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How the ACS Shaped **Surgical Cinema** and Preserved a Century of Medical Films

Michael C. Trotter, MD, FACS

THE PHRASE "movies for surgeons" may evoke classic medical dramas such as 1937's *Internes Can't Take Money,* 1970's *M*A*S*H*, or 2004's *Something the Lord Made.*[1-4]

Although these films portray real people or events, this article focuses on motion pictures produced specifically for medical education, including *Diagnosis and Treatment of Infections of the Hand, Gangrene Bowel Resection, and Gallstone Ileus.*[5-7]

The history of the ACS film program encompasses its leadership in the medical film community, an initial preservation success, and current efforts to digitize the remaining works from the former ACS motion picture library.[8-13]

The use of motion pictures to teach surgery dates to 1898, when French surgeon Eugène-Louis Doyen had himself filmed performing a craniotomy and a hysterectomy. In July of that year, he screened the films in Edinburgh, Scotland, for the British Medical Society. In October, he held public screenings in France, reportedly marking the first public presentation of surgical films.[14-18] A competing claim involves a below-the-knee amputation performed by German surgeon Ernst von Bergmann and filmed by German cinema pioneer Oskar Messter.[17]

The following year, Argentine surgeon Alejandro Posadas filmed the removal of a pulmonary hydatid cyst, a milestone for which one author recently claimed historical priority.[19] Historical consensus, however, generally favors Dr. Doyen rather than Dr. Posadas as the first to use film for this purpose.

In 1912, Rudolph Matas, MD, FACS, an ACS founder and former vice president of the organization, endorsed the medium in his presidential address to the Southern Surgical and Gynecological Association. During the address, he showed several films by Dr. Doyen that he had obtained in Paris.[20] By 1914, Dr. Doyen was advocating for a "great museum of surgical art" that would preserve films of unique or difficult operations that might otherwise be lost.[21]

ACS Medical Motion Pictures Program

ACS Founder Franklin H. Martin, MD, FACS, recognized cinema's potential for surgical education.

Dr. Hilger Perry Jenkins, 1960

Cinematographic exhibitions of operations began at the Clinical Congress in 1916 and continued the following year, with films appearing intermittently through the 1920s.[8]

After viewing well-produced films in Paris in 1925, Dr. Martin secured approval from the ACS Board of Regents to develop a formal program. A plan was created with support from Will H. Hays, the first president of the Motion Picture Producers and Distributors of America, and ACS cofounder J. Bentley Squier, MD, FACS, the 16th President of the ACS.[8-9,11,22]

The ACS Board on Medical Motion Pictures was approved on October 26, 1926.[8,11] Its goals included surveying existing films, identifying appropriate subjects, establishing production standards, and creating a noncommercial clearinghouse at the ACS.[8]

Hays enlisted George Eastman, president of the Eastman Kodak Company, to support the initiative, leading to a collaborative arrangement between the ACS and the company.[8-10] The first film developed through the program, *Diagnosis and Treatment of Infections of the Hand*, was produced by Allen B. Kanavel, MD, FACS, an ACS cofounder and later President, in association with Sumner L. Koch, MD, FACS. The film premiered at the 1927 Clinical Congress.

Through rigorous review, approval, and cataloging processes, the ACS quickly assumed a leadership role in surgical film education. Its endorsement became highly sought after. Following Eastman Kodak's departure from the program in 1931 and George Eastman's death in 1932, longtime ACS Secretary Eleanor K. Grimm assumed responsibility for coordinating the program.[8-9,11]

The College then shifted away from film production and concentrated on reviewing, approving, and cataloging films. Medical film production companies emerged, as did film departments within pharmaceutical companies, surgical equipment manufacturers, and other organizations. Most sought ACS endorsement.[5]

The number of films shown at Clinical Congress increased during the 1930s and 1940s, largely replacing live "wet clinics."[11] During World War II, the ACS partnered with the US Department of State to provide teaching films to South America. The ACS also produced two nursing recruitment films during this time, *White Battalions* and *R.N.—Serving All Mankind*, with support from the military and industry.[8-9,11]

In 1948, Grimm announced that she planned to retire in 1951 and recommended reorganizing the Motion Picture Department. H. Perry Jenkins, MD, FACS, was appointed chair of the Committee on Medical Motion Pictures in 1950 and served until 1966.[8-10] Dr. Jenkins has been credited with contributing more to the program than any other individual.[11]

Under his leadership, and with support from Davis & Geck, a medical device and surgical suture manufacturer founded in 1909, several prominent film initiatives were introduced: Cine Clinic in 1950, the Motion Picture Symposium in 1952, and Spectacular Surgical Problems in 1954.[5,11] By 1961, the approved film list contained 884 titles across 18 major categories.[5]

Michael E. DeBakey, MD, FACS, became the committee's archivist

"Approved, Issued, and Passed" – Seals of Approval

and bibliographer in 1962 because of his interest in archival materials held in the ACS Film Library and his interest in providing cardiovascular surgery films from Baylor University to the library.[5] No major effort to preserve the library's historic films, however, appears to have been undertaken at that time.

In 1963, Dr. Jenkins updated the program's policies. The ACS discontinued its approval program and film lists and cooperated with the American Medical Association (AMA) on cataloging the films. In 1970, C. Rollins Hanlon, MD, FACS, who later served as ACS President, presented 22 Cine Clinic films produced from 1951 to 1969 to the National Library of Medicine. He described the collection as "a superb historical treasure" of "incalculable value."[5]

By the mid-1970s, ACS archivist George W. Stephenson, MD, FACS, recognized that the films were deteriorating and faced the possibility that they would need to be discarded. No preservation action was taken. The historic value of the collection prompted further discussion in 1986, but preservation efforts were again sidelined as video technology advanced.[5]

Davis & Geck became the distributor for the ACS Film Library in 1972 and merged its library with that of the College. Cine-Med assumed management in 1992, and US Surgical Corporation became the sole sponsor in 1996.[5] Although the technology has changed, "visual education in surgery" and "learning by seeing" remain ACS priorities.

Through rigorous review, approval, and cataloging processes, the ACS quickly assumed a leadership role in surgical film education.

The ACS, Dr. Nichtenhauser, and the Medical Film Institute

The ACS led surgical teaching film efforts in the US by combining cinematic standards with surgical expertise, qualities the commercial film industry could not independently replicate. This combination positioned the College as a gatekeeper for high-quality surgical teaching films.

The College's interactions with the broader and less-organized medical film community are illustrated by its relationship with a little-known but highly regarded physician.

Born in Vienna in 1903, Adolf Nichtenhauser, MD, developed a profound interest in film during the 1920s. He studied motion-picture technology before receiving his medical degree from the University of Vienna in 1931. Following a rotating internship, Dr. Nichtenhauser served as a staff and attending physician at several hospitals in Vienna while also working as a film reviewer, critic, correspondent, producer, editor, and educational film programmer. Persecuted under Nazism, he fled Austria and arrived in New York in 1939.[23-24]

Dr. Nichtenhauser applied for US citizenship, which he obtained in 1944. During this period, he dropped "Adolf" and began going by "Nick." His parents remained in Europe and died at the Treblinka death camp in 1942.[24]

He subsequently undertook a series of short-term contracts and consulting assignments with government agencies involved in health and medical films. Through this work, he had three notable interactions with the ACS.

In November 1941, during the ACS Clinical Congress in Boston, Dr. Nichtenhauser reviewed 102 ACS-approved films for the American Film Center. He identified cinematic shortcomings, including poor image quality, insufficient animation, and failures to show pathology and patient outcomes. As a nonsurgeon, he declined to evaluate surgical technique or propose operative modifications.[23]

The following year, Dr. Nichtenhauser served as secretary of an AMA planning group focused on the development, production, and use of medical films. Malcolm MacEachern, MD, FACS, a former ACS Co-Executive Director, also participated.

During one planning meeting, Dr. Nichtenhauser presented a detailed assessment of the

Eleanor K. Grimm and Dr. Malcolm MacEachern, 1950

medical cinema field, while Dr. MacEachern described the scope and comprehensiveness of the ACS program. The group viewed the ACS film program favorably for surgical subjects but considered it less applicable to nonsurgical material. No definitive action emerged from the meeting. During the remaining war years, however, the need for—and perceived value of—medical training films expanded dramatically.[23]

In 1946, the federal government established the US Interdepartmental Committee on Medical Training Aids. The committee included representatives from the Army, Navy, Veterans Administration, and US Public Health Service and reportedly had a budget of $3 million.[8]

Dr. Nichtenhauser was involved early in developing the rationale, prospectus, and budget for a centralized medical film center. In 1947, the Association of American Medical Colleges (AAMC) was invited to join the committee and establish the Medical Film Institute (MFI).

As a member of an AAMC workgroup, Dr. Nichtenhauser proposed a plan addressing film use, cataloging, distribution, medical film training, and international outreach. He also produced much of the documentation needed to govern the new organization. He emphasized that the MFI "is a film agency serving medicine rather than a medical agency dealing with films." In early 1948, the AAMC selected David S. Ruhe, MD, to direct the MFI when the organization was formally established.[23]

As Johnson & Johnson's support of the ACS film program ended, Dr. MacEachern and Grimm became interested in the government initiative. Grimm was authorized to represent the ACS in the exploratory venture.

A few months later, she spent a week in Washington, DC, meeting with committee members and discussing potential ACS collaboration. Upon returning to Chicago, she reported that "the ACS will, in my opinion, be in the foreground of the medical motion picture production program and will receive as much credit in every film in which it has a part on the cooperative basis (with the government assuming all production responsibility)."

ACS advisors, she reported, would be compensated "on the basis of a consultant's fee of from $40 to $50 per day, plus $6 per day maintenance, plus any travel expense that may be involved"—approximately $590 to $740 per day in today's dollars.[8]

By 1948, Dr. Ruhe was actively advocating for the MFI's launch. The organization also represented a potential employment opportunity for Dr. Nichtenhauser. In correspondence between Drs. Ruhe and Nichtenhauser, Dr. Ruhe described time spent at the AMA discussing the MFI "both above and below the board." He also wrote about cataloging work that would provide income for the institute, suggesting they "make them ['potential foes'] do the scut work of the cataloging job while we preempt the cream." Regarding the ACS collection, he proposed that they "force Grimm to review again from scratch the ACS films."[23]

A year later, the AAMC's Medical Film Institute opened at the New York Academy of Medicine. Dr. Nichtenhauser first served as a temporary consultant and became an MFI staff member in 1950.[23] Although he possessed exceptional

knowledge of medical films and was respected for his wide-ranging expertise, he also gained a reputation among some employers and colleagues for being difficult and alienating.[24]

Throughout 1949, ACS leaders engaged in considerable discussion about the College's potential role in the MFI. By October, the institute's funding was uncertain, and it was seeking grants to produce a comprehensive medical film catalog. The catalog, which would be sold by subscription to medical schools, hospitals, medical societies, and other professional organizations, was expected to become the MFI's primary source of income.

The ACS ultimately declined to participate.[8] The College would have been limited to an advisory role on selected projects, and its leaders decided not to place the organization's considerable experience, knowledge, and capabilities at the disposal of an institute with uncertain finances.

Between 1948 and 1949, Grimm devoted considerable time to defining and developing a possible ACS role in the MFI. She also would have been familiar with the views of the surgeon leaders with whom she worked. Whether these circumstances influenced her decision to step away from the ACS film program is unknown.

During this period, Dr. Nichtenhauser was researching and writing a manuscript titled "A History of Motion Pictures in Medicine," which he hoped to publish as a book.[23] His work on the manuscript brought him into direct contact with Grimm.

In March 1949, while both were in Washington, DC, Dr. Nichtenhauser discussed with Grimm "the first film project of the American College of Surgeons, of 20 years ago." Their correspondence over the following months provided him with the information needed to produce the first historical study of the ACS film program, which became part of his manuscript.[23]

His "story of the College of Surgeons films" noted that "the film project of the College and Eastman Kodak was the first large-scale attempt at teaching film production by a medical organization."[23]

Dr. Nichtenhauser did not live to see his manuscript published. He died in November 1953, "after a short, violent illness," at age 50. Three months before his death, Dr. Ruhe had described him as "the most knowledgeable reference person in medical films today."

His wife, Margaret, donated his papers to the Armed Forces Medical Library in 1954 and worked through 1955 to secure publication of the manuscript, but her efforts were unsuccessful.[23] Today, the unpublished manuscript—which many consider an authoritative document—and the Nichtenhauser Papers are housed at the National Library of Medicine and are fully digitized and accessible.[25]

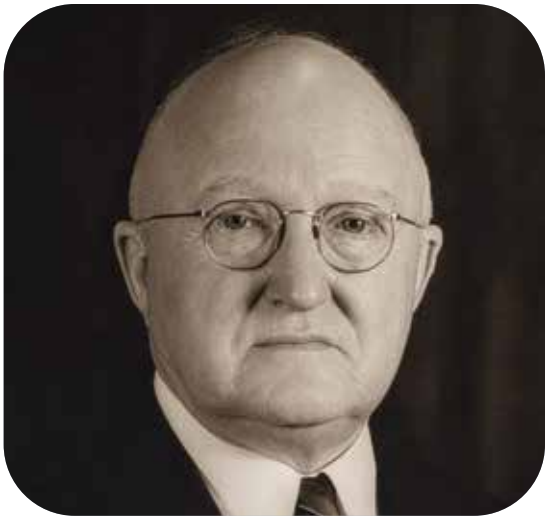
At the time, the ACS possessed considerable resources and influence. Dr. MacEachern and Grimm were familiar with Dr. Nichtenhauser and his work, but a sustained professional collaboration between the College and this medical film pioneer never came to fruition.

Gamble Films

One of the clearest examples of ACS film preservation involves the collection of Hugh A. Gamble, MD, FACS (1876–1954), a general surgeon from Greenville, Mississippi, and an original Fellow of the ACS.

From 1937 to 1951—primarily during the 1940s—Dr. Gamble collaborated with a local professional photographer to produce educational surgical films, which he presented at professional meetings.[26-27]

In 2004, Hugh A. Gamble II, MD, donated his grandfather's collection to the ACS. Because the films had been stored in closets and an attic for several years, it was unknown if they were salvageable. Once the films arrived at the ACS, the high cost of archival preservation prevented moving ahead with the project.



Dr. Hugh A. Gamble (1876–1954)

An opportunity emerged in 2010, when University of Chicago PhD candidate Caitjan Gainty was working as a research assistant on the ACS Centennial project. She also was involved in a separate project examining medicine and science in film and was collecting archival films in Chicago for digitization.

Gainty included Dr. Gamble's films in the project and collaborated with Andy Poulos, a colleague in the university's audiovisual department. Poulos digitized the films at no cost, completing the work in 2012. Item-level descriptions of the films were added to the ACS Archives bibliographic database, and the digital files are available for scholarly research at ACS Headquarters in Chicago.[28]

ACS Film Digitization Project

Digital technology has rendered motion-picture film and videotape largely obsolete. Yet the visual records they contain (of anatomy, open surgical techniques, and historic procedures) retain immense educational and historical value.

Preserving content that otherwise would deteriorate and become inaccessible allows these films to inform the broader history of surgery, document the contributions of the ACS, and sustain the legacies of prominent surgeons.

In 2022, Davis & Geck sent 674 films to the ACS, most of them on U-matic, an analog cassette-based videotape format. The materials were placed in off-site storage.

The ACS Film Digitization Project began in January 2025. With support from the ACS History and Archives Committee, Michael Beesley, Archivist in the ACS Division of Member Services, managed the conversion of 100 tapes. Discussions are ongoing about incorporating the remaining tapes into a larger project that would preserve their educational and historical value.

The ACS has a rich history in medical film. Its program began as a noncommercial initiative that provided a highly sought-after indicator of quality through the College's seal of approval. Dr. Nichtenhauser was the first historian to document the ACS's important role in the development of medical cinema.

Digitizing surgical films preserves unique resources for historical study, education, and research. The ACS already has demonstrated that such preservation is possible through its work with the Gamble collection and the first phase of its current digitization initiative.

Building on these successes, the century-old legacy of surgical cinema offers the College another opportunity to safeguard historically significant materials and make them available to future generations.

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Original 16-mm Gamble Films

Digitizing surgical films preserves unique resources for historical study, education, and research.

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ACS Advocacy Builds Momentum for Medicare Payment Reform

Don J. Selzer, MD, FACS
Hallie Koch

The ACS has been a leading voice in Medicare physician payment reform for decades and continues to lead these efforts on Capitol Hill and across the physician community.

ensuring appropriate surgical reimbursement is fundamental to maintaining access to high-quality surgical care for patients across the US.

The current physician payment system was established under the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, which was widely viewed as a meaningful and positive step toward value-based care and a transition away from the Sustainable Growth Rate (SGR).

Under the SGR, Congress was forced to enact repeated temporary legislative fixes to prevent automatic payment cuts whenever Medicare spending exceeded the economy's target growth rate. Repealing the SGR and replacing it with MACRA was intended to shift Medicare toward value-based care while ending the cycle of annual payment reductions.

While the transition to the new system eliminated the annual financial cliffs associated with the SGR, it continues to impose annual payment cuts by reducing the Medicare Physician Fee Schedule (MPFS) conversion factor (CF), leaving physicians vulnerable to recurring reductions in reimbursement. Although many aspects of the current Medicare physician payment system function well, key components have created an unsustainable payment model that threatens surgeons' ability to care for the nation's most vulnerable populations.

An omnibus legislative package in 1989 (Public Law 101-239) created the current system used by the MPFS to value physician services, including the Resource-Based Relative Value Scale and Relative Value Units (RVUs). The legislation also established a budget neutrality requirement that has remained unchanged since 1992. As a result, when the value of some billing codes is increased, those increases must be offset by reductions in the value of other billing codes to maintain budget neutrality and control spending.

In addition, unlike other Medicare payment systems, the MPFS budget neutrality requirement is not coupled with a mechanism that adjusts physician payment for inflation. Together, these policies are significant features of the Medicare physician payment system and among the many external pressures that have contributed to the shift from independent practice to employed models. While decades of legislative and policy changes have shaped the current Medicare physician payment system, the value assigned to surgical care continues to erode.

The ACS Division of Advocacy and Health Policy leads efforts to advance meaningful reimbursement reform, and surgeons play an important role in shaping the future of sustainable physician payment.

Current State of Medicare Physician Payment

Major surgical procedures with 90-day global periods continue to face reimbursement challenges, including payment instability caused by budget neutrality and the lack of an inflationary update, as well as calendar year 2026 MPFS changes, such as the efficiency adjustment and updates to indirect practice expenses. The ACS has consistently engaged with policymakers to address these long-term reforms, which are necessary to resolve structural issues in the MPFS.

However, urgent short-term issues often arise, and the ACS continues to be a leading voice on Capitol Hill, advocating for immediate relief. These issues typically stem from years of conversion factor cuts, the lack of adjustments to align Evaluation and Management (E/M) global codes with standalone E/M codes, and most recently, the efficiency adjustment. Although these challenges require prompt action, they also must be addressed while maintaining a robust strategy for long-term Medicare physician payment reform.

Both long- and short-term policy issues create financial strain and uncertainty for surgical practices, especially small and independent practices. Without an inflationary update, reimbursement fails to keep pace with the rising costs of operating a practice and employing staff, placing increasing financial pressure on physician practices. The budget neutrality requirement can further reduce reimbursement when certain codes are revalued upward, requiring offsetting reductions in the conversion factor. Because these annual cuts are unpredictable, practices face significant challenges in planning for the future when reimbursement levels remain uncertain.

The efficiency adjustment introduced additional unpredictability, under which all work RVUs were reduced by 2.5% without supporting evidence. This cut is the first of what could become a series of reductions under a recurring 3-year cycle in which work RVUs may continue to decline based on productivity data for the entire Medicare Economic Index (MEI), which is not physician specific.

This cycle of RVU reductions affects all surgeons because RVUs determine direct reimbursement in private practice and serve as the basis for compensation in many employment contracts.

The current system of annual payment cuts, now compounded by an additional cyclical reduction, is unsustainable for surgery and threatens the future of the surgical workforce and patient access to high-quality surgical care. Although these policies impact employed and independent surgeons differently, the failure to adjust the conversion factor for inflation or the Consumer Price Index has placed increasing pressure on surgeons to increase hours in the office and OR.

Financial relationships and investments in healthcare facilities have helped surgeons, but surveys consistently show an average workweek of 60 hours or more, excluding time spent on call at home. Even before and during the early stages of the COVID-19 pandemic, unrealistic workloads contributed to high levels of burnout, prompting many surgeons to scale back their practices or leave clinical medicine altogether. Today, the average age of physicians leaving clinical medicine is younger than 50 years. Ongoing cuts to the conversion factor and the implementation of the efficiency adjustment have only exacerbated the problem.

> The efficiency adjustment introduced additional unpredictability, under which all work RVUs were reduced by 2.5% without supporting evidence.

Data published last year in the *Journal of the American College of Surgeons* demonstrate that surgical care has not become more efficient. In fact, it has become more challenging, requiring longer operative times. The implementation of the efficiency adjustment does not accurately reflect

As surgical reimbursement has been steadily devalued over several decades, surgeons have compensated by working longer hours.

the current realities of surgical care. As surgical reimbursement has been steadily devalued over several decades, surgeons have compensated by working longer hours. As demand for surgical care continues to grow because of the nation's aging population, balancing the needs of the patient with increasingly complex conditions has become more difficult. Without additional workforce capacity or more hours in the day, current payment policies threaten access to high-quality surgical care, particularly for patients with the most complex clinical needs.

ACS Advocacy: Leading the Charge

The ACS has a dedicated advocacy team in Washington, DC, that works with congressional and executive branch decision-makers on policies affecting surgical practice. Through direct lobbying and engagement of its grassroots network, the College has helped mitigate several years of planned MPFS CF cuts while continuing to advocate for broader physician payment reform.

The 2026 CF cut was prevented by legislation passed in summer 2025, due in part to the ACS's consistent advocacy emphasizing the urgency of avoiding the reduction. The additional funding Congress provided to avert the cut was a clear sign that lawmakers value the physician workforce. However, temporary investments remain constrained by competing budget priorities and finite federal resources, making long-term physician payment reform more difficult to achieve.

Recent estimates suggest that implementing a permanent inflationary update would cost approximately $65 billion annually over the next 10 years. To put that figure in perspective, it represents about 4% of current annual mandatory federal spending. Despite its significant cost, the ACS continues to push for legislation that would provide a permanent inflationary update.

Improving payment stability and predictability is a central goal of the ACS's advocacy efforts, and engaging key members of Congress is essential to building support for reforms with significant budgetary costs. One of the College's most effective strategies has been coalition building. The ACS not only leads the surgical coalition on Capitol Hill but also works alongside the broader community of procedural specialties to restore work RVUs.

The ACS's leadership on Medicare physician payment begins during the MPFS public comment period, when the College helps shape policy by responding to proposed changes and new initiatives.

As the impact of the proposed policies on affected specialties becomes clear, the ACS often identifies allies across the physician community. The College's legislative team translates that information into a strategy to engage Congress while balancing political feasibility with opportunities for success. Once federal rulemaking in the executive branch is finalized, the most effective way to modify those policies is often through legislation. By engaging Congress, the ACS helps lawmakers understand how these policies affect surgeons and the patients they serve.

This approach is reflected in the ACS's response to the 2026 efficiency adjustment. When the Centers for Medicare & Medicaid Services (CMS) first proposed the policy, the ACS submitted comments

opposing the reduction as flawed and unsupported by evidence. In support of those comments, ACS Fellows and members of the Resident and Associate Society provided data refuting CMS's assertion that operative times were decreasing. Using data from the ACS National Surgical Quality Improvement Program® (NSQIP), the authors published a peer-reviewed article during the public comment period. The publication was cited by the ACS and numerous healthcare organizations in their comments to CMS. Although CMS ultimately finalized the policy, the ACS shifted its focus to pursuing legislative action.

Using the evidence and data prepared during the public comment period, the ACS successfully advocated for the introduction of bipartisan legislation to address the cut: HR 7520, the Efficiency Adjustment Delay Act. The bill would prohibit future efficiency adjustments unless CMS provides evidence demonstrating the need for an across-the-board reduction in procedural RVUs.

While this bill is still in the early stages of gaining support, each step in the legislative process represents meaningful progress for the ACS's advocacy efforts. Introducing bipartisan legislation is challenging in today's political environment, and every additional cosponsor strengthens the bill's prospects. As these incremental legislative successes translate into policy changes, ACS advocacy helps shape reimbursement trends, practice management decisions, and the long-term sustainability of surgical practices.

How Surgeons Can Get Involved

HR 7520 was a central focus of the 2026 ACS Leadership & Advocacy Summit (LAS), where surgeons from across the US traveled to Washington, DC, to meet with members of Congress and advocate for legislation affecting their patients, their practices, and the future of surgical care. Through the advocacy efforts of ACS Fellows, awareness of the bill has grown substantially, while the bill has gained bipartisan cosponsors.

By participating in LAS, surgeons have the opportunity to speak directly with members of Congress about the policy priorities the ACS advances year-round. The College extends those advocacy efforts through its Advocacy at Home program, which enables Fellows to meet with their congressional representatives in their home districts and continue those conversations throughout the year.

As the value of surgical care continues to decline, the ACS remains a leading advocate for surgeons, working with the broader physician community and providing Congress with trusted expertise on policies affecting surgeons and their patients. As a convener across the surgical community, the College helps shape sustainable solutions that benefit the full House of Surgery®.

The work of the ACS Division of Advocacy and Health Policy is strengthened by the collective voices of Fellows. Surgeons can participate through the SurgeonsVoice platform to communicate directly with their members of Congress and share how these policies affect everyday surgical practice and patient care. B

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Dr. Benoît Blondeau

"Invisible" Surgical Queues May Delay Care for Nonemergent Patients

Benoît Blondeau, MD, MBA, FACS

It is late afternoon. ORs are still running, but not for the patient who has been waiting on the add-on list for hours.

A PATIENT ARRIVED through the emergency department with a condition that clearly requires surgery. It is not immediately life-threatening, but it also cannot wait for a clinic visit or a scheduled slot several days later. She has been evaluated, stabilized, made NPO, and consented. Everything is ready, except access to the OR.

We often describe modern surgical care as patient centered. Yet, for a substantial group of patients, the experience is defined less by clinical urgency than by when the system can accommodate them.

In many respects, surgical systems perform remarkably well when patients fit established pathways. Elective patients follow a predictable course: They are scheduled in advance, prepared on arrival, treated by a ready team, and moved efficiently into recovery. Critically ill or injured patients follow a different but equally well-engineered pathway: When life-threatening hemorrhage or instability is present, teams mobilize and an OR opens within minutes.

But between these two groups lies another population: patients who are neither scheduled nor unstable. They require surgery, often within hours—not days—but they do not trigger the same urgency or access.

These patients do not move through a care pathway. They move through a gap.

A System that Works but Still Leaves Patients Waiting

This gap in OR access is not the result of inattention or a lack of commitment. It stems from how OR systems are structured and how performance is defined.

Most hospitals organize surgical access around two priorities: maintaining a full elective schedule during business hours and preserving the ability to respond to true emergencies at any time. Both priorities are appropriate, and both are measurable.

But another group of patients exists in the shadow of those priorities: patients who require surgery during their current hospitalization and cannot safely return home, yet do not meet the threshold for immediate operative access.

This conundrum does not exist outside the system. It is built into it.

The lack of access is not simply a matter of whether the OR is busy. At the core of the issue is how we define performance and whether that definition is broad enough to include patients whose waiting has become routine.

When Delay Is Not a Failure but a Feature

We often describe these situations as delays, implying that they result from breakdowns in an otherwise well-functioning system.

But in many cases, they are not breakdowns. They are the predictable consequence of design.

Daytime schedules are tightly allocated, while after-hours capacity is often constrained. Decision-making is distributed across services, each balancing its own priorities and challenges. Even when systems protect time for unscheduled cases, that capacity is often insufficient to absorb demand. Individual decisions—to defer a case to the next daytime slot, avoid displacing a scheduled case, or wait until morning—may be reasonable in isolation.

Once a patient has been admitted and a decision to operate has been made, time is no longer neutral. It becomes part of the care we deliver—or fail—to deliver.

Collectively, however, these deferrals create a queue that no one owns, no one routinely reports, and for which no one is truly accountable.

Over time, this approach becomes normalized. Surgeons anticipate the barriers and adapt accordingly. Cases that might benefit from earlier intervention are deferred because timely access seems unlikely. The system appears to function because behavior has adjusted to its limits.

We speak easily about care without delay. Yet for many patients, the reality is care delivered within a structure that quietly normalizes delay.

Operational Blind Spot

One reason these delays persist is that they can be difficult to identify.

OR performance is typically measured using metrics that emphasize scheduled throughput, business-hours use, and responsiveness to emergencies. These are important benchmarks, but they do not capture the experience of the unscheduled, nonemergent patient.

Time to operation may be measured from the moment a case is posted or cleared rather than from when the patient enters the system. Delays may be attributed to clinical optimization or coordination without examining whether access itself is the constraint.

Part of the challenge lies in how incentives are structured. OR use during business hours is closely tracked and optimized. In contrast, care delivered after hours is often treated as a deviation to be minimized rather than as a component of timely care.

What Does "Timely" Actually Mean?

In an era of constrained staffing, limited margins, and pressure on throughput, hospitals have become highly attuned to efficiency within the scheduled day. But an important question remains: Can we afford not to provide these patients with timely surgical care?

The challenge, of course, is that "timely" is rarely defined for patients who are neither elective nor emergent.

For this group, timeliness is not about immediacy. It is about aligning clinical need with OR access without prolonged, nontherapeutic waiting. Once a patient has been admitted and a decision to operate has been made, time is no longer neutral. It becomes part of the care we deliver—or fail—to deliver.

Any definition of timely care in this context should be pragmatic. It must be ambitious enough to prevent routine delay from becoming acceptable, but realistic enough to account for staffing, competing priorities, and finite capacity. The goal is to aim high without pretending that constraints do not exist.

Without that balance, systems tend to oscillate between rigid targets that fail in practice and flexible approaches that quietly accept delay as inevitable.

For patients, prolonged preoperative waiting exposes them to pain, immobility, and the cumulative effects of hospitalization. In older adults, each additional hour may increase the risk of delirium, deconditioning, and loss of independence. For others, delay may allow disease to progress or make procedures more technically complex.

For surgeons practicing in this environment, clinical judgment is repeatedly constrained by access rather than need. Efficiency also suffers as inpatient length of stay increases and downstream capacity tightens.

For organizations, this is a throughput problem, a quality problem, and, increasingly, a financial problem. The costs of delay are dispersed across units, days, and services, making them easy to overlook. But they are not negligible.

Making the Invisible Visible

Addressing these delays does not begin with adding more ORs or staff, although these measures may eventually be part of the solution. Improving timely surgical care begins with making the problem visible.

1. **The patient population must be recognized.** Whether or not a formal label is used, identifying patients who are neither elective nor emergent, but remain time sensitive, is essential. Some healthcare professionals refer to this group as nonelective, nonemergent (NENE) patients. The label matters less than recognizing the distinct needs of the cohort.

2. **Measurement must shift toward the patient's experience.** Tracking time from arrival or the decision to operate, rather than from administrative milestones, focuses attention on metrics that reflect what patients actually experience.

3. **The OR queue must be visible to all stakeholders.** A shared daily view of pending unscheduled cases transforms delay from an individual negotiation into a system responsibility.

4. **Escalation pathways must be defined.** Without clear thresholds for when wait times are no longer acceptable, decisions default to the path of least resistance.

5. **Hospitals must confront the practical reality of capacity.** Most organizations cannot easily expand the number of staffed ORs. Flexibility, therefore, may require extending hours and absorbing demand beyond the scheduled day. But this approach depends on alignment among surgeons and colleagues in anesthesia, nursing, sterile processing, transport, recovery, and inpatient units.

6. **System leaders must acknowledge that decisions are often made from service-specific perspectives.** What appears reasonable for one department may contribute to delay at the system level. Without a shared view of the patient journey, local optimization can undermine overall flow.

We have built highly reliable models for scheduled surgery and highly responsive models for life-threatening emergencies. But between those two domains lies a substantial portion of surgical care: patients who fit neither model, yet whose outcomes still depend on timely intervention. B

Disclaimer

The thoughts and opinions expressed in this article are solely those of the author and do not necessarily reflect those of the ACS, HealthPartners, or the University of Minnesota.

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Dr. Satyan Shah

Professional Dress Still Matters in Surgery

Satyan K. Shah, MD, FACS

As social and professional missteps go, mine was memorable.

IT WAS A SPRING DAY in Anaheim, California. Thousands of surgeons had gathered for the American Urological Association Annual Meeting. I was a resident at the time and felt privileged to attend such a major conference. The most important lesson I learned that day, however, had nothing to do with surgery.

Upon entering the convention center, my heart sank. I was the only person not wearing a necktie, or, for women, a business suit. It got worse. A mentor spotted me and began introducing me to several of his colleagues. Their body language conveyed obvious disapproval of my business-casual attire. That's when I learned what everyone else already seemed to know: Casual attire may be acceptable in the hospital, but professional meetings call for semiformal dress, unless they're held in Hawaii.

After residency, I noticed the same contrast again and again. The same physicians who wore scrubs and fleece jackets during the workweek were impeccably dressed at professional gatherings. One colleague told me the ACS Clinical Congress was his once-a-year opportunity to pull a suit out of the closet. This unspoken expectation of semiformal attire seemed to hold true regardless of specialty or season. I was particularly struck by it last year at an early summer meeting in Las Vegas. Among the tourists and Elvis impersonators were crowds of physicians looking uncomfortable in dark wool suits.

I don't mean to imply that dressing up is somehow wrong. If semiformal attire is appropriate for weddings and funerals, it is certainly appropriate for medical meetings. After all, these are the places where physicians network, interview for fellowships, meet future employers, and celebrate their specialty.

My concern is the sartorial double standard that has become increasingly common in surgery. In the hospital, casual attire is now widely accepted. It's common to see physicians in polo shirts, khakis, and even sweatshirts. Scrubs are routinely worn outside the operating room. The white coat, once ubiquitous, has often been replaced by the fleece jacket. Neckties have fallen out of favor, partly because of concerns that they may serve as vectors of infection. Dress shoes? Sneakers increasingly seem to be the footwear of choice.

Etiquette experts have long argued that clothing reflects the importance we attach to an occasion.[1] Attire communicates respect and consideration for others. By that measure, what could be more important than caring for a patient? It is a privilege to be a surgeon and to earn our patients' trust. We owe it to them to demonstrate that respect not only through our words and actions, but also through our appearance.

What message are we sending when we wear fleece jackets at the hospital but suits at professional meetings? Could radically different dress codes

unintentionally suggest that patients are less important than our colleagues? Research on physician attire suggests that patients have greater confidence in physicians who wear white coats.[2] They also associate more formal dress with competence and professionalism. In general, patients prefer physicians to dress more formally.[3] Unfortunately, many of us do not seem to be listening.

Professional dress in medicine wasn't always this relaxed. At The University of New Mexico, medical students in the Class of 1968 were simply told to "come dressed appropriately" at the start of the school year.[4] No further explanation was needed: the men wore neckties, and the women wore professional dresses. Things were not much different when I was a medical student in the 1990s. At the start of my surgery rotation, we were told that scrubs were not appropriate outside the OR. In clinic, professional attire and a short white coat were expected. Even *Surgical Recall*, my indispensable companion during that rotation, reminded students that "...appearance is so important [because] the patient sees only the wound dressing, skin closure, and you!"[5]

In the early 21st century, workplace norms began to shift. Society as a whole became more casual. Silicon Valley embraced sneakers and T-shirts as part of its corporate culture. Iconic retailers such as Brooks Brothers, long associated with presidents and business leaders, declared bankruptcy. Comfort and convenience increasingly became the priorities.

Scrubs also took on a new role as the wardrobe of the entire hospital. Pharmacists, radiology technologists, internists, and many others began wearing them. For some, scrubs even became a form of branding, embroidered with practice logos and names. Physicians also began wearing scrubs beyond the hospital—in grocery stores and other public settings. Television shows such as *Grey's Anatomy* helped normalize some of these trends. Another series, *Dr. 90210*, even featured a California plastic surgeon whose scrub sleeves were cut off like a muscle shirt.

Many professions with significant public responsibility have largely resisted the trend toward increasingly casual dress. Pilots, members of the military, and law enforcement officers continue to wear uniforms that reflect the importance of their roles. Medicine has not been entirely immune to this shift, but traces of more traditional standards remain. At many hospitals, there is still the occasional physician wearing a bow tie or making rounds in a bespoke suit. The Mayo Clinic, in particular, is well known for its culture of professional dress. The suits that define "Mayo wear" are considered a "... way of showing respect and honor at being able to serve patients."[6] Although that standard may not be practical for every institution, the principle behind it is worth considering.

I would encourage my colleagues to be more intentional and consistent in how we present ourselves. A more professional appearance can only strengthen the public image of surgery. Patients value it, and we already recognize its importance when we gather for professional meetings. Will it require a little extra effort? Perhaps. But the benefits are worth it.

Professional attire has also become easier to wear. Modern fabrics are more comfortable, require less maintenance, and are available at a wide range of price points. Dressing professionally need not be expensive or impractical.

Physician attire should not be guided solely by comfort and convenience. Professionalism and patient perception matter as well. Professional attire need not mean returning to outdated norms, but it should reflect the same respect for patients that we naturally convey to colleagues at professional meetings. Our patients deserve that same level of respect, and a more professional appearance can only strengthen the patient-physician relationship.

Disclaimer

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

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Joint Commission Expands Surgical Safety Through Shared Best Practices

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

FOR 75 YEARS, Joint Commission has played a central role in advancing healthcare quality and patient safety across the US. Today, the organization is undergoing a significant transformation, reframing how it partners with clinicians, surgical teams, and healthcare organizations.

For many surgeons, Joint Commission surveys have long been associated with extensive documentation, paperwork, and operational disruption. Accreditation was often perceived as focusing more on process compliance than on the realities of clinical care. While that perception was understandable, it no longer reflects today's Joint Commission.

The organization has evolved from a guard dog to a guide dog—less focused on identifying failure and more focused on preventing it. Central to that evolution is the newly launched Survey Analysis for Evaluating STrengths (SAFEST™) program, which identifies and shares leading practices that advance quality and patient safety.

From Policing to Partnership

Historically, accreditation feedback focused almost exclusively on deficiencies. During a survey, Joint Commission representatives visited healthcare organizations to evaluate operational processes and identify opportunities for improvement. Teams of trained surveyors determined whether standards were in place and being followed appropriately. When deficiencies were identified, organizations were required to develop and implement corrective action plans. Failure to do so could affect reimbursement and licensure.

This process unquestionably improved the quality and safety of healthcare. Nevertheless, it also contributed to the apprehension many healthcare organizations felt leading up to a Joint Commission survey.

Rather than asking, Where did you fail? SAFEST asks, What should others learn from you? What are you doing right?

Today, the mission remains unchanged: ensuring that every patient receives the highest-quality, safest care possible. What has changed is the approach.

Through the SAFEST program, surveyors formally identify and document performance strengths—novel, innovative, or exceptionally reliable practices observed during a survey that contribute to safe, high-quality care. These strengths are summarized in a SAFEST report shared with the organization at the conclusion of the survey.

Rather than asking, Where did you fail? SAFEST asks, What should others learn from you? What are you doing right?

Joint Commission began collecting performance strengths during hospital and critical access hospital surveys in February 2026, and the initiative has been met with widespread enthusiasm. The long-term vision is to create a searchable database of leading practices that healthcare organizations can use to address common safety challenges.

Joint Commission currently accredits nearly 4,000 hospitals in the US. As SAFEST expands, surgeons can expect the accreditation process not only to identify gaps in care, but also to recognize and disseminate effective surgical safety practices as part of a dynamic, shared learning system.

The organization is using a sophisticated information platform to collect, evaluate, and categorize these data. In the not-too-distant future, surgeons and other healthcare professionals will be able to access proven practices at their fingertips, share successful approaches, strengthen benchmarking, and ultimately improve patient outcomes.

Why This Matters for Surgeons

Surgeons practice in environments where outcomes, reliability, and teamwork are paramount. Joint Commission's evolution brings accreditation closer to those realities by highlighting excellence—not just deficiencies—and reinforcing a culture of learning rather than blame. In many ways, the approach mirrors the philosophy behind surgical quality improvement programs by promoting transparency, benchmarking, and continuous learning.

One of the most promising aspects of SAFEST is the opportunity to translate leading practices into practical tools that clinicians can use every day.

Consider the reprocessing of endoscopes, a critical patient safety issue. Under a SAFEST-informed model, a high-performing organization's approach could be identified, validated, and shared broadly. Rather than relying solely on written standards, clinicians could access concise visual guidance—such as a short instructional video or checklist—demonstrating the key steps needed to ensure proper reprocessing.

Looking ahead, these resources could be delivered through mobile applications, allowing surgical teams to review essential steps immediately before a procedure. This kind of real-time support represents a fundamental shift from retrospective evaluation to prospective, point-of-care guidance.

For the surgical community,

SAFEST: Highlighting What Works in Patient Safety

What Is SAFEST?	· SAFEST stands for Survey Analysis for Evaluating STrengths. · Launched in February 2026, SAFEST is a Joint Commission initiative that identifies and recognizes high-performing practices during accreditation surveys.
How It Works	· Surveyors document performance strengths—exceptional processes that support safe, high-quality care. · These strengths are summarized in a formal SAFEST report provided at the conclusion of the survey. · Selected practices may be developed into shared resources for other healthcare organizations.
Why It Matters	· Balances the accreditation process by recognizing excellence, not just deficiencies. · Promotes peer-to-peer learning through the sharing of real-world solutions. · Supports a culture of continuous improvement and innovation.
What Healthcare Organizations Gain	· Formal recognition of leading practices that can be shared with staff, leadership, and patients. · Access to a growing library of proven safety and quality strategies. · More balanced, actionable feedback alongside SAFER® Matrix findings.

Part of a Broader Shift

SAFEST is a core element of Accreditation 360: The New Standard, reflecting Joint Commission's broader shift toward learning, transparency, and systemwide improvement—not simply compliance.

Learn more at www.jointcommission.org/en-us/accreditation/accreditation-360/safest

Understanding performance strengths creates a strong foundation for improvement. Building on what organizations do well helps them address ongoing challenges more effectively.

To support this work, Joint Commission also is launching Impact 360, a learning series focused on common Requirements for Improvement. The series begins with educational resources on high-level disinfection and sterilization.

these changes signal a more engaged and practical partnership with Joint Commission. By integrating data, highlighting performance strengths, and delivering actionable insights, the organization is making safety guidance more accessible, relevant, and immediately useful.

The rigor that established a national baseline for patient safety is now being paired with tools and insights designed to accelerate improvement across the healthcare system. For surgeons and health system leaders, this evolution offers a more constructive, and ultimately more effective, path toward achieving the shared goal of safer care for every patient.

Accreditation is no longer simply something to "get through." It can become another tool—alongside registries, peer review, and morbidity and mortality conferences—for advancing surgical quality, patient safety, and trust. B

Disclaimer

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

Dr. Lenworth Jacobs *is a professor of surgery at the University of Connecticut in Farmington and director of the Trauma Institute at Hartford Hospital in Connecticut.*

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Dr. Justus Ohage Pioneered the Modern Cholecystectomy

Peter J. Kernahan, MD, PHD, FACS

On the evening of September 27, 1886, Justus Ohage, MD, presented an unusual surgical specimen to the Ramsey County Medical Society in Saint Paul, Minnesota.

THE SPECIMEN was a gallbladder he had removed 3 days earlier.[1] Described in the meeting minutes as "very interesting," it was only the ninth gallbladder removed in the world at that time and the first outside Germany or France.

The following month, Dr. Ohage presented a well-received paper to the society titled "The Surgical Treatment of Diseases of the Gall-Bladder."[2] In it, he observed that surgeons were now performing "operations [that were] but a few years ago considered absurd." His operation and accompanying paper provide a window into the state of surgery in the 1880s, a decade widely regarded as transformative for the profession.

From Soldier to Surgeon

By his own account, Dr. Ohage (1849–1935) led a colorful early life.[3] The son of a German surgeon, he immigrated to the US in 1864 at age 14. He joined a New Jersey regiment during the American Civil War, where he was wounded in action. While recovering in a military hospital, he met President Abraham Lincoln, who was visiting wounded soldiers. Dr. Ohage returned to Germany from 1865 to 1870, then spent time in the American west with Buffalo Bill Cody before graduating from the University of Missouri

Dr. Justus Ohage

Medical School in 1880. After a year of additional study in Europe, he settled permanently in Saint Paul in 1881.

He quickly established himself as a prominent physician and surgeon. Although his education lacked the structure of later surgical training, by the standards of the day he was a well-trained clinician. As a native German speaker, he also had direct access to the leading surgical literature of the era, including Carl Johann August Langenbuch's pioneering cholecystectomy in 1882.[4]

For abdominal operations to no longer be considered "absurd," four prerequisites had to be met: evidence that the organ—in this case, the gallbladder—was not essential to life; the availability of anesthesia; antisepsis and asepsis; and an understanding that internal diseases originated in specific organs rather than reflecting a systemic imbalance of "humors" or "fibers." By the 1880s, all four conditions had been met.

The technical aspects of these operations also required refinement. Dr. Langenbuch practiced on cadavers, while Dr. Ohage, closely following developments in Europe, rehearsed the procedure on canine specimens at his hospital. As historians have noted, every abdominal operation performed during this period was, in many respects, experimental. It is little wonder that most surgeons approached these procedures cautiously.

Although his education lacked the structure of later surgical training, by the standards of the day he was a well-trained clinician.

Preparation Meets Opportunity

Because of his background, education, and experimentation, Dr. Ohage was well prepared when 35-year-old "Mrs. Lena A., Swede" presented to his office on September 23, 1886, with a 3-month history of pain, intermittent jaundice, and a palpable right upper quadrant mass.

He admitted the patient and operated the following day using strict antiseptic technique, although without carbolic acid spray. Notably, he maintained the operating room at 90°F. Assisted by the house surgeon and four prominent practitioners, he ensured the presence of respected professional witnesses, a recommended safeguard for surgeons undertaking major operations at the time.

Dr. Ohage used a 6-inch (15.2-cm) incision parallel to the lateral border of the rectus muscle. By comparison, Dr. Langenbuch used a T-shaped incision consisting of a 10–15 cm horizontal limb along the liver edge

Dr. Ohage's experience illustrates how many internal diseases became the domain of surgery during the late 19th century.

intersected by a 10–15 cm vertical incision along the rectus border.

After mobilizing the gallbladder, Dr. Ohage milked a large, impacted stone from the cystic duct. He ligated the cystic duct with carbolized silk, removed the gallbladder, irrigated the operative field with antiseptics, and closed the incision in layers with silk sutures. Remarkably, the gallbladder contained 135 stones. The patient was allowed to sit up on postoperative day 11 and was discharged on postoperative day 13.

Eight months earlier, when confronted with a thickened, friable, edematous gallbladder, Dr. Ohage had instead performed a delayed cholecystostomy. He brought the gallbladder fundus to the wound, secured it with iodoform packing, and opened it at the bedside on postoperative day 8. Aside from an intermittent fistula, the patient recovered well.

Dr. Ohage's Recommendations for Gallbladder Surgery

Dr. Ohage published his case report and literature review in *Medical News*.[2] Including his two patients, only 50 cholecystotomies and 9 cholecystectomies had been reported worldwide. At that time, cholecystotomy carried a mortality rate of 22%, compared with 11% for cholecystectomy.

He described three operative approaches to gallbladder disease:

1. Suturing the gallbladder to the abdominal wall with delayed opening ("natural cholecystotomy")
2. Emptying and closing the gallbladder ("ideal cholecystotomy")
3. Cholecystectomy ("Langenbuch's operation")

Reflecting the evolving understanding of gallbladder disease, Dr. Ohage directly addressed and affirmatively answered the question many physicians of the day were asking: "Is life compatible without the existence of a gallbladder [sic]?"

The Dr. Justus Ohage Memorial at Harriet Island Regional Park in Saint Paul, Minnesota, honors the physician, surgeon, and public health leader.

Drawing on his limited personal experience and the existing literature, Dr. Ohage offered several recommendations. He considered surgery indicated for (1) repeated attacks of pain; (2) obstruction of the cystic or hepatic ducts; and (3) perforation of the gallbladder, even in the presence of shock.

For elderly (those older than 50 years) or debilitated patients or for patients with extensive inflammation or uncertain duct patency, Dr. Ohage recommended cholecystotomy. For younger, healthier patients, he considered cholecystectomy the preferred operation. He emphasized meticulous antiseptic technique and cleanliness, and forcefully asserted that "the diseases of the gallbladder belong to the surgeon."

Dr. Ohage's experience illustrates how many internal diseases became the domain of surgery during the late 19th century. This transformation reflected an evolving understanding of disease, growing confidence that organs could be safely modified or removed, and the availability of anesthesia and antisepsis. Dr. Ohage also recognized that physicians and the public needed convincing that these new operations were effective rather than absurd.

The age of radical surgery, and of the surgeon as an intrepid pioneer, had begun.[5]

Dr. Peter Kernahan *is chair of the ACS History and Archives Committee and an adjunct faculty member in the Department of Surgery at the University of Minnesota in Minneapolis.*

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Annual Business Meeting of Members

ALL MEMBERS are welcome and encouraged to attend the Annual Business Meeting of Members of the American College of Surgeons (ACS) on Tuesday, September 29, 2026, at 2:30 pm in Room 140AB on Level 1 of the Walter E. Washington Convention Center. This session is held in accordance with Article I, Section 6, of the *Bylaws*.

During the meeting, the ACS Officers and Governors will be elected, and College officials will present brief reports on the activities of the Board of Regents, Board of Governors, ACS Foundation, and more. Members are respectfully requested to attend.

Sherry M. Wren, MD, FACS
Secretary
American College of Surgeons
September 1, 2026

Learn more about registering for Clinical Congress and attending the Annual Business Meeting of Members at *facs.org/clincon2026*.

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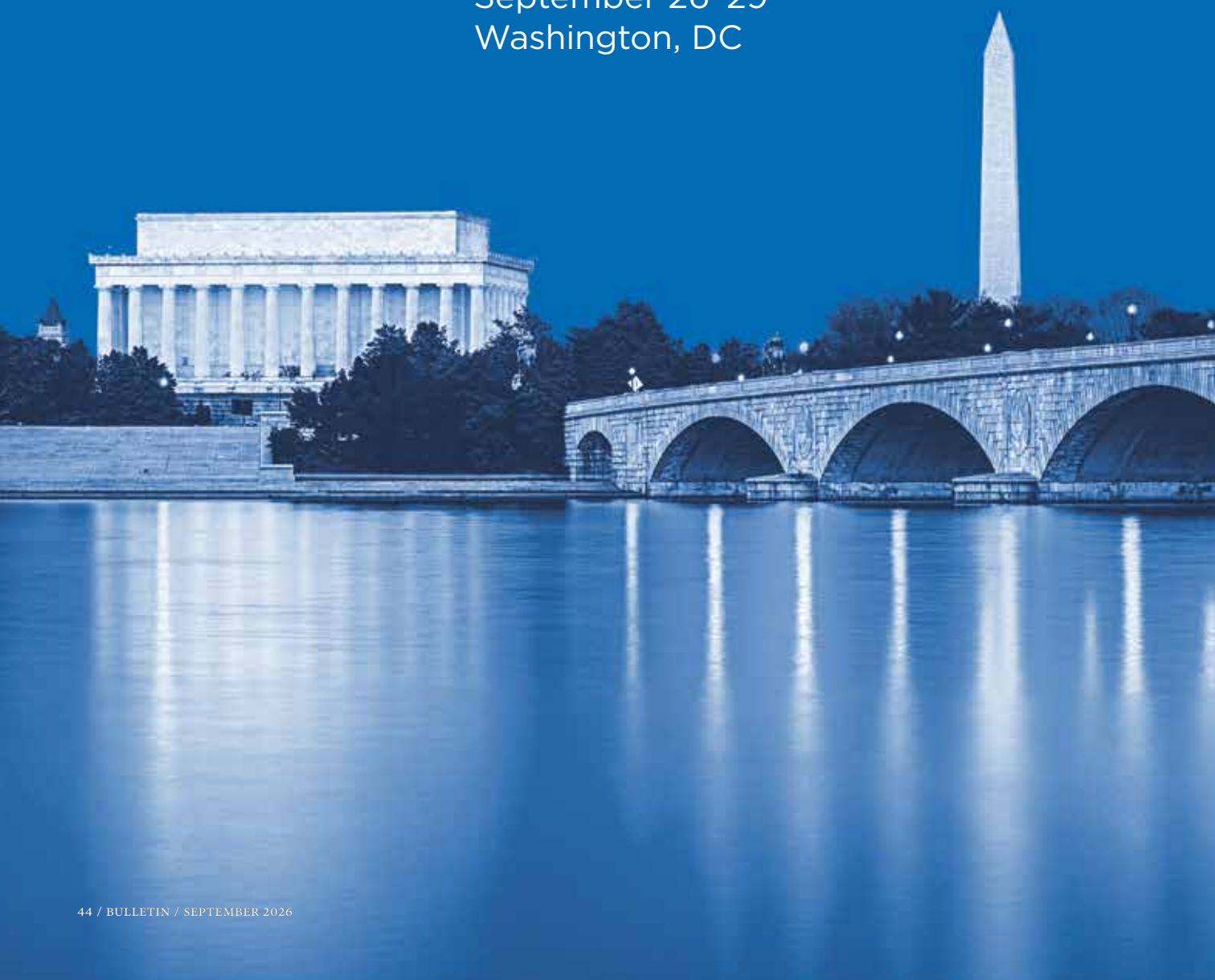

Major Awards at Clinical Congress 2026

SINCE THE FIRST CLINICAL CONGRESS in 1910, the conference has stood for the rigorous advancement of quality in surgical care. In addition to cutting-edge educational sessions, professional development, and networking opportunities, the meeting includes an annual presentation of awards to surgeons who exemplify excellence in surgery.

These honors recognize surgeons who have made outstanding contributions to patient care, science, leadership, and education. In addition to their professional achievements, the recipients have demonstrated extraordinary skill, dedication to scientific progress, and commitment to doing their utmost for others.

Award presentations will begin on Saturday, September 26, during Convocation. During the ceremony, the Distinguished Service Award, the highest honor of the College, will be bestowed upon an ACS Fellow who has demonstrated a career of exceptional service. The Dr. Mary Edwards Walker Inspiring Women in Surgery Award will recognize a surgeon who has advanced the status of women in surgery. The ceremony begins at 5:45 pm and will be livestreamed at *facs.org/convocation*.

On Sunday, September 27, from 12:45 to 2:15 pm, the ACS/Pfizer Surgical Volunteerism and Humanitarian Award recipients will share their insights at the Panel Session, "Humanitarian Surgical Outreach at Home and Abroad." These annual honors spotlight ACS Fellows and members who have made a positive impact through their efforts to provide surgical care, leadership, education, and research worldwide. The awards will be presented at the annual Board of Governors dinner on Monday, September 28.

Finally, the Wangensteen Scientific Forum Award will be presented on Tuesday, September 29, from 12:45 to 2:15 pm. This recognition is named after pioneering surgeon Owen Wangensteen, MD, PhD, FACS (1898–1981). It honors an academic surgeon whose career has demonstrated excellence in clinical, educational, and research pursuits.

For more information and to register for Clinical Congress, visit *facs.org/clincon2026*.

Distinguished Service Award Will Honor Dr. Charles Mabry

CHARLES MABRY, MD, FACS, surgeon-in-chief of Jefferson Regional Medical Center in Pine Bluff, Arkansas, will receive the ACS's highest honor, the Distinguished Service Award, at Convocation during Clinical Congress 2026 in Washington, DC.

Established in 1957 by the ACS Board of Regents, the award recognizes exceptional and continuous service by an ACS Fellow, as well as a career marked by an outstanding emphasis on patient care and commitment to the ideals of surgical practice.

"I'm very honored," Dr. Mabry said. "I never thought I'd get such a prestigious award."

Transforming Trauma Care

Dr. Mabry's engagement with the ACS began during his residency at the University of Arkansas for Medical Sciences (UAMS) in Little Rock, when he first encountered Advanced Trauma Life Support® (ATLS®). The program, now in its 11th edition and approaching its 50th anniversary, was brand new at the time.

As he completed his residency and began practicing surgery, Dr. Mabry was asked to develop the first trauma service at UAMS Medical Center. As part of that effort, he became an ATLS instructor, serving for 12 years and receiving the 1986 ACS Young Surgeon Award in recognition of his work.

He has remained involved in trauma care and education ever since. As he climbed the career ladder to become chief of surgery at Jefferson Regional Medical Center, he also engaged with the ACS through several trauma care programs. These roles included serving as the Arkansas state chair of the ACS Committee on Trauma and course director for the Arkansas Trauma Evaluation and Management (TEAM)™ Course, a collaboration between the Arkansas Trauma Society and Arkansas ACS Chapter.

Outside the ACS, he has served as medical director of the Arkansas Trauma Society and chair of the Governor's Trauma Advisory Council within the Arkansas Trauma System. He remains involved in training trauma teams.

"I develop trauma education for the state as part of the Arkansas trauma system and the Arkansas Chapter of the ACS, including different courses to teach surgeons and emergency physicians, nurses, and paramedics," he said.

Over the course of his career, Dr. Mabry has seen tremendous improvement in trauma care. "How we handle trauma patients now is really, truly, completely different than in the 1970s. It's been very interesting and very exciting to me to see the development of trauma over the years and how we've helped in managing trauma."

He credits the ACS with helping make that progress possible: "One of the things that has been very gratifying to me is to take the lessons learned at the national level and the international level and then incorporate that into our education here in Arkansas."

Dr. Mabry cited a 2024 study published in the *Journal of the American College of Surgeons* to further explain the impact. "One of the papers that I participated in was a study of the preventable mortality rate over time. Before the trauma system, around 30% of the trauma deaths were judged to be preventable or possibly preventable. Now we're down to around 1% or 2% preventable, and around 5% possibly preventable. So, it's really dropped over time," he said.

Defending Surgeon Compensation, and Much More

Dr. Mabry also has contributed to the ACS General Surgery Coding and Reimbursement Committee (GSCRC) for nearly 35 years. "Since 1992, I've been involved in trying to help the ACS get the appropriate value for the work we do, and that's been very gratifying," he said.

The work focuses on ensuring that Current Procedural Terminology codes and relative value units for surgical procedures are valued appropriately. Dr. Mabry is proud to be part of the team of Fellows who have represented general surgeons, who do not have a specialty-specific society outside the ACS, on the American Medical Association/Specialty Society Relative Value Scale Update Committee.

"The GSCRC does a lot of defensive work to prevent incorrect valuation of codes," he explained. "We've been very successful at preventing damage to the reimbursement for general surgeons over many years."

His contributions to the ACS have encompassed many roles beyond trauma and compensation issues. These include serving as course director for the ACS Basic and Advanced Coding Seminar, President of the ACS Arkansas Chapter, a member of the ACS Advisory Councils on General Surgery, Pediatric Surgery, and Health Policy, and chair of the ACS Health Policy Advisory Committee. Dr. Mabry also held positions on the ACS Board of Regents from 2003 to 2011 and as 2016–2017 ACS First Vice-President.

For more than 45 years, Dr. Mabry has served the ACS in numerous leadership roles.

Advice to Younger Surgeons

Dr. Mabry said his enduring involvement with the ACS reflects the benefits he has gained through his participation.

"In looking back over my career, I've gained so much from working in the College and working with the Regents, Governors, and Executive Directors, and all the directors in the College. It's just unbelievable how much I've learned from them. They are all very good mentors, and they want to teach you," he said.

Asked what advice he would offer younger surgeons, he returned to this idea. "I think the simplest and hopefully most memorable thing to say to them is get involved with the College," he said. "Whatever the College does, its goal is to help the surgical patient, and so you help the surgical patient, and you also help your fellow surgeons."

> "It's been very interesting and very exciting to me to see the development of trauma over the years and how we've helped in managing trauma."
>
> Dr. Charles Mabry

Enduring Commitment

Through his service, Dr. Mabry exemplifies the ACS motto "To Heal All with Skill and Trust" and the values the Distinguished Service Award recognizes.

His career also reflects both steadfast dedication and joy in his work. As Dr. Mabry, a lifelong Arkansan raised in Pine Bluff, said, "When I was in high school, I was an orderly in our hospital here. Now I'm back at the same hospital as a surgeon and the chief of surgery."

Although he didn't intend to come back to his hometown, he is happy to be there, serving his community and the wider world. "You can't beat the job I've got."

Dr. Timothy Billiar Will Receive Wangensteen Scientific Forum Award

SINCE 1940, the annual Owen H. Wangensteen Scientific Forum has showcased innovative academic research, with a particular focus on introducing new ideas, shaping future surgical practice, and engaging young surgeons.

This year, the Forum also will celebrate the 30th anniversary of the Wangensteen Scientific Forum Award. This annual honor recognizes a surgeon who has shown outstanding achievements in surgical innovation and mentorship throughout their career. For his cutting-edge investigations into nitric oxide and advances in understanding the human injury response, Timothy R. Billiar, MD, FACS, the George Vance Foster Professor and Chair of Surgery at the University of Pittsburgh School of Medicine in Pennsylvania, is the 2026 honoree.

Wangensteen Connections

Owen Wangensteen, MD, FACS (1898–1981), an eminent surgeon and scientist, created the Wangensteen Scientific Forum. Dr. Wangensteen also helped establish the University of Minnesota in Minneapolis as an outstanding institution for surgical training; Dr. Billiar later began his surgical training there.

The two surgeon-scientists share other traits as well. Both were raised in small farming towns, where early experiences with animals shaped their future careers. Dr. Wangensteen credited his interest in medicine to helping sows give birth to piglets on his father's rural Minnesota farm. Dr. Billiar's father was a veterinarian in small-town Nebraska who involved his son in the veterinary OR from a young age. Dr. Billiar credited his father, as well as his mother, a nurse, with inspiring his ambitions.

Although the two men never met at the University of Minnesota, Dr. Wangensteen's influence has resonated throughout Dr. Billiar's career.

"He was a legend there, and we all knew of his transformative thinking around the training of surgeon-scientists. He added a very fundamental part to this, and that is dedicated time for research training," Dr. Billiar explained. "That became the Minnesota model, which was ultimately adopted by a number of other places. Dr. Simmons and I built on this model in Pittsburgh."

Notable Scientific Achievements

After beginning his surgical residency at the University of Minnesota, Dr. Billiar followed his mentor, prominent transplant immunologist and surgeon Richard L. Simmons, MD, FACS, to the University of Pittsburgh. Both men have remained there, with Dr. Billiar eventually succeeding

Dr. Simmons as chair of surgery. Dr. Simmons, who received the Wangensteen Scientific Forum Award in 2001, remains chair emeritus.

Dr. Billiar has not only led improvements in trauma care but also built and led a prominent research laboratory. A trauma surgeon, he has investigated the mechanisms of organ injury and immune dysfunction in shock, trauma, and sepsis.

His scientific contributions include groundbreaking studies of nitric oxide in biological systems.

"Nobody anticipated that this small gaseous molecule, which is a component of air pollution, was actually a critical signaling molecule in the body," he said. "We were able to definitively show that humans express one of the high-output pathways for producing this gaseous molecule, and then ultimately clone the human inducible nitric oxide synthase gene."

Today, his laboratory focuses on multiomics approaches to understanding the physiological response to severe injury. "The thing that fascinated us was why some severely injured patients, say young, healthy patients in car accidents, do well, and others don't. That remains a poorly understood area," he said.

His laboratory has advanced this understanding through "the multiomics revolution, which is the measurement of thousands of molecules across different classes simultaneously in, say, the circulation," he said.

"We dove into multiomics about a decade ago, and we've been one of the programs that has been at the forefront of studying the multiomics of severe human injury."

Through biobanking, large databases, and advanced computational methods, the group has tracked thousands of proteins and metabolites simultaneously, enhancing the understanding of how the biology of trauma patients changes in multiple dimensions over time. "These massive datasets give us a global picture. You can now see all the biology simultaneously at the systemic level," he said.

His accomplishments include 35 years of continuous funding from the National Institutes of Health, authorship of more than 900 peer-reviewed publications, and nine patents. His insights have informed trauma care and clinical practice across surgical disciplines.

Dr. Billiar has mentored surgical and scientific trainees, including many who have gone on to careers in academic medicine and leadership roles. "That's one of the greatest pleasures of what we do: to see a person that we've been involved with, either directly or indirectly, succeed in this mission of performing meaningful research," he said.

Highly Honored and Humble

Throughout his career, Dr. Billiar has received numerous awards, including several from the ACS.

This award is particularly meaningful, he said. It reflects a nomination by colleagues and recognition through a forum that shaped both his early career and his current professional environment. The most profound aspect, though, is the full circle represented by the award.

> "It's through the generosity and the vision of surgical leaders who have led those initiatives that people like me have had accelerated careers as surgeon-scientists."
>
> Dr. Timothy Billiar

"I won an ACS Resident Research Scholarship in the late 1980s, and I was also a Traveling Fellow for the College as a resident. I also received the George Clowes Junior Faculty Award, the very first one," he said, referring to the George H.A. Clowes Jr., MD, FACS, Memorial Research Career Development Award.

The Wangensteen Scientific Forum Award carries greater meaning in light of the earlier ACS funding support, he said: "It's through the generosity and the vision of surgical leaders who have led those initiatives that people like me have had accelerated careers as surgeon-scientists. In a way, this is an award that the College should feel represents a success of its programs in supporting surgeon-scientists, by having someone who was supported so heavily early in their career by the ACS recognized this way."

Dr. Jo Buyske Is Recognized with Inspiring Women in Surgery Award

JO BUYSKE, MD, FACS, is the 2026 recipient of the Dr. Mary Edwards Walker Inspiring Women in Surgery Award. A general surgeon who specialized in minimally invasive, foregut, and acute care surgery, Dr. Buyske is being honored for her significant contributions to advancing women in surgery.

Transforming the ABS

Dr. Buyske is a groundbreaking surgeon. She has served as the executive director and CEO of the American Board of Surgery (ABS) since 2017 (having earlier been a volunteer oral examiner, then a director and the associate executive director of the same organization). She is the first woman to hold the role of ABS CEO. She was also the first female president of the Society of American Gastrointestinal and Endoscopic Surgeons.

Her work has helped to reshape the process of surgical training nationwide. Early in her tenure, she led an organization-wide restructuring that realigned specialty representation in governance and created a general surgery board as an individual unit.

Under her leadership, the ABS modernized board certification in multiple ways. These included updating the lifelong certification process to reflect the pace of clinical advancement and better meet the needs of practicing surgeons.

Dr. Buyske also helped advance the use of entrustable professional activities and competency-based learning to train surgeons.

Separately, she has worked to institute greater flexibility throughout surgical training via leave policies, updated approaches to scheduling, and international rotation options. "There was no flexibility in the system. It wasn't an education demand; it was a workforce demand," she explained, with a lot of "mythology" around being constantly available to patients: "You have to be available to your patients all the time, so you can't have a family. I was like, 'I hear you, yet I also note that you went to Germany to give a keynote address. So, were you available for your patients? It sounds like you can be unavailable for some reasons.'"

Interested in ensuring the surgical workforce remains robust, Dr. Buyske helped devise family-friendly policies, create on-ramps back to clinical practice for surgeons who had stepped away, and foster a cultural shift around workplace standards.

For Dr. Buyske, this was about serving all surgeons, not just women.

"I didn't set about trying to inspire and uplift women in surgery," she said, referring to the award she will receive. "It was about trying to be fair, do the right thing, and be practical. Too often,

I think women don't get treated fairly, people don't necessarily do the right thing, and the practicalities are absurd… if you do that, you end up really helping women."

A Civil War Shaped Her Calling

Dr. Buyske received her medical degree from Columbia University in New York, New York, and completed a general surgery residency and research fellowship at Massachusetts General Hospital in Boston. After starting her career at the Lahey Clinic in Burlington, Massachusetts, she eventually became chief of surgery and director of minimally invasive surgery at Penn Presbyterian Medical Center and associate professor of clinical surgery at the University of Pennsylvania, both in Philadelphia.

However, that biography does not capture a pivotal part of her life's work: her involvement in global surgery.

As a medical intern, she earned a spot on a Médecins du Monde and Médecins Sans Frontières mission to Mozambique, which was then in the late stages of a lengthy civil war. Shocked by the country's profound needs, she felt a strong commitment to help. "I knew I wanted to do surgery in underserved environments, wherever those might be," she said.

It took nearly another quarter-century to begin. Using a directory of volunteerism opportunities maintained by the ACS Health Outreach Program for Equity in Global Surgery (ACS H.O.P.E.®; then known as Operation Giving Back), she contacted three organizations. She collaborated with each but made her strongest connection to Partners In Health, a nonprofit with significant reach in Haiti.

She initially served as a respite surgeon in Port-au-Prince, relieving local surgeons for time off. "I loved the MacGyver aspect of it. I loved taking care of people who just needed to be taken care of," she said. "My favorite operation was a machete wound to the forearm. I was like, 'Machete wound? I'm a nice girl from northern New Jersey. I've never seen this.' But I fixed it."

Eventually, she used her position at ABS to offer more, spending 5 years helping to secure accreditation for the country's main teaching hospital, Hôpital Universitaire de Mirebalais in Mirebalais, and creating a system for training surgeons, nurse anesthetists, obstetrician-gynecologists, and emergency physicians. "We built it from the ground up, specific to Haiti, in cooperation with the government, the Ministry of Health, and Partners In Health," she said.

"They asked me back for their graduation when that first class of entering interns came. That, I think, that was one of the most profound moments of my life," she said. "I was the right person with the right skills that they needed right now, and this is what I was put here to do."

One-Way Ticket

Dr. Buyske is a member of the board and past director of the Accreditation Council for Graduate Medical Education-International and a director of the American Board of Medical Specialties. She also is an adjunct professor of surgery at the University of Pennsylvania, where her practice has included minimally invasive general and gastrointestinal surgery and acute care surgery.

However, in 2027, she will retire from the ABS and all other roles in the surgical profession. "I don't cling to the past in any way," she said. "I have a one-way ticket to Paris."

> "Surgery is an incredible career, in whatever form it morphs into going forward."
>
> Dr. Jo Buyske

She is happy to share her thoughts for younger surgeons, however.

"Surgery is an incredible career, in whatever form it morphs into going forward. It's not going to be the career I had. It's not going to be the one that my predecessors had," she said. "But the core of it is caring for people and helping them through some of the most difficult times of their life. It's such a gift to have the tools and the opportunity to be that person."

The Inspiring Women in Surgery Award is presented annually at Clinical Congress in recognition of an individual's contributions to the advancement of women in the field of surgery. The award honors the fortitude and accomplishments of Mary Edwards Walker, MD (1832–1919). Dr. Walker volunteered as a surgeon during the Civil War, becoming the first female surgeon to receive a commission with the US Army. As a result of her service, she became the only female recipient of the Congressional Medal of Honor.

Six Surgeons Are Honored for 2026 ACS/Pfizer Volunteerism and Humanitarian Awards

THE ACS BOARD OF GOVERNORS Surgical Volunteerism and Humanitarian Awards Workgroup announced the recipients of the 2026 ACS/Pfizer Surgical Volunteerism and Humanitarian Awards. These prestigious honors recognize and celebrate ACS Fellows and other members whose altruism, vision, leadership, and dedication serve as models for others and whose contributions have made a lasting difference to caregivers and patients around the globe. The awards are administered through the ACS Health Outreach Program for Equity in Global Surgery (ACS H.O.P.E.®).

The contributions of the six award recipients are briefly summarized in this article and will be formally recognized at Clinical Congress 2026 in Washington, DC. Clinical Congress attendees are invited to hear the honorees speak on their experiences at the Panel Session, "Humanitarian Surgical Outreach at Home and Abroad: Reports of the 2026 Surgical Volunteerism and Humanitarian Award Recipients," on Sunday, September 27.

Academic Global Surgeon Award
Juan Carlos Puyana, MD, FACS

For more than 3 decades, Dr. Juan Carlos Puyana has transformed trauma care and surgical education in some of the world's most resource-limited settings. Through enduring partnerships across Africa, Asia, and Latin America, he has strengthened trauma systems, advanced emergency surgical care, and cultivated generations of surgeon-leaders whose work continues to improve the lives of patients and communities long after his involvement has ended.

An internationally recognized trauma surgeon, critical care specialist, educator, and humanitarian, Dr. Puyana serves as a professor of surgery and critical care medicine at the University of Pittsburgh in Pennsylvania, and as the O'Brien Chair of Global

At the heliport of University of Pittsburgh Medical Center Presbyterian Hospital's Level I Trauma Center in Pittsburgh, Dr. Juan Carlos Puyana is joined by colleagues from the Division of Trauma and Acute Care Surgery, whose support has enabled his longstanding work in global health.

Surgery at the Royal College of Surgeons Ireland University of Medicine and Health Sciences in Dublin. Throughout his career, he has combined clinical excellence with a steadfast commitment to building sustainable systems of care. His collaborative efforts have strengthened trauma programs, expanded blood transfusion services, established trauma registries, and supported the development of national treatment protocols that have improved patient outcomes in low- and middle-income countries.

Education and mentorship have been central to Dr. Puyana's work. Supported by decades of National Institutes of Health-funded global health research and training programs, he has mentored more than 25 international trainees who have gone on to lead hospitals, academic departments, trauma programs, registries, and ministries of health throughout Latin America and Africa. By investing in local expertise and leadership, he has created a lasting ripple effect that continues to strengthen surgical care far beyond the institutions where he has served.

Dr. Puyana's influence extends well beyond the operating room and classroom. Through leadership in the Panamerican Trauma Society, instruction in Advanced Trauma Life Support® (ATLS®) program and Definitive Surgical Trauma Care programs worldwide, and advocacy for equitable access to surgical care, he has helped shape education, research, and policy on a global scale. His career exemplifies the mission of academic global surgery, demonstrating how research, education, and sustained international collaboration can build local capacity, strengthen health systems, and improve surgical care for generations to come.

International Surgical Volunteerism Award
Steven M. Roser, DMD, MD, FACS

For more than 50 years, Dr. Steven Roser has dedicated his surgical expertise to restoring lives and expanding access to care for children born with cleft lip and palate deformities in underserved communities worldwide. Over decades of volunteer service, he has combined compassionate patient care with a steadfast commitment to education, creating sustainable partnerships that continue to improve surgical care long after each mission ends.

An internationally respected oral and maxillofacial surgeon, educator, and humanitarian, Dr. Roser is the Delos Hill Chair of Oral and Maxillofacial Surgery, a professor of surgery, and the residency program director at Emory University School of Medicine in Atlanta, Georgia, and chief of oral and maxillofacial surgery at Grady Memorial Hospital, also in Atlanta.

Beginning with Project HOPE in China and continuing through annual volunteer missions across Africa, the Caribbean, Latin America, and Southeast Asia, he has led multidisciplinary surgical teams that have provided life-changing care to children with cleft lip and palate deformities. Since 1992, he has organized and directed recurring outreach programs in Bolivia, Colombia, Ecuador, Ethiopia, Guatemala, Haiti, Nicaragua, Thailand, and Rwanda, helping provide reconstructive surgery to more than 3,000 children.

Orthodontists from the Rotofeliz Cleft Lip and Palate Team gather around Dr. Steven Roser as he reviews cleft lip and palate surgical techniques before they observe procedures at Hospital Municipal Bajío del Oriente in Santa Cruz, Bolivia. The orthodontists provide ongoing care for children treated through the partnership.

Recognizing that lasting impact depends on local expertise, Dr. Roser has made education and mentorship central to every volunteer effort. He has trained more than 60 US surgical residents and 30 international trainees while working alongside local surgeons and healthcare teams to establish enduring cleft care programs. His collaborative approach has fostered longstanding partnerships, strengthened residency education, and expanded access to specialized surgical care in communities where these services were once limited or unavailable.

Beyond his volunteer missions, Dr. Roser has championed global surgical equity through leadership in the International Association of Oral and Maxillofacial Surgeons, the G4 Alliance, and the ACS Health Outreach Program for Equity in Global Surgery (ACS H.O.P.E.). His many honors, including multiple humanitarian awards, an honorary doctorate from Bolivia, the Beckman Mentoring Award, and induction into the ACS Academy of Master Surgeon Educators, reflect a lifetime of service, mentorship, and the building of sustainable surgical capacity. His career embodies the spirit of international surgical volunteerism by demonstrating that the greatest legacy of service is not only the patients whose lives are changed today, but also the clinicians and communities empowered to provide care for generations to come.

Domestic Surgical Volunteerism Award
Ingrid M. Lizarraga, MBBS, FACS

A nationally recognized breast surgical oncologist, health services researcher, educator, and advocate, Dr. Ingrid Lizarraga serves as medical director of the Holden Comprehensive Cancer Center Breast Health Center and program director of the multidisciplinary breast fellowship at the University of Iowa Hospitals and Clinics in Iowa City. She also serves as the medical director of the Iowa Cancer Affiliate Network. Her commitment to rural healthcare was shaped by her early experience as a rural general surgeon, where she witnessed firsthand the barriers faced by patients and hospitals with limited access to specialized cancer services.

Through extensive volunteer service with the ACS Commission on Cancer (CoC), including her leadership as Iowa State Chair, Dr. Lizarraga has partnered with hospitals across the region to achieve CoC accreditation, implement evidence-based quality standards, establish multidisciplinary cancer programs, and improve access to comprehensive cancer care closer to home. Her efforts have enabled rural hospitals to deliver higher-quality care while reducing the burden of travel for patients and families facing a cancer diagnosis.

Education and mentorship have remained central to Dr. Lizarraga's service. She has trained fellows, residents, surgeons, nurses, cancer registrars, and hospital leaders, fostered local expertise, and strengthened multidisciplinary systems of care throughout the region. Her leadership also helped shape the CoC's Rural Accreditation pathway, extending innovative approaches to rural cancer care to communities nationwide.

Dr. Ingrid Lizarraga (center) and members of the Iowa Cancer Affiliate Network team meet with leadership from St. Anthony Regional Hospital in Carroll, Iowa, to review progress toward CoC accreditation and identify additional resources to support the hospital's growing cancer program.

Honored with the CoC Outstanding State Chair Award and the Iowa Cancer Champion Award, Dr. Lizarraga has demonstrated how volunteer leadership can transform healthcare far beyond a single institution. Through her unwavering commitment to quality improvement, mentorship, and equitable access to cancer care, she has strengthened communities, empowered healthcare professionals, and improved outcomes for countless patients throughout rural America.

Military Surgical Volunteerism Award
Brian Gavitt, MD, MPH, FACS

Throughout his military career, Colonel Brian Gavitt has demonstrated that surgical volunteerism extends far beyond providing care during times of crisis. By building trauma systems, strengthening international partnerships, and investing in sustainable medical education, he has improved access to high-quality surgical and trauma care while creating lasting benefits for the communities he serves.

A distinguished military surgeon, trauma leader, and humanitarian, Dr. Gavitt has combined clinical excellence with a commitment to strengthening healthcare systems through collaboration, innovation, and service. Among his most significant volunteer contributions was serving as the inaugural trauma director for the US military's embedded Trauma, Burn, and Rehabilitation Medicine team in the United Arab Emirates. From 2019 to 2023, he worked alongside civilian clinicians at Sheikh Shakhbout Medical City in Abu Dhabi to establish a comprehensive trauma program that measurably improved survival after injury. During the COVID-19 pandemic, he also led the hospital's critical care response while continuing to advance trauma quality improvement initiatives.

Working in partnership with the Abu Dhabi Department of Health, Dr. Gavitt authored the nation's first trauma center standards, enacted in 2023, establishing the foundation for a regional trauma system that continues to strengthen trauma care today. His collaborative approach emphasized local leadership, education, and sustainable system development, ensuring that improvements would endure long after his direct involvement.

Since 2024, Dr. Gavitt has led the US Air Force's medical engagements across Central America, South America, and the Caribbean. Beyond deploying medical teams in support of shared global health objectives, he has fostered enduring partnerships among Ministries of Health, local physicians, and nongovernmental organizations to develop sustainable solutions that expand access to surgical care. His leadership has transformed short-term humanitarian missions into long-term collaborations that strengthen surgical capacity, improve trauma care, and build locally led solutions to complex healthcare challenges.

Through his volunteer service, humanitarian leadership, and commitment to sustainable health system development, Dr. Gavitt has demonstrated the profound impact military surgeons can achieve when they partner with communities to build

Dr. Brian Gavitt speaks with a US Air Force dental team during the 2025 Lesser Antilles Medical Assistance Team mission on Canouan and Union Islands in Saint Vincent and the Grenadines. The mission, conducted in partnership with the country's Ministry of Health, provided medical and dental care to communities recovering from Hurricane Beryl.

local expertise, strengthen healthcare systems, and improve patient care for generations to come. His career embodies the spirit of the Military Surgical Volunteerism Award through service that extends well beyond the mission itself, leaving a legacy of collaboration, resilience, and improved surgical care.

Resident Surgical Volunteerism Award
Phillip J. Hsu, MD, PhD

Even as a surgical resident, Dr. Phillip Hsu has demonstrated an extraordinary commitment to improving access to surgical care through service, innovation, and education. Over the past decade, he has developed programs that expand care for underserved communities, strengthen local surgical capacity, and create sustainable educational partnerships both in the US and around the world.

A general surgery resident at the University of Michigan Health in Ann Arbor, Dr. Hsu earned his medical degree and doctorate from The University of Chicago in Illinois before completing advanced global surgery training through Harvard Medical School's Program in Global Surgery and Social Change in Boston, Massachusetts, and the National Institutes of Health's Fogarty Global Health Fellowship. Following residency, he will continue his commitment to caring for children as a pediatric surgery fellow at the University of California, San Francisco.

Dr. Hsu's dedication to volunteer service began long before residency. As cofounder and director of the Bridgeport Free Clinic in Chicago, he led teams of physicians and students in providing screening and urgent care services to economically disadvantaged immigrant families while connecting patients with long-term healthcare resources. He also co-founded the Chicagoland Free Clinics Consortium, bringing together 14 student-run clinics to share expertise, improve collaboration, and expand access to care across the region.

During residency, Dr. Hsu broadened his impact through sustained work in Afghanistan, Cameroon, Chad, Ethiopia, Kenya, Rwanda, and other low-resource settings. Among his most significant contributions is ADEPT Rwanda, a Ministry of Health-supported educational initiative that equips general practitioners to recognize and manage pediatric surgical conditions while building long-term teaching capacity through a train-the-trainer model. By emphasizing locally led education and sustainable systems, the program continues to strengthen pediatric surgical care beyond the direct involvement of international partners.

In addition to his volunteer service, Dr. Hsu has established himself as a researcher, educator, and advocate for global surgery. His publications on pediatric surgical outcomes, surgical systems strengthening, and global surgical education, together with his leadership in the ACS, the Global Initiative for Children's Surgery, and other international organizations, reflect a deep commitment to advancing equitable surgical care. Through vision, initiative, and sustained service,

Dr. Phillip Hsu (center) with the pediatric surgery team at the University Teaching Hospital of Kigali (CHUK) in Rwanda, where he helped create the ADEPT course to train general practitioners in the initial management of pediatric surgical conditions.

Dr. Hsu represents the next generation of surgeon leaders whose work is already improving patients' lives and strengthening surgical systems worldwide.

Surgical Humanitarian Award
Stephen M. Kelley, MD, FACS

Since 1996, Dr. Stephen Kelley has made southeastern Bangladesh his home, devoting nearly 3 decades to providing surgical care for patients who would otherwise have little or no access to lifesaving treatment. His career reflects an extraordinary commitment to humanitarian service, combining exceptional surgical skill with an unwavering dedication to expanding access to care, strengthening local healthcare capacity, and serving communities facing poverty, natural disasters, and humanitarian crises.

After graduating from SUNY (State University of New York) Downstate Health Sciences University in Brooklyn, New York, and completing his general surgery residency and thoracic surgery fellowship through the US Air Force, Dr. Kelley answered a call to long-term missionary service at Memorial Christian Hospital. There, he expanded the scope of surgical care available in the region by introducing the region's first laparoscopic, thoracic, vascular, and advanced endoscopic procedures. Guided by the needs of the community, he broadened his expertise to include trauma and orthopaedic surgery while continuing to provide comprehensive general, pediatric, thoracic, urologic, gynecologic, and emergency surgical care.

Over the course of his service, Dr. Kelley has performed more than 30,000 operations while investing just as deeply in the people who will carry the work forward. He has mentored generations of Bangladeshi physicians and healthcare professionals and helped establish training programs for nurses, medics, operating room technicians, and surgical trainees. By developing local expertise and sustainable care systems, he has created a legacy that extends far beyond his own clinical practice.

As medical director of Memorial Christian Hospital, Dr. Kelley also led the planning, fundraising, and construction of a modern 125,000-square-foot replacement hospital, a transformative undertaking completed after more than 20 years of perseverance. During the Rohingya refugee crisis, he directed emergency expansion efforts that enabled the hospital to care for hundreds of wounded refugees while coordinating international volunteer teams to meet an unprecedented humanitarian need.

Dr. Kelley has chosen service over comfort and commitment over convenience, dedicating most of his professional life to caring for some of the world's most vulnerable patients. Through compassionate care, visionary leadership, and an enduring investment in the people and communities he serves, he has transformed countless lives while leaving a sustainable foundation for future generations. His career represents the very essence of the Surgical Humanitarian Award. B

Members of the Memorial Christian Hospital OR team, including Dr. Stephen Kelley (back row, center), 14 OR technicians, four orthopaedic technicians, and OR Nurse Supervisor Glenda Akershoek, gather in one of the hospital's 10 operating rooms.

Surgeons Harness AI, Resilience, and Teamwork to Transform Quality

Matthew Fox, MSHC

THE 2026 ACS Quality, Safety & Cancer Conference (QSCC), July 30–August 2 in Orlando, Florida, combined the ACS's former Quality & Safety Conference and the Cancer Conference for the first time, providing attendees with actionable insights and expert perspectives.

Approximately 1,450 surgeons, nurses, oncologists, and data registrars attended the event, which carried the theme of "QI Powered by AI." The potential of artificial intelligence (AI) and other advances in technology and technique were woven through the conference's 10 plenary General Sessions, several of which are summarized in this article. The ACS Quality Programs were well represented in these and the more than 50 Breakout Sessions that focused on discipline-specific content.

The event began with a welcome address by Clifford Ko, MD, MS, MSHS, FACS, Senior Vice President of the ACS Division of Research and Optimal Patient Care, who highlighted the importance of collective expertise and the role of attendees in achieving high-quality care.

Referencing the magical framing of the conference, Dr. Ko suggested that while quality professionals may dream of a magic spell to meet their goals, achieving healthcare quality and patient safety takes real effort.

"In our view, the individuals who uphold quality are those people who roll up their sleeves and do it. The people who persevere are those who really uplift and uphold quality, and achieve better quality and safety going forward," Dr. Ko said.

Joining Dr. Ko on the stage was Ronald J. Weigel, MD, PhD, MBA, FACS, Medical Director of ACS Cancer Programs, who discussed the importance of quality improvement (QI) in cancer. He also humorously observed that there are parallels between quality expertise and magic.

"For both of them, you're not born with that knowledge. It takes years of disciplined practice to develop the skills and knowledge needed, which is

Dr. Ronald Weigel (left) and Dr. Cliff Ko welcomed attendees to the QSCC, saying QI professionals were "Quality Wizards"—but that hard work and dedication achieved results, not magic.

Dr. Jonathan Chen delivered the conference's first Keynote Address, which explored the rapid innovation and evolution of artificial intelligence, as well as the continuing need for human oversight.

why it requires continuous improvement. And that's how you achieve quality, in practice, precision, evidence, and teamwork," Dr. Weigel said. Both Drs. Ko and Weigel noted that there was no "waving a magic wand" in QI, and the time, effort, and dedication are what achieve results.

Potential and Pitfalls for AI in Quality

A robust discussion on the current state of AI as a clinical and administrative aid, including its potential and pitfalls in QI, kicked off the conference.

Surgeons and QI professionals can lean into the current strengths of AI as a tool for QI data aggregation and collation, according to Bruce Lee Hall, MD, PhD, MBA, FACS, from UC Davis Health in California.

Current AI models can effectively be used to review literature, assist in designing a QI study, generate a process and materials list, and significantly improve efficiency in these tasks.

"If you take 10 minutes of time to develop a strong QI project prompt for AI to interpret, wait for the results, and then spend an additional 30 minutes or an hour fine-tuning what it provides, you can potentially save hours of time and real dollars to get to a very usable project," Dr. Hall said.

As the frontline health professionals often most closely involved in QI implementation, nurses play an invaluable role in determining the success of AI in quality projects.

Kristen Fessele, PhD, RN, of Memorial Sloan Kettering Cancer Center in New York City, said AI could help improve quality metrics by streamlining data collection, identifying trends, and standardizing workflows, but emphasized that human oversight remains essential for identifying and analyzing unexpected discrepancies in patient outcomes or processes.

"An AI disagreement with expected results should not just disappear into the workflow. It should become a reviewable quality event," Dr. Fessele said.

Nikhil Thaker, MD, MHA, MBA, FABS, a radiologist at Capital Health in Pennington, New Jersey, further discussed the current risks of using AI in medicine. Current questions include: What data can the tools access? What happens if something goes wrong?

"The failure modes are relatively consistent, including the problem of missing source data, poor generalizability, and hallucinations where the answers or outcomes seem good, but they can be completely made up," Dr. Thaker said. "And if those small errors get propagated at scale, we're looking at compounding errors that could risk patients."

Humans Remain Essential as AI Transforms Medicine

The AI focus continued in the conference's first Keynote Address by Jonathan H. Chen, MD, PhD, director for medical education in artificial

"It's getting difficult to tell what is real and what is not in the world of AI."

Dr. Jonathan Chen

intelligence at the Stanford Center for Biomedical Informatics Research in California.

Dr. Chen, a magician himself, showed some convincing illusions on the stage to reinforce a point about AI.

"It's getting difficult to tell what is real and what is not in the world of AI," he said.

Recent advancements in AI technology have radically changed perceptions of the technology within healthcare. For example, when ChatGPT debuted and every professional started to wonder how it would impact their own field, researchers found that the early models were unable to pass a medical licensing exam.

But AI accuracy has grown exponentially with the release of each model of ChatGPT, and now "multiple AIs have emerged that can handily pass a medical exam," Dr. Chen said.

A key distinction between early AI and human clinical experts was the clinicians' ability to reason through complex, open-ended questions, distinguish relevant from irrelevant information, summarize a case, and develop a differential diagnosis. But in the past 2 years, AI models have advanced to such a degree that they can now provide answers to complex scenarios.

Dr. Chen cited recent studies comparing ChatGPT-4 (already outdated in 2026) with physicians in diagnostic reasoning cases. The results were surprising, as ChatGPT-4 alone arrived at more correct answers than physicians using either traditional internet sources or an AI model.

"This flies in the face of our understanding of technological advancement, that humans were always needed as a guide. Now, it appears that humans are slowing the computer down," Dr. Chen said.

However, in case management reasoning, physicians who had access to ChatGPT-4 and were trained to use it effectively achieved the best results.

Attendees participated in 50 Breakout Sessions that spanned the ACS Quality Programs and other topics.

Access related video content online.

He said that clinicians play an invaluable role in implementing AI into healthcare in its current state, because while the technology has information, "you need human judgment to discern what is credible when evaluating the output of an AI model."

Dr. Chen provided a look at several other recent developments in AI, including the deployment of AI "agents," which can not only provide information but also act on their own volition, which could have implications for medication prescribing and even autonomous surgery far in the future.

While AI may end up having a permanent, transformative impact on healthcare, human clinicians and surgeons will be needed to "manufacture trust" from patients that will allow the technology to thrive. But clinicians must also be ready to adapt to the changing times.

Chaunté Lowe provided the conference's second Keynote Address, in which the four-time Olympian and medalist emphasized how perseverance and collaboration drove her to succeed in the high jump and helped her cancer care team to deliver patient-centered care.

"Any doctor who could be replaced by a computer should be," Dr. Chen said. "While AI is not going to replace anybody, those who learn how to use it will replace those who cannot."

Embracing Failure Can Improve Quality

Improvements in healthcare aren't always linear, as long-term successes are frequently born from short-term failures. In fact, recovering from failure and "getting it wrong" can be a gift that imparts actionable lessons for future success.

Failures in both clinical and QI contexts can have a formative impact on a surgeon, according to Stephanie A. Savage, MD, MS, FACS, from the University of Wisconsin School of Medicine and Public Health in Madison.

Dr. Savage recalled her experience as medical director of a Level 1 trauma center when she tried to understand and change some of the processes at her new institution.

She wanted to bring the various groups involved in trauma care together, "but when I didn't understand who needed to be there, people started to think the meetings were a secret, where we were trying to hide things, and that started to undermine trust." While she was able to create an effective team, she said the failure to connect in those early days may have prevented the care teams from meeting their full potential, and she learned to "slow down, because good ideas stand up to testing."

Fully embracing failure as not just an unfortunate byproduct of healthcare or QI, but as fertile ground for continuing innovation, can provide ongoing growth, according to Ashley Arehart, MSN, RN, NPD-BC, from Oregon Health & Science University in Portland.

She described her attempt to launch a pediatric critical care transition process program that began with promise but came apart within about a year, and from that experience, she started the "Fail Club," a group that comes together regularly to share their failures and learn from them. It is a safe space for learning, listening, telling a story, and taking a lesson. And if QI professionals implement a fail club at their institutions, they may see real change take place.

Conference attendees participated in an interactive General Session, "An Escape Experience." As the clock ticked, they worked together in small teams to analyze clues and "crack the code" by testing assumptions and applying problem-solving approaches to reach clarity.

"The goal is not that failure disappears; it's that we get to try again," Arehart said. "It may not be better, but it will be different, and that is where improvement happens."

Perseverance Fuels Olympic Success and Cancer Care Teams

Responding to challenging circumstances in clinical care and in QI projects is often a test of perseverance, an attribute that Chaunté Lowe, a four-time Olympian, a bronze medalist, and a breast cancer survivor, has exemplified in her athletic career and cancer treatment.

She shared her story, and the deep commitment of her care team, in the conference's inspiring second Keynote Address.

Lowe began by discussing a life-changing event from when she was 4 years old and saw Florence "FloJo" Joyner dominate in track at the Olympics, which set her on a path of athletic accomplishment from a young age.

Lowe said she took inspiration from her grandmother, who never gave up on a dream to be a singer, and her persistence eventually led her to sing at a small event, where presidential candidate Ronald Reagan asked her to sing at his inauguration if he was elected. When he eventually won, Juanita Booker did indeed sing the National Anthem at his inauguration in 1981.

"You have absolutely no idea how a small thing can have a ripple effect that will impact people for years to come. It might be a patient conversation, it might be filling out a form a certain way, it might just be listening and taking the extra step," Lowe said.

Lowe's early attempts, including participating in the qualifying rounds in the 2004 Olympics, did not meet immediate success, but she took what she learned, refined her processes, and tried again. Even in the face of finishing college while pregnant with her first child and resuming training with all those physical changes, she returned to the track and started to succeed. She eventually participated in several Olympics, winning the bronze in the women's high jump in 2008.

But Lowe's biggest challenge would come after athletics, when she found a small painless lump in her breast during a self-exam. She was diagnosed with triple-negative breast cancer, and she underwent a double mastectomy and chemotherapy. In the course of her treatment, she said she was able to remain positive and hopeful because of the attitude, professionalism, and quality of her care team.

"I was able to smile because of you all. I had a team that humanized me. Reminded me that I was a person. I was still the athlete, still the mom, and the rest of my story was still being written," she said.

Now, 6 years cancer-free, Lowe has learned that the same mindset of perseverance and teamwork that brought her success in athletics can bring success to healthcare teams.

"The champion's mindset isn't avoiding challenges. It's meeting them with integrity and confidence,

Panelists from the General Session, "The Gift of Getting It Wrong," discussed how failure in QI is not something to be feared, but rather embraced as a source of future success.

and it's built in little moments where you see the person," she said. "When each person does their part so the collective moves together, resilience becomes sustainable, and culture stays strong."

Education Can Improve Care and QI

Effective education doesn't just focus on learner outcomes; instead, education in healthcare should be centered on the patient, according to Kyla P. Terhune, MD, MBA, FACS, ACS Senior Vice President of Education and moderator for the education-focused General Session.

Dr. Terhune suggested that education serves as a form of implementation science, translating the work of educators into practice, and while there are many ways to measure how well medical education is proceeding—board pass rates, ABSITE scores, and so on—the true measure of quality in education is more direct.

"Education outcomes shouldn't be dependent on the learner. They should be dependent on the patient. The more we can connect quality to education, the better," Dr. Terhune said.

In keeping with the theme of the conference, Kevin W. Sexton, MD, from Vanderbilt Health in Nashville, Tennessee, explored the practical use of AI in education, emphasizing the importance of human oversight and the potential for AI to augment learning.

Dr. Sexton highlighted an area of great potential, but also peril, that was brought up a number of times at the conference: the idea that the use of AI may lead to "deskilling."

"Every tool you're using is either teaching you something or it could be quietly deskilling you," Dr. Sexton said.

Using polyp detection during colonoscopy as an example, he noted that AI has helped increase gastroenterologists' polyp detection rates, but cautioned that if the technology becomes unavailable, clinicians' detection skills may atrophy. With that in mind, AI tools must be used thoughtfully to enhance learning, and humans must remain in the loop.

To ensure that the tenets of QI remain embedded in medical training, experiential learning practices and deliberate practice must be emphasized, according to Tyler J. Loftus, MD, PhD, FACS, from the University of Florida College of Medicine in Gainsville.

Dr. Loftus emphasized that effective QI education is necessarily experiential and that educators must encourage learners to reflect on their projects. He illustrated this point with a QI project focused on improving patient handoffs.

"Here's a high-quality handoff, here's a low-quality handoff, here is one where it was going sideways, something was missing, but the team recovered and had a good and effective handoff," Dr. Loftus said. "What allowed them to be resilient? What can we teach based on what we observed in that recovery? That reflection is a really good basis for creating change."

Rural Cancer Care, AI Policy, and Sustainability

The final session provided a high-level view of three QI topics.

Ingrid Lizarraga, MBBS, FACS, from the University of Iowa Health Care Clinical Cancer Center in Iowa City, began by addressing the challenges of providing high-quality care in rural areas, highlighting disparities in cancer mortality between rural and urban patients—differences she attributed to factors such as limited access to high-quality care, financial constraints, and staff shortages.

All the same, hospitals want to provide cancer care, and patients will prioritize being close to home.

"Patients are already receiving care in rural communities, whether they are receiving care from the most capable centers or not, so it behooves us to improve the care available to them," she said, as she went on to discuss the impetus and early success of the recently launched ACS Commission on Cancer Rural Cancer Program Accreditation.

The conference made clear that medicine in the US is evolving at a rapid pace, sometimes in response to a volatile political environment in Washington, DC, according to Christian Shalgian, ACS Senior Vice President of Advocacy and Health Policy. Much of his discussion focused on AI policy, which remains largely undeveloped.

"There's a rush to use AI, but what is the policy? Who's in charge of AI? It's kind of the Wild West at the moment. But at the ACS, we know there needs to be appropriate surgical input into AI policy in order to protect our members and their patients," Shalgian said.

Who owns the data AI companies use? Which federal department regulates AI? Who owns the liability? He said that these questions, among others, are being addressed in AI policy grand rounds that the ACS has started hosting with subject matter experts.

Benjamin Miller, MD, FACS, from Cleveland Clinic in Ohio, concluded by discussing the responsibility that surgeons and health systems have to understand and address the environmental impact of surgical care. Importantly, he noted that QI and sustainability work hand in hand.

"When you drive down complications, you're going to reduce the resources you need to take care of those complications to enhance sustainability. Quality also focuses on decreasing the variability of surgical care through standardized care paths, decreasing hospital length of stay, and decreasing unnecessary testing and imaging, which all improve sustainability," Dr. Miller said.

The ACS has recently delved into this area with last year's launch of the Surgical Sustainability Team for Action and Innovation (SUSTAIN) Collaborative.

This year saw the launch of the Preference Card Optimization Campaign, which provides education and resources for individual surgeons to formulate their bespoke surgical tool and supply lists. This level of customization will reduce wasted single-use tools that go unused during procedures, Dr. Miller said.

Save the Date

The 2027 QSCC will take place July 29–August 1 in Seattle, Washington. B

Matthew Fox *is the Digital Managing Editor in the ACS Division of Integrated Communications in Chicago, IL.*

More than 1,450 QI professionals attended the conference.

ACS, The Leapfrog Group Launch Recognition Program for Excellence in Geriatric Surgery

HOSPITALS providing high-quality surgical care for older adults soon will have a new way to demonstrate their commitment to patient safety and quality. The ACS and The Leapfrog Group announced the Recognized Leader in Geriatric Surgery designation, a national recognition program that identifies hospitals meeting rigorous standards for the care of older surgical patients. Hospitals will be eligible to earn the designation beginning in 2027.

As the US population continues to age and more older adults undergo surgical procedures, the program is designed to help patients, caregivers, employers, health plans, and other healthcare purchasers identify hospitals equipped to meet the unique needs of this growing patient population.

The designation combines evidence-based standards from the ACS Geriatric Surgery Verification (GSV) Program with patient safety measures from the Leapfrog Hospital Survey and Leapfrog Hospital Safety Grade.

To qualify, hospitals must participate in the ACS GSV Program, earn an A or B Leapfrog Hospital Safety Grade, and demonstrate strong performance on key patient safety measures assessed through the Leapfrog Hospital Survey. These measures include computerized prescriber order entry, barcode medication administration, medication reconciliation, and the use of safe surgery checklists.

The ACS GSV Program helps hospitals improve surgical care for older adults by implementing evidence-based practices that address the medical, functional, and social needs of aging patients. Participating hospitals adopt approaches such as comprehensive geriatric assessments, medication reviews, mobility programs, and discharge planning to reduce complications and support recovery after surgery.

"Older adults face higher risks when undergoing surgery, and factors like frailty can significantly increase the likelihood of complications. They benefit greatly from shared decision-making and care designed specifically for their goals," said Clifford Y. Ko, MD, MS, MSHS, FACS, Senior Vice President of the ACS Division of Research and Optimal Patient Care. "By working with The Leapfrog Group, we can recognize hospitals that are meeting rigorous standards and advancing surgical care for older patients."

The Leapfrog Hospital Survey and Hospital Safety Grade complement the GSV standards by evaluating hospitals using nationally recognized measures of patient safety and quality.

"The Recognized Leader program highlights hospitals that are going the extra mile to protect older patients facing higher surgical risks," said Leah Binder, president and CEO of The Leapfrog Group. "Together we will help guide patients and families, as well as employers and health plans, toward the best care."

The new designation builds on Leapfrog's existing Recognized Leader program, which first recognized hospitals providing high-quality care for patients with diabetes.

Additional information, including a webinar recording that provides an overview of the Recognized Leader in Geriatric Surgery program, is available on *facs.org*.

Access related video content online.

Clowes Award Winner Targets Glycosylation to Break Immunotherapy Resistance in Neuroblastoma

Eric J. Rellinger, MD, FACS

ERIC J. RELLINGER, MD, FACS, a pediatric surgeon-scientist at the University of Kentucky in Lexington, has been selected to receive the 2026–2031 ACS George H. A. Clowes, MD, FACS, Memorial Career Development Award for his project, "Rewiring Glycosylation to Overcome Immunotherapy Resistance in High-Risk Neuroblastoma."

Neuroblastoma is the most common extracranial solid tumor in children, and those diagnosed with high-risk disease face a 5-year survival rate of only about 50% despite aggressive multimodal treatment, including chemotherapy, radiation, stem cell transplantation, and immunotherapy. Dr. Rellinger's research targets glycosylation, the post-translational addition of glycans to cell-surface proteins, as a novel and largely unexploited therapeutic axis for improving outcomes in this devastating disease.

His laboratory was the first to map the glycome of human neuroblastoma tumors in situ using matrix-assisted laser desorption ionization mass spectrometry imaging, identifying core fucosylation as a metabolic vulnerability enriched in MYCN-amplified tumors. MYCN amplification, present in nearly half of high-risk cases, drives upregulation of GDP-mannose 4,6-dehydratase (GMDS), the rate-limiting enzyme in de novo GDP-fucose biosynthesis. Genetic and pharmacologic disruption of this pathway impairs tumor growth in preclinical models.

The funded project investigates how aberrant core fucosylation helps tumors evade the immune system and reduces the effectiveness of existing immunotherapies. Dr. Rellinger

has shown that core fucosylation regulates surface trafficking of the immune checkpoint proteins B7-H3 (CD276) and PVR (CD155), both of which suppress NK and T cell activity in the tumor microenvironment.

His central hypothesis is that blocking fucosylation will reprogram innate immune responses and enhance anti-GD2 immunotherapy. Although anti-GD2 immunotherapy improves survival in patients with high-risk neuroblastoma, its effectiveness against bulky tumors remains limited because NK cell–mediated antibody-dependent cellular cytotoxicity is often insufficient.

The project is organized around three specific aims:

1. Using CRISPR-based loss-of-function models and lectin-based affinity proteomics to comprehensively define which cell-surface proteins depend on core fucosylation for their localization
2. Characterizing how fucosylation blockade modulates NK cell activation, degranulation, cytokine production, and cytotoxicity in co-culture models with neuroblastoma cells
3. Testing whether pharmacologic inhibition—using 2-fluorofucose or the selective GMDS inhibitor Fucotrim I—can sensitize large, treatment-refractory tumors to anti-GD2 therapy in the immunocompetent 9464D syngeneic model

Dr. Rellinger earned his medical degree at Vanderbilt University School of Medicine in Nashville, Tennessee, and completed general surgery residency at Vanderbilt University Medical Center followed by a pediatric surgery fellowship at Cincinnati Children's Hospital Medical Center in Ohio. During residency, he devoted 3 years to a dedicated research fellowship in the laboratory of Dai H. Chung, MD, MBA, FACS, studying novel therapeutic strategies targeting N-MYC in neuroblastoma.

Since joining the faculty at the University of Kentucky in 2021, he has built an independent research program within the Markey Cancer Center.

The Clowes Award is supported through contributions to the ACS Foundation with funding from The Clowes Fund, Inc., of Indianapolis, Indiana. Its purpose is to help advance the research of a promising young surgical investigator. The award provides a stipend of $45,000 per year for 5 years and is not renewable.

More information is available at *facs.org/clowes*.

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Member News

Schiff Heads NIH Global Research

Steven Schiff, MD, PhD, FACS, has taken over as director of the Fogarty International Center (FIC) and National Institutes of Health (NIH) associate director for international research. A pediatric neurosurgeon and global health researcher, Dr. Schiff currently serves as the Harvey and Kate Cushing Professor of Neurosurgery, vice chair for global health in the Department of Neurosurgery, and professor of epidemiology and of electrical and computer engineering at Yale University in New Haven, Connecticut. As director of FIC, Dr. Schiff will lead NIH's global health research efforts by supporting collaborations between US and international investigators, strengthening partnerships among research institutions worldwide, and training future global health scientists.

Turgeon Takes Over as AST President

Nicole Turgeon, MD, FACS, began her term as president of the American Society of Transplantation (AST). A kidney-pancreas transplant surgeon, Dr. Turgeon is a professor, division chief, and director of transplant surgery in the Department of Surgery and Perioperative Care at The University of Texas at Austin Dell Medical School. She also is transplant director of the Abdominal Transplant Center partnership between Dell Medical School and Ascension Seton. The AST, which is the largest transplant organization in North America, advances the field of transplantation and improves patient care by promoting research, education, advocacy, and organ donation.

Warburton Is Named UMSOD Interim Dean

Gary Warburton, DDS, MD, FACS, has been appointed interim dean for the University of Maryland School of Dentistry (UMSOD) in Baltimore. An expert in temporomandibular joint and maxillofacial trauma surgery, Dr. Warburton is a professor and chair of the Department of Oral and Maxillofacial Surgery at UMSOD and chief of oral and maxillofacial surgery at the University of Maryland Medical Center and the R Adams Cowley Shock Trauma Center.

Weiss Steps into Executive Role

Matthew J. Weiss, MD, MBA, FACS, is senior vice president and chair of the Department of Surgery at the Donald & Barbara Zucker School of Medicine, Long Island Jewish Medical Center, and North Shore University Hospital in New York. He will continue as deputy physician-in-chief and director of the surgical oncology program at Northwell Cancer Institute. In 2027, Dr. Weiss also will assume the role of executive director of Northwell Health's surgery service line. Recruited to Northwell from Johns Hopkins in 2019, he has dedicated his career to advancing the treatment of hepatobiliary and pancreatic diseases.

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

Nakaji Expands Leadership Roles in Arizona

Peter Nakaji, MD, FACS, has been named academic division chief of neurosciences at Arizona State University (ASU) John Shufeldt School of Medicine and Medical Engineering in Phoenix. A neurosurgeon, researcher, and educator, Dr. Nakaji also will continue in his role as physician executive director of the Bob Bové Neuroscience Institute at HonorHealth. He will help shape the future of neurosciences while strengthening collaboration between ASU Health and HonorHealth's neuroscience leadership.

Momeni Leads Plastic Surgery at Stanford

Arash Momeni, MD, FACS, is chief of the Division of Plastic and Reconstructive Surgery at Stanford Medicine in California. An associate professor who joined the Stanford faculty in 2017, Dr. Momeni specializes in microsurgery and serves as co-leader of the Stanford Breast Cancer Care Program.

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