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I recently had the privilege of serving as a visiting professor at the University of New Mexico (UNM), Albuquerque, at the request of Ashwani Rajput, MD, FACS, chief, division of surgical oncology, and John Russell, MD, FACS, professor of surgery; chair, department of surgery; and dean, graduate medical education. As part of this event, I participated in a memorial service for UNM patients who had recently died. Bridget Fahy, MD, FACS, surgical oncologist and associate professor of surgery, department of surgery, UNM School of Medicine, and Erika Ketteler, MD, FACS, associate professor of surgery and associate program director, residency program, department of surgery, UNM, and a vascular surgeon with the New Mexico Veterans Affairs Health Care System, have led this program for the last two years.

A moving, memorable experience
The memorial service at UNM takes the place of the traditional morbidity and mortality conference once a year and provides an opportunity for faculty and residents to spend an hour remembering the patients whom they have recently lost and revealing how the experience personally affected them. Participation is voluntary, yet all of the residents and faculty from the department attended. A total of nine cases were discussed, and presenters ranged from interns to attendings.

The participants shared their experiences in providing care to dying cancer patients, explained how they used critical decision-making skills to treat trauma patients and, perhaps most movingly, described what it was like to lose pediatric patients whose lives were cut far too short. Particularly noteworthy was the thoughtfulness, introspection, and maturity that the interns and residents displayed when telling their stories. All of us were truly mesmerized as we listened to these young health care professionals convey their personal experiences. The reports were extemporaneous but comprehensive, really cutting to the soul of what it means to be a surgeon and provide care to a patient who is dying.

In fact, these presentations were some of the most honest and emotionally moving discussions of patient outcomes and care that I have had the honor of hearing in 40 years of surgical education, training, and practice. Even the most self-assured residents opened up and articulated their feelings about the grieving process and how they were able to find the resilience to continue caring for critically ill patients.

Building on past experience
The organizers of the event, Dr. Fahy and Dr. Ketteler, are among the only 65 or so U.S. surgeons board-certified in hospice and palliative medicine, and both are members of the American College of Surgeons Palliative Care Committee. Unquestionably, both of these surgeons are deeply concerned about the quality of care that end-of-life patients receive. “With two surgeons with expertise and training in palliative care, our residents have learned that speaking about patient death and the impact that these losses have on our trainees is acceptable and supported,” Dr. Fahy said.

The memorial service program builds upon a quarterly program called Surgery Death Rounds, which Dr. Ketteler has facilitated since her arrival at UNM eight years ago. “These death rounds have been well received by faculty and residents and have contributed to an environment that allows our residents to share their patient death experiences. Since Dr. Fahy’s arrival here two years ago, the discussion that a patient has died—not passed, expired, or some other euphemism—is even more in focus,” Dr. Ketteler added. “Palliative care input for our surgical patients is not taboo at UNM, and the residents participate in providing that care and see such care as just a normal part of being a thorough and competent surgeon.”

Dr. Fahy agreed, adding, “In the [death rounds] program, residents present cases of patients who have died, with an emphasis on the ethical, emotional, and other nonmedical aspects of the case. We believe that having this background has contributed to an environment that allows our residents to share their experiences of patient death.”
The camaraderie and support not only of the faculty for their residents, but also among the residents for each other was palpable and struck me as getting at the essence of developing the peer connections needed to work together effectively in surgical teams. At a time when we are bombarded by demands for greater efficiency in clinical care and education and of increased scrutiny of our outcomes, it was refreshing to see a group of surgeons focused on the human side of surgery. I think that forming these bonds of compassion for one another can have a significant impact on averting feelings of isolation, frustration, burnout, disillusionment, and cynicism.

Drs. Fahy and Ketteler are in the process of preparing a manuscript based upon a survey they sent to faculty, residents, and medical students about their responses to patient loss and their impressions of how this important topic should be addressed in surgical training. The Editor-in-Chief of the Bulletin has been in touch with Dr. Fahy about publishing an article based on the results of that study in the near future.

Death is almost always an uncomfortable topic, particularly among surgeons who enter the profession with the goal of saving lives, not watching them end. However, I believe programs like the one at UNM will help the next generation of surgeons attain a broader perspective on death and dying and what quality really means when caring for the end-of-life patient.

If you have comments or suggestions about this or other issues, please send them to Dr. Hoyt at lookingforward@facs.org.
“Seeking success” is the theme of the 2015 Resident and Associate Society of the American College of Surgeons (RAS-ACS) issue of the Bulletin. While writing this introduction, I realized how difficult it can be to define that simple word—success. In fact, when you look up success in the dictionary you’ll find it has a variety of definitions. It is the end goal for which most, if not all, of us strive. However, for me, it is the goals we set out to accomplish that drive us forward and determine a true measure of success.

Some surgeons decide success means achieving a work-life balance so they have time to participate in their children’s activities, such as football and hockey games. Others might dedicate their lives to accomplishing specific career goals, such as maintaining the triple-threat physician model of researcher, teacher, and clinician that Sir William Osler described in the latter half of the 19th century. And there are those of us who, in our quest to do it all, find ourselves hovering around the mean of the proverbial bell curve, even as we continue to work toward our goals.

Regardless of one’s individual definition of success and the underlying motivators that drive each of us toward it, high achievers share some commonalities. The following five concepts, described in this article, are, I believe, essential to success not only in surgery, but life in general:

- The power of listening
- Striving for purpose, not position
- The importance of emotional intelligence (EI)
- Imperfection as a source of strength
- Every day is Super Bowl Sunday
Regardless of one’s individual definition of success and the underlying motivators that drive each of us toward it, high achievers share some commonalities.

The power of listening

“Listen with the intent to understand, not the intent to reply.”

—Stephen Covey

One of the most important components of communication is listening—a skill that is often taken for granted and one that is surprisingly difficult to apply. Some individuals confuse hearing with the act of listening. Hearing is one of five natural senses, whereas listening requires mental focus. In fact, active listening is a skill that can be learned and needs to be practiced.

A number of barriers can impede active listening, including personal bias or judgment. Many of us have experienced being in a conference room or other setting where an individual makes a statement with which we disagree or that we perhaps find thoughtless. When this happens, typically we stop the active listening process and end up severing that path to great communication. Considering that some researchers suggest that up to 90 percent of communication is nonverbal, this type of reaction can obviously disrupt the flow of productive communication. Taking the time to minimize preconceived notions and reserve judgment at the beginning of a conversation can significantly enhance our ability to communicate. Being an active listener does not necessarily mean you agree with the comments that someone is making; rather, it positions you to ask the right questions and better solve the issues at hand.

Strive for purpose, not position

“True happiness......is not attained through self-gratification, but through fidelity to a worthy purpose.”

—Helen Keller

This past year I had the opportunity to study public policy with a tremendous group of diverse individuals. Several of my classmates expressed an interest in running for public office. My first question was always, “Why?” The various responses were fascinating. Some individuals wanted to attain a certain status (such as governor, congressman, president, and so on) with no clear underlying motivation other than to attain the prestige associated with these positions. Others viewed serving in public office as a means to achieving a greater purpose; it was this group that most impressed me because they appeared to have a deep understanding of the underlying values that set them in pursuit of their broad vision. Understanding our goals and how to achieve them keeps us focused and sets us on a clear pathway toward success.

Those of us who are honest with ourselves will admit that ego plays a role in our pursuit of success, but it cannot be the sole motivating factor. Rather, let finding the answer to the question that weighs on your mind as you fall asleep, the one that wakes you up in the middle of the night or gets you out of bed in the morning, be the driving factor, and let it guide you to success.

The importance of EI

“If your emotional abilities aren’t in hand, if you don’t have self-awareness, if you are not able to manage your distressing emotions, if you can’t have empathy and have effective relationships, then no matter how smart you are, you are not going to get very far.”

—Daniel Goleman

Over the last decade or so, EI has become increasingly important in the professional world and may be as important, if not more so, in determining success as an individual’s intelligence quotient (IQ). Daniel Goleman, a science writer who is credited with having brought EI into the mainstream, describes the five components of EI as follows:

- **Self-awareness**: The ability to recognize one’s own emotions and how they might affect his or her behavior and decision making
RAS-ACS: SEEKING SUCCESS

• Self-regulation: The ability to control one’s impulses and adapt to dynamic circumstances

• Internal motivation: The ability to complete a task despite potential adversity

• Empathy: The ability to put oneself in other people’s shoes when making decisions

• Social skills: The ability to identify social cues while building networks and managing relationships to move people in a desired direction

Few would argue that a certain level of fundamental knowledge and technical skill is not required in order to succeed in surgery—ours is a profession of scholars, after all. However, it seems that the manner in which we interact with our colleagues may, at times, be more important than having the right idea. For young surgeons entering practice in new and unfamiliar environments, it is especially important to take the time to understand the atmosphere in which you are working. As the adage goes, if you drop a frog into boiling water it will jump out, so the key is to slowly warm the pot. You might be the smartest person in the room, you might have an incredible idea, but taking an approach that is out of sync with the setting in which one is functioning is a sure path to failure.

Imperfection as a source of strength

“There is something perfect to be found in the imperfect: the law keeps balance through the juxtaposition of beauty, which gains perfection through nurtured imperfection.”

—Dejan Stojanovic

It has been said that no two snowflakes are alike; each one takes on a certain composition that maximizes its journey. Despite heading toward the same destination, the journey can be completely different for each snowflake, and some will combine forces while others collide. And yet, each is perfectly shaped to complete its unique journey.

As surgeons, each of us may be well-formed for our individual journey as health care professionals, but we are unlikely to possess all the positive attributes of our esteemed colleagues, making us perfectly imperfect. While some might view this as a point of weakness, I would argue it is a strength. Each one of us alone might be imperfect, but collaboration with colleagues who can compensate for our weaknesses allows for genuine success and positive outcomes. Over the years, we have seen the results of building multidisciplinary teams that encourage innovative thinking and lead to the development of products or solutions that are more robust than any one individual could produce independently. We need to understand the barriers that divide us so that we can ultimately get past them and work as a cohesive unit with our colleagues and teams. When we do, we build strength in numbers and ultimately enhance our own professional journey.

Everyday is Super Bowl Sunday

“Good is the enemy of Great.”

—Jim Collins

Sometimes we find ourselves sitting in a meeting thinking about a variety of things other than what the speaker is saying. Who’s next on the schedule? What should I have for dinner tonight? How many cases do I have on the books for tomorrow? In many ways, it is natural for the mind to wander to what lies ahead. However, if we are always thinking ahead, then we can never really take part in the present. What would happen if we were able to give 100 percent of ourselves to whatever the task at hand might be? Michael Lipkin, a South-African motivational speaker, describes the Nine Star Social Values,
which focus on bringing the best to whatever you happen to be doing every day.10 We should live each day as if it is Super Bowl Sunday, and we are in the game.

Bringing your best to the table also means being willing to view things from an unfamiliar perspective. Executives at successful companies, such as Jeff Bezos, founder and chief executive officer of Amazon.com, apply unique and innovative approaches to their work. A reporter once asked Mr. Bezos how far he believes his company has come and how far it can go. His response was, “It’s day one,” meaning he views every day as if it is the very first day of the business being open.11 To keep moving forward, surgeons need to view each day as if it is day one.

Parting thoughts
Each of us defines success differently, and only you—with guidance from experienced mentors—can determine what it means to you and how to achieve it. This RAS-ACS issue of the Bulletin explores a variety of topics related to “seeking success,” ranging from effective communication, teaching in the operating room, surgical advocacy, training for future leaders, and providing feedback for trainees.

Having nearly been killed at the age 17, I am often reminded of how fortunate I am to have had this second chance at life. I am also reminded of the limited and unknown amount of time we each have on this earth. As surgeons, we have the special ability to profoundly affect people and society. Applying some of these common principles of success will allow us to better achieve the desired impact. When the time comes to take that last breath, one can only hope to have achieved success on his or her own terms. ♦

REFERENCES
Medical school is unlike any other type of graduate school. The first two years are filled with basic science and little patient interaction, so the opportunities to hone communication skills are diminished in comparison to those available to the average law or business student, for example. In fact, a medical school curriculum contains far fewer requirements for oral presentations, written assignments, and collaborative team efforts.

Furthermore, the nature of medicine—where a person’s life is in the physician’s hands—complicates matters. For example, a lawyer may decline a case if it is likely to be unwinnable. When a venture capitalist or a businessperson fails to see potential in a startup or investment, he or she simply puts money into the development of a different product. But when a patient comes through the hospital doors, a physician must provide care to that individual. In each patient encounter, communication is necessary, starting from the initial history and physical to follow-up visits. In The 7 Habits of Highly Effective People, Stephen Covey writes, “Communication is the most important skill in life.” Regardless of profession, this ability is the cornerstone of success.

General surgery education is changing, and residency programs are placing greater emphasis on trainee assessment. Among the most challenging
competencies to evaluate are surgical residents' interpersonal and communication skills. The importance of communication in medicine has been emphasized since the pre-scientific era and is described strikingly well in Hippocrates' aphorism: “Life is short, and Art long; the crisis fleeting; experience perilous; and decision difficult. The physician must not only be prepared to do what is right himself, but also to make the patient, the attendants, and externals cooperate.”

In this article, the authors discuss how to develop a successful career track by learning how to negotiate contracts with superiors, how to effectively communicate with multidisciplinary teams or co-residents, and, perhaps most importantly, how to talk with patients. These basic guidelines should prove useful to surgical residents seeking a successful career.

Contract negotiation and a successful career track
In a recent study of 43 surgical residents entering practice, less than a quarter of those surveyed said they feel confident in their understanding of practice management and leadership. It is admittedly difficult, especially during the rigors of training, for a resident to figure out which questions to ask to determine whether a practice meets his or her needs. How is a newly minted surgeon able to undertake the Herculean task of selecting a practice, negotiating a contract, and making his or her own way in a large group or hospital employment setting? The appropriate timing, transparency, and tone when communicating with mentors, family, and potential partners and employers are essential to starting a successful career.

Timing
Before looking for a practice, a surgeon should make several decisions with regard to the practice environment in which he or she would like to work beyond choosing between private practice and academia. Residents should ask themselves what type of practice they are interested in (solo, small group, large group, employment by a health maintenance organization [HMO] or a hospital), determine the potential for advancement, and ascertain whether the location is satisfactory, to name a few important considerations. A recent article indicates that approximately 75 percent of physicians (n=2,813) are employed by large groups, hospitals, or health management organizations. In fact, a smaller group or solo practice may ultimately be absorbed by one of these larger entities—a possibility that the new surgeon should consider before joining one of these practice settings. It also is important to discuss these options with those who may be affected by your decision, such as one’s spouse or family, to determine what setting would be workable for all concerned. Practical concerns include location, mobility, call schedule, vacation, and so on. Contacting a mentor at the beginning of your search may streamline this process and help prioritize non-negotiable expectations versus factors that have greater flexibility.

After the physician determines the type of practice desired, there will often be telephone discussions with a specific practice to gather additional information. This will usually be followed by a letter of intent from the practice, which describes in writing what was discussed. This document is not legally binding. At this point, the surgeons should contact a contract lawyer for advice. Next, an offer letter is usually sent; this document is a binding contract that may limit the surgeon’s options at a later date. This letter provides surgeons with the opportunity to seek more information before negotiating the final contract.

Transparency
It is important to be transparent with the practice when developing a contract. The contract should contain details regarding the term length of the contract, automatic renewal of the contract, call schedule, benefits, retirement planning, vacation, bonus and productivity incentives, tail coverage, disability coverage, non-compete clauses, contract termination, and so on. The surgeon should decide what he or she can and cannot live with, and then communicate these items to the contract lawyer, who can offer advice on what
contract terms to alter, how to phrase the terms, and help to identify red flags.

Likewise, you should expect transparency and clarity from the practice with which you are negotiating. Be sure to read the entire contract and ask detailed questions if you have any concerns. If you find a provision objectionable, ask the organization to remove it. Think twice before agreeing to terms that sound suspicious, even if the practice insists that they will never be enforced. Once the surgeon has signed the contract, he or she will have no recourse if there is a disagreement.

Ask for copies of corporate bylaws and partnership agreements, as these documents may contain elements that will affect your practice. For example, a partnership agreement may allow more established partners to take call less frequently or have more vacation, resulting in an increased workload for newer surgeons. Also, the financial documents of the group and hospital should be reviewed, as their finances may affect your future earning potential.

It is important that the surgeon fully understand the leadership structure of the organization. Physician satisfaction in the workplace is heavily influenced by the efficiency of the immediate work environment, the schedule flexibility and autonomy granted by the leadership, and the workload requirements.

Additionally, you may be expected to standardize aspects of your practice, such as referral patterns. Be aware that compensation may be different in an integrated practice than in a typical group practice, so educate yourself on the exact stipulations of the compensation plan. Success in a large organization is driven more by collaboration than the “deficit-based” thinking that rules the clinical setting. If the institution's leaders value collaboration, they will more likely listen to your concerns, and you may be better able to make beneficial changes once you begin your practice.

**Tone**

Tone refers to how you present yourself to potential employers or group partners. Everyone appreciates someone who is pleasant, hard-working, and has good decision-making ability, so avoid exuding “the surgical personality” in your negotiations. Keep an amiable tone at all times, especially when discussing the finer points of the contract or when discussing a point in the contract with which you don’t agree. How you interact initially will set the stage for interactions later in your career.

**Effective communication with colleagues**

Communication breakdowns between the provider and the patient, the provider and the family members, or both are reported as the second-most common cause of inpatient surgical errors resulting in patient injury. It is a well-documented fact that limiting communication breakdowns could substantially decrease complications, delays in care, and overall morbidity of the surgical patient. Effective communication increases patient satisfaction and improves health outcomes, while poor communication is linked to patient complaints and liability claims.

One of the most important skills for effective communication is the ability to manage one’s own emotions and to perceive the emotions of others—also known as emotional intelligence. The surgeon's ability to identify and manage his or her emotions as well as the ability to understand the emotions of patients, family members, and colleagues is fundamental to the successful provision of optimal patient care. Finding ways to train surgeons and residents with the aim of improving their emotional intelligence is a growing field of research in medical education, although its value has been demonstrated in the business community for many years.

Interpersonal attributes such as trust are known to contribute to the success of interpersonal communication between surgeons, both in the emergent and nonemergent hospital setting. Building a foundation of trustworthiness in interpersonal relationships with colleagues can be a complex, laborious process. Seniority and a proven track record are often synonymous with increased trust in the surgical setting.
The surgeon’s ability to exhibit effective communication skills in specific circumstances is crucial. For example, knowing how to discuss operative risks and benefits, obtain informed consent, and convey bad news are all important elements of patient care communication. But the ability to modify communication strategies and personalize the message for a co-resident, attending, patient, or patient’s family is equally important for success in delivering the best possible surgical care.

Ineffective communication between surgery residents and attendings typically occurs when the resident fears losing autonomy or being a bother, revealing a knowledge gap, and creating misunderstandings. Although there is a proven link between miscommunication and medical errors, few surgical residency programs have formal communication training or specific guidelines for the residents about when, how, and why to communicate with their attendings. This lack of guidance could be detrimental to patient care, especially during the intern year when most surgical residents teach themselves through a time-consuming “trial and error” development of their communication skills.

Identification of communication mishaps and understanding why they occurred is the first step in dealing with medical errors resulting from ineffective communication between patients and surgeons. One effective way to deal with communication breakdowns is the implementation of a policy-based intervention across different hospitals such as the one organized by the Risk Management Foundation of the Harvard Medical Institutions in 2005. This collaboration brought together the chiefs of surgery at Brigham and Women’s Hospital, Massachusetts General Hospital, Beth Israel Deaconess Medical Center, and Children’s Hospital, Boston, who all endorsed three communication standards that had been previously proven to significantly diminish patient harm because of gaps in communication. Indeed, this program was deemed to be beneficial as significant changes in patient management were noted in 33 percent of the cases in which trainees and attendings adhered to the enforced communication strategies.

Communication breakdowns may lead to medical errors, and medical errors may lead to legal claims. The University of Michigan Health System (UMHS), Ann Arbor, designed and implemented a comprehensive medical error disclosure with offer program in 2001. This program was based on three main principles:

- Compensate patients quickly and fairly when inappropriate medical care caused harm
- Support caregivers and the hospital vigorously when patient care was appropriate
- Reduce patient harm (and therefore claims) by learning from previous mistakes

<table>
<thead>
<tr>
<th>Catalyst for change</th>
<th>Acknowledge what can and cannot be controlled. Identify the patient’s current stage of change.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alter thoughts to change feelings</td>
<td>Acknowledge feelings toward the patient and assess the effect on the relationships. Ask: “What can I tell myself about this situation to make me feel less angry or frustrated?”</td>
</tr>
<tr>
<td>Listen and then make a diagnosis</td>
<td>The physician is better equipped to listen without bias after completing the above two steps.</td>
</tr>
<tr>
<td>Make an agreement</td>
<td>Explicitly agree to continue to treat the patient and to work on the problem as agreed upon.</td>
</tr>
<tr>
<td>Education and follow up</td>
<td>Give an achievable task based on the patient’s stage of change and schedule structured follow-up.</td>
</tr>
<tr>
<td>Reach out and discuss your feelings</td>
<td>Reflect on how you feel after the patient encounter and reach out to other physicians to engage in discussion and for support.</td>
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</tbody>
</table>
The UMHS medical error disclosure program managed to decrease the number of lawsuits and liability costs and significantly shortened the time required for resolution of a claim.\textsuperscript{15}

In 2014, Atul Gawande, MD, MPH, FACS, delivered four British Broadcasting Corporation Reith Lectures on The Future of Medicine.\textsuperscript{21} In one lecture, Dr. Gawande noted that there are two primary reasons why surgeons fail. The first one is ignorance—the limited understanding of the conditions that apply to any given problem. The second reason is ineptitude—having the knowledge but failing to apply it correctly.\textsuperscript{21} A blended mix of formal education for surgical residents to improve their communication skills and implementation of surgical checklists is the recipe for a brighter future of surgery in which optimal communication and reduced errors are the norm in the surgical patient care.

### Communicating with the difficult patient

The difficult patient may pose a challenge even for the most experienced and composed physician. In the adult primary care setting, 15 percent to 30 percent of patient encounters are labeled as difficult, according to the physician.\textsuperscript{22,23} (It should be noted that most of the literature on difficult patients comes from the primary care sector.) Although the day-to-day practices of surgical and primary care differ, the principles of patient communication apply to all specialties. The patient encounter is shaped by the behavior of the patient, the response of the physician, and the situational factors. Each of these factors must be recognized and addressed to optimize communication.

Earlier studies have tried to characterize difficult patients and suggested these individuals are more likely to have multiple poorly defined symptoms, personality or psychiatric disorders, and subclinical behavior traits, and they are often older, recently widowed or divorced, and of lower socioeconomic status. The difficult patient also is likely to be non-adherent to the treatment plan. In a 1978 \textit{New England Journal of Medicine} article, James E. Groves MD, further classified difficult patients as belonging to one or more of four subgroups: (1) dependent clingers, (2) entitled demanders, (3) manipulative help-rejecters, and (4) self-destructive deniers.\textsuperscript{24} The article recommends screening for psychiatric diagnoses or a history of physical or substance abuse and then approaching the difficult patient with motivational interviewing and patient-centered communication through which symptoms are validated and boundaries are set.

Perhaps most importantly, the physician should identify the subtype of difficult patient and tailor the encounter accordingly. Dependent clingers exhibit neediness and evoke aversion from the physician. The physician must be firm but tactful and set limits on the patient’s expectations. The entitled demanders often threaten the physician with punishment, mainly lawsuits, and evoke a counterattack response. The physician should acknowledge the patient’s right to receive excellent care and redirect the entitlement into a partnership. Manipulative help-rejecters are often smugly satisfied when the prescribed treatment is ineffective and have a pathologic dependency on the patient-physician relationship, evoking feelings of depression, guilt, or inadequacy in the physician. The best approach here is to commiserate with the patient.

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**TABLE 2. THE BREATHE OUT TECHNIQUE**

<table>
<thead>
<tr>
<th>Previsit</th>
<th>Post Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>B List at least one Bias you have about the patient.</td>
<td>O Reflect on the Outcome of the encounter.</td>
</tr>
<tr>
<td>Re Reflect on why you identify the patient as difficult.</td>
<td>U Did you learn anything Unexpected?</td>
</tr>
<tr>
<td>A List one thing you would like to Accomplish today.</td>
<td>T List one thing you look forward to addressing if you run into this patient Tomorrow.</td>
</tr>
<tr>
<td>Th Think about one question you would like to ask to further explore your assumptions.</td>
<td></td>
</tr>
<tr>
<td>E Stop before Entering the exam room, and take three deep breaths in through your nose and out through your mouth.</td>
<td></td>
</tr>
</tbody>
</table>

\textsuperscript{15} The UMHS medical error disclosure program managed to decrease the number of lawsuits and liability costs and significantly shortened the time required for resolution of a claim.\textsuperscript{15}

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The patient encounter is shaped by the behavior of the patient, the response of the physician, and the situational factors. Each of these must be recognized and addressed in order to optimize communication.

and assure him or her that successful treatment of the condition will not result in loss of the patient-physician relationship. The self-destructive deniers evoke all of the feelings of the other subtypes in addition to malice. These patients require decreasing expectations that perfect care will be delivered and may require a psychiatric consultation. In the end, how the physician feels about the patient is of little importance; what matters is how he or she behaves toward the patient.

The physician plays a role of equal importance to the patient in difficult encounters. The physician may have a negative bias toward a specific disease, have poor communication skills, lack experience, feel overworked, or suffer from personal health issues. Although most literature on the difficult encounter focuses on the difficult patient, one study attempted to characterize the difficult physician. A total of 1,391 family medicine, internal medicine, and internal medicine subspecialists completed the Physician Worklife Survey regarding personal and practice characteristics and work satisfaction. On multivariable analysis, high work frustration was independently associated with age younger than 40 years old, higher stress levels, subspecialty practice, and higher number of patients with psychosocial or substance abuse disorders. The number of hours worked greater than 55 hours per week had borderline significance. Another study showed female physicians who had lower scores on the physician satisfaction scale and were less satisfied after difficult encounters than their male counterparts. To better navigate difficult encounters, physicians must practice self-reflection and recognize bias and should seek support from trusted colleagues or Balint groups, which focus on the clinician-patient relationship.

Situational factors also must be considered. Time is a precious resource in all aspects of medicine, and time limits can compromise the ability to communicate effectively. The physician should acknowledge time delays and plan for additional counseling time with difficult patients. The physician also should maximize the time available by sitting at the patient’s level, maintaining eye contact, and conducting the encounter with a

REFERENCES


continued on next page
relaxed demeanor. Complex social issues and limited resources may also put a strain on the encounter and may require the involvement of a social worker.

Various communication tools have been developed to guide the physician through difficult patient encounters. The CALMER strategy is a six-step process to serenity when dealing with difficult patients and combines elements from Prochaska and DiClemente’s Stages of Change model, Shahady’s Rule of Five, and Gillette’s Practical Approach for Managing Problem Patients, as well as principles of cognitive-behavioral therapy (see Table 1, page 19). The BREATHE OUT approach is a similar tool and was developed for a randomized controlled trial at six family medicine clinics in urban, suburban, and rural locations (see Table 2, page 20). A total of 57 clinicians, including physicians, physician assistants, nurse practitioners, and residents, completed the Physician Satisfaction Scale (PSS) after implementing the BREATHE OUT technique, and those who were instructed in the use of BREATHE OUT had improved PSS scores after difficult encounters (p=0.02). Use of the tool took less than three minutes.

Conclusion
Effective communication is a key skill for successful surgeons and the delivery of high-quality patient care. The ability to communicate with your superiors is equally important as the ability to communicate with your peers and patients. Although these interpersonal skills are difficult to measure and standardize, the author’s anticipate that these guidelines and techniques will prove useful in each of those encounters.

REFERENCES (CONTINUED)

The mission of the Resident and Associate Society of the American College of Surgeons (RAS-ACS) and of the College itself are closely aligned. The ACS Mission Statement explains that members of the ACS are “dedicated to improving the care of the surgical patient and to safeguarding standards of care in an optimal and ethical practice environment.” Improving the care of the surgical patient is contingent upon residents becoming successful surgeons, leaders, and teachers. It hinges on our mastering the fundamentals of surgery, teaching our junior colleagues, and recruiting our brightest medical students.

Unfortunately, medical students often fear their surgical rotations. They dread the long hours and dealing with the malignant surgical personality—that is, the stereotypical fire-breathing, instrument-throwing surgeon. As the culture of surgical professionalism has evolved over the years, the ACS has worked to encourage the expansion of surgical clerkships as well as recruitment of medical students to general surgery and the surgical subspecialties. The RAS-ACS continues to foster an encouraging learning environment while supporting its members for ongoing success with each knot, each suture, each decision, and each patient.

What is the RAS-ACS?

The RAS-ACS was conceived by former ACS Director of Surgical Education and Research Olga Jonasson, MD, FACS, in 1999. The group’s mission of fostering the College’s relationship with surgical trainees and recent residency graduates remains strong. It has been a continuing goal of the RAS-ACS to recruit residents and young surgeons to have a voice and presence in the ACS, as the future success and responsibilities of the College will eventually be assumed by our young leaders. With more than 9,000 current members, the RAS-ACS continues member recruitment efforts both in the U.S. and internationally by increasing the exposure of the group and promoting the benefits of resident engagement with the ACS.

The mission statement of the RAS-ACS is as follows: “The RAS-ACS will serve to familiarize all surgical trainees and young surgeons with the ACS, its programs, and leadership; provide an avenue for
Building on the tenet of professional development through mentorship, leadership, advocacy, and education, the RAS-ACS offers myriad opportunities for young surgeons and trainees in addition to providing invaluable career support and a path toward initiation as an ACS Fellow.
to leverage your quest in shaping your future but also provides you with a set of values that can serve as your moral compass.” Building on the tenet of professional development through mentorship, leadership, advocacy, and education, the RAS-ACS offers myriad opportunities for young surgeons and trainees in addition to providing invaluable career support and a path toward initiation as an ACS Fellow. These opportunities include participating in leadership positions on the RAS-ACS committees and scholarships for leadership and educational development at various annual meetings, such as the Residents as Teachers and Leaders course and the ACS Leadership & Advocacy Summit. The opportunity to network with leaders and mentors along with influential policymakers at these meetings is a unique educational experience that provides young surgeons with the tools to advocate for quality health care policies. The RAS-ACS continues to challenge its members to remain knowledgeable but also continues to guide their development into honest surgeons who behave with integrity.

These benefits are only a few offered by the RAS-ACS to its members. In an effort to connect with young surgeons and to highlight the numerous benefits of involvement in the ACS, the College launched the Realize the Potential of Your Profession campaign. One aspect of this initiative was the release of a video identifying “100 reasons” to be involved in the ACS, with brief statements delivered by various members and staff members of the College. In addition to providing mentorship, unparalleled education, and leadership opportunities, one of the most important reasons to join the RAS-ACS may be its structured path for continuous professional development and its lasting legacy of excellence.

**RAS-ACS structure**

The RAS-ACS was established in part to encourage the development of future leaders of surgery and to provide them with the tools and opportunities they need to succeed. Therefore, we offer members several opportunities for leadership and involvement. The Executive Committee of the RAS is composed of the Immediate Past-Chair (ex officio), the Chair, the Vice-Chair, and the Secretary, each of whom serves a year in each role. The RAS also has a Governing Board, which comprises the RAS Executive Committee, the Chair of the four standing committees of the RAS, the RAS Advisory Council Liaisons, and the RAS Liaison to the Board of Governors. The four standing committees of the RAS are the Advocacy & Issues, Communications, Education, and Membership committees. Each committee...
has a Chairman and a Vice-Chair, with progressive ascendancy. Some standing committees also have a Secretary, who serves a one-year term and does not automatically ascend to Vice-Chair. The RAS has liaisons to each of the 13 Advisory Councils mentioned earlier; these individuals serve three-year terms. There also are RAS representatives on most standing ACS committees and Board of Governors Workgroups; these individuals serve three-year terms.2

There are many pathways to leadership in the RAS-ACS. First, each standing committee has a monthly conference call on a Wednesday night at 9:00 pm ET. During these conference calls, committee members discuss the projects of the committee, provide updates on projects from the previous month, and recommend new initiatives. Most Chairs and Vice-Chairs of standing committees, as well as members of the Executive Committees, initiate their involvement by calling in to the monthly conference calls and then volunteering for a project of interest.

Each committee focuses on specific goals and projects, including the following:

• The Advocacy & Issues Committee collaborates with the ACS Division of Advocacy and Health Policy and the American College of Surgeons Professional Association Political Action Committee (ACSPA-SurgeonsPAC). The Advocacy and Issues Committee also hosts a debate regarding a controversial topic in surgery during the RAS symposium at the Clinical Congress. The debate occurs among contest winners and national experts in support of, or in opposition to, the issue. First- and second-place essays are published in the Bulletin.

• The Communications Committee publishes a bimonthly e-newsletter, contributes to the RAS theme issue of the Bulletin, maintains the RAS Facebook page and Twitter accounts, and oversees the annual RAS essay contest. Each standing committee contributes an article to the RAS issue of the Bulletin, which is chosen by the Communications Committee, with an introductory article by the RAS Chair. Additionally, this committee promotes the ACS Communities, which are an online tool that allows surgeons with common interests to engage in virtual discussions and to share resources.10

• The Education Committee hosts the annual Surgical Jeopardy competition among residents from programs across the nation at Clinical Congress and has created a Surgical Jeopardy Tool Kit for use by ACS chapters.11

• The Membership Committee helps educate Residents and Associates about the benefits of membership in the RAS and ACS. The efforts have included the development of a brochure and the creation of a top ten list of benefits.12,14 The Membership Committee also organizes outreach efforts to surgical subspecialties and supports the International Exchange Scholarship Program.3,14

The ACS also fosters leadership development among residents and provides various educational conferences to that end. Clinical Congress is the flagship meeting of the organization, held every fall, and is free for Resident Members who register in advance. Each spring, the ACS hosts the Leadership & Advocacy Summit in Washington, DC, where residents are encouraged to take political action. The ACS also hosts the Residents as Teachers and Leaders course in Chicago, IL, the Scholars in Residence program (a two-year paid research fellowship in Chicago working on outcomes and health service research using data from the ACS National Surgical Quality Improvement Program), and the Surgeons as Leaders course. The ACS facilitates the transition from medical school into residency with its publication, Successfully Navigating the First Year of Surgical Residency: Essentials for Medical Students and PGY-1 Residents, available online at www.facs.org/education/division-of-education/publications/navigatefirstyear.

The medical student mission
The ACS Committee on Medical Student Education (CMSE) is charged with recruiting and educating medical students, and this committee coordinates the Medical Student Program at the annual Clinical Congress. This three-day program, spearheaded by
Medical students often lose sight of the big picture because they are focused on details such as step exams, anatomy dissections, and getting “honors” on their clerkship. Unfortunately, they often miss the more important objective of choosing a fulfilling career, which could be in one of the surgical specialties.

Andre Campbell, MD, FACS, professor of clinical surgery, University of California, San Francisco, is dedicated to providing future generations with information about a career in surgery.

Although the topics change each year to remain relevant and up-to-date, as well as to appeal to those students who may have previously attended the program, the general format remains the same. The students begin their three-day experience with a lecture from one of the best and brightest minds in the ACS, such as Thomas M. Krummel, MD, FACS, who presented a keynote address in 2014. The afternoon includes a Lifestyles Panel Session, as well as opportunities to meet residents, discuss “the match,” and speak with program directors at residency programs throughout the country. The Lifestyles Panel demonstrates how surgeons maintain work-life balance. This panel has featured surgeons with diverse outside interests, including marathon-enthusiast surgeons, family-oriented surgeons, medical-mission surgeons, make-my-own-schedule surgeons, and so on. Although a life in surgery can certainly be grueling and time-consuming, the Lifestyles Panel urges students to realize that they do not have to permanently forsake hobbies, interests, and goals outside of surgery for the sake of their professional aspirations.

Often medical students believe that a life in general surgery means rarely seeing their families and missing birthdays, weddings, and soccer games. One of the most poignant speakers at the 2014 Medical Student Program provided a very humorous example of how he created work-life balance. At the beginning of every year he requested four very specific days off—his birthday, his wife’s birthday, and their two children’s birthdays. He would stay home, make pancakes, have birthday parties, and every year, ensure “something special” happened. He also made a point of living near the hospital to minimize travel time and so he could sneak away to sporting events. Medical students often lose sight of the big picture because they are focused on details such as step exams, anatomy dissections, and getting “honors” on their clerkship. Unfortunately, they often miss the more important objective of choosing a fulfilling career, which could be in one of the surgical specialties. The Medical Student Program has provided students every year with this big-picture perspective.

One of the newest additions to the Medical Student Program is the Out of the Box SIG—or surgical interest group. This competition among the students encourages innovation and creativity. The students initiate a project at their home institution and submit an application. The students with the most innovative SIG activity are
invited to speak at the Medical Student Program and share their ideas with the audience. Program activities include a Great Surgical Games competition in which students participate in suturing and knot-tying, a student trauma call, and medical student surgery research mentoring programs.

Medical SIGs can play a key role in recruitment of students to surgical residency and the profession. Both the Association for Surgical Education and the ACS encourage the development of these groups, which can provide medical students with exposure to both general surgery and surgical subspecialties. Additionally, from the student’s perspective, SIGs can help develop mentors, investigate research opportunities, and may even help students select surgery as a specialty. Nearly half of all U.S. medical schools have established a SIG.\(^9\) There have been concerns in recent years from program directors and other educators about levels of recruitment to the field of general surgery and that the interest in general surgery as a specialty is dwindling. Surveys in the past have identified minimal interaction between surgeons and medical students, resulting in a negative impression of general surgery in a significant number of students.\(^10\) SIGs, with faculty and resident participation, may improve the perception of surgery as a specialty and help convey the positive, exciting, and fulfilling aspects of a surgical career.

The students also participate in knot-tying and suturing sessions with world-renowned surgeons, including (all MD, FACS) Christopher Brandt, Andre Campbell, Rebecca Evangelista, Celeste Hollands, Mary Hooks, Joseph Iocono, Deborah Loeff, Paul Schenarts, Susan Steinemann, and Stephen Yang. This stellar group of surgeons works all year to create the best schedule of events to encourage students to pursue a career in surgery. They travel to Ohio, California, and even Hawaii with this mission in mind. Each year, the CMSE’s Medical Student Program attracts more students from across the country, and with that, seeks to encourage students to join us in this rewarding career.

**Conclusion**

The culture of surgery thrives on hard work, energy, compassion, and education. During the progression of training, the adage of “see one, do one, teach one” becomes more and more important. The RAS-ACS works to not only help its members thrive in their careers as surgeons, but also to attract the best and brightest minds to surgery—and teach them to strive for success, one knot at a time. ♦

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**REFERENCES (CONTINUED)**


“See one, do one, teach one” has been the principle applied in passing down operative techniques from one generation to the next for decades. Learning in this manner, known as the Halstedian training model, the surgeons who now serve as mentors to the present generation of surgery residents were able to accept increased responsibility in the operating room (OR) as they progressed through their years of training.¹

For the past decade, however, changes in surgical residency have brought to light the need for innovative teaching methods in the OR. Today’s residents are seeing a greater variety of surgical procedures during their training—for example, operative volume for graduates increased 21 percent from 2005 to 2010.² Nonetheless, the number of specific operations performed more than 10 times during residency has not changed.²
This imbalance between the increased scope of education and a reduced number of work hours with which to provide this training highlights the need for more efficient and structured intraoperative teaching by faculty surgeons.

The evolution in surgical education has raised concerns about whether residents have sufficient time to master surgical techniques. A national survey published in 2009 highlighted these concerns, indicating that 27.5 percent of residents are concerned they will not feel confident performing procedures independently once in practice, which was magnified by the implementation of duty-hour regulations in 2003 and again in 2011 by the Accreditation Council for Graduate Medical Education. This imbalance between the increased scope of education and a reduced number of work hours in which to provide this training highlights the need for more efficient and structured intraoperative teaching by faculty surgeons. A variety of different educational strategies, each implemented with the aim of updating operative skills assessment and instruction, have recently been described in the literature. Effective use of these novel educational tools by surgical educators may serve to improve the quality and efficiency of intraoperative resident education.

**Preoperative briefing, postoperative debriefing**
The utility of briefing and debriefing tools in the OR has been well established, both in quality improvement endeavors and as a means of promoting a culture of safety in surgery. Additionally, this strategy has value as an educational tool. The preoperative briefing and postoperative debriefing educational model has been shown to vastly improve the intraoperative learning experience for surgical trainees when combined with residents’ preoperative identification of learning objectives. Clearly identifying learning objectives before a case and integrating them with educational briefings and debriefings facilitates a guided learning process for the trainees, as well as a structured, targeted teaching model for the surgeon.

A study published in 2013 specifically examined the effect that incorporating perioperative briefings and debriefings into surgical education and training had on achieving previously identified resident learning goals. This study, which used direct observation within the OR as well as pre- and post-implementation surveys from resident learners, demonstrated a significant change in communication styles between faculty and learners. Also observed was a decrease in idle and unstructured conversation between the learner and educator in operative cases.

Before the initiation of briefing and debriefing interventions, surgical residents in this study of 263 operative cases reported a significantly higher frequency of faculty description of procedural steps and evaluation of their personal performance. When comparing baseline communication styles with those used after the initiation of briefings and debriefings, there were significantly increased observed demonstrations of surgical techniques (from 45.2 percent to 88.4 percent), encouragement of trainees (48.4 percent to 76.8 percent), use of nonverbal teaching (from 3.2 percent to 23.2 percent), warnings given (from 24.2 percent to 75.8 percent), and use of constructive feedback (from 33.9 percent to 63.2 percent). Following implementation of this teaching model, surveyed trainees were significantly more likely to agree with the following statements about the attending surgeon: “describes steps if I am unfamiliar with steps,” “asks me to describe critical/key points,” “provides frequent verbal feedback,” “provides frequent nonverbal feedback,” “confirms I understood the procedure,” and “provides clear feedback on my performance.” In an unstructured environment, trainees inconsistently recognize educational experiences. Preoperative self-identification of learning objectives reminds the trainees of specific tasks to work toward successfully completing. In addition,
discussing these goals preoperatively with faculty reinforces their role during the instruction process. Combining structured educational briefings and debriefings with preoperative resident identification of learning objectives focuses faculty on resident needs and reinforces to the resident what he or she needs to learn.

The Zwisch model
Joseph (Jay) Zwischenberger, MD, FACS, developed a model at the University of Kentucky, Lexington, to aid in the training and assessment of his residents to achieve operative independence. The goal of the so-called Zwisch model is to provide both faculty and residents with specific stages of supervision allowing for adequate, safe training in a graduated manner to develop fully trained surgeons.

The four stages of the Zwisch model of supervision are as follows:

- Show and tell
- Smart help
- Dumb help
- No help

Each stage identifies the manner in which the attending surgeon behaves and teaches during the case, as well as the expectations of the operating resident. In the show-and-tell stage, the attending surgeon performs the critical portions of the operation while explaining each step to the resident. The smart help stage involves the attending surgeon actively guiding the resident through the critical portions of the procedure. In the dumb help stage, the resident performs critical portions of the operation independently while the attending surgeon passively provides skilled assistance, intervening only when necessary. At the most advanced level, the no help stage, the attending surgeon is present only to guarantee patient safety while the resident performs the operation independently with a less-skilled assistant. (See Table 1, this page.)

A major benefit of the Zwisch model is the simplicity with which it can be implemented and used to train and assess residents in the OR. In fact, many attending surgeons may feel they already use this teaching modality. Additionally, since the publication of the Zwisch method in 2013, other studies have shown the benefits of using this model in assessing residents, residency programs, and faculty.

### Table 1. The Zwisch Model

<table>
<thead>
<tr>
<th>Zwisch stage</th>
<th>Attending surgeon behaviors</th>
<th>Resident learner behaviors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Show and tell</td>
<td>- Performs key portions of procedure</td>
<td>- Performs opening and closing of procedure</td>
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<tr>
<td></td>
<td>- Narrates the case (“thinks out loud”)</td>
<td>- Acts as first assistant and observes procedure</td>
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<tr>
<td></td>
<td>- Demonstrates key steps and anatomy</td>
<td>- Shifts roles between surgeon and first assistant</td>
</tr>
<tr>
<td></td>
<td>- Performs opening and closing of procedure</td>
<td>- Demonstrates increasing ability to perform key steps of procedure with attending assistance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Is knowledgeable of all the component technical skills</td>
</tr>
<tr>
<td>Smart help</td>
<td>- Shifts roles between surgeon and first assistant</td>
<td>- Follows lead of the resident</td>
</tr>
<tr>
<td></td>
<td>- When first assisting, leads resident in surgeon role</td>
<td>- Performs the procedure with an experienced first assistant</td>
</tr>
<tr>
<td></td>
<td>- Optimizes the field and exposure</td>
<td>- Safely completes the procedure without faculty</td>
</tr>
<tr>
<td></td>
<td>- Coaches on next steps of procedure</td>
<td>- Recovers from most errors</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Recognizes when to ask for help or advice</td>
</tr>
<tr>
<td>Dumb help</td>
<td>- Associates increasing ability to perform key steps of procedure with attending assistance</td>
<td>- Provides no unsolicited advice</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Monitors progress</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Ensures patient safety (as during all stages)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Performs the procedure with an experienced first assistant</td>
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<tr>
<td></td>
<td></td>
<td>- Safely completes the procedure without faculty</td>
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<td>- Recovers from most errors</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Recognizes when to ask for help or advice</td>
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</tbody>
</table>

development. In particular, this tool can provide residents with a specific measurement of their expected level of competence for a specific operation. It allows assessments to be more concrete, thus pointing out residents’ strengths and potential areas of improvement. It also can be used as a method of resident evaluation, as procedure-specific expectations for certain Zwisch stages can be established for each postgraduate year level.

As mentioned previously, the Zwisch model also may be used for faculty development through analysis of faculty consistency and adjustment of behavior in the OR depending on a resident’s stage. This model provides faculty with a structured means of teaching in the present-day culture that emphasizes increased productivity, litigation concerns, and patient safety regulations. Additionally, attending surgeons may appreciate a sense of accomplishment by systematically witnessing a resident’s progress from internship to their chief year using this model.

Teachable moments
Identifying specific learning objectives before operative cases is helpful in maximizing surgical education. However, many opportunities for education are unplanned. These teachable moments may arise from either technical errors by the learner or demonstrated knowledge deficits within the case. When these events occur, the resultant interactions between teachers and learners may take on a variety of forms. Some interactions focus on correcting learner actions, thereby ensuring a successful patient outcome, while other interactions focus on improving a learner’s knowledge base or understanding of a case.

A recent study by Roberts and colleagues sought to optimize operative teaching opportunities by looking specifically at how surgeons interact with residents during an operation. In this study, intraoperative verbal communication was observed during four videotaped surgical procedures. Each of the 1,306 observed interactions was categorized into one of four main types: instrumental, pure teaching, instrumental and teaching, and banter.

Interactions were described as instrumental when their purpose was solely to move the operation forward successfully. This descriptive name is derived from the sociologic concept of instrumental action, which centers on how behaviors, needs, and perceptions are shaped by specific goal-directed activities. With this form of interaction, educators make specific requests of the learner that, when performed, will result in a positive patient outcome. The burden here, though, is on the resident to translate these specific tasks into a broader understanding of surgical technique and decisions. These discrete, goal-oriented interactions were viewed as the most basic level of instruction.

Conversely, pure teaching represented the opposite extreme of observed interactions. These communications provided education to the trainee, shaped judgments, or enhanced resident performance without directly affecting the outcome of the current surgical case. In instrumental and teaching interactions, educators balance both approaches in one exchange. These interactions provide specific instruction germane to the case at hand but also support the instruction with a broader explanation of the situation. Such a strategy moves a case forward and also increases the resident’s broader understanding of the operation. This combination of directed action with accompanying explanation increases the likelihood of that experience producing long-term changes to the learner’s thinking and practices. Banter, described in this study as discussion unrelated to the operation or disease process, may at first appear less educational than other intraoperative interactions. However, banter can humanize the parties involved in the case, thereby creating an environment that is more conducive to both teaching and learning.
Most teaching events were prompted by resident performance errors. High-acuity situations often demand instrumental interactions without additional communications to ensure patient safety. Banter and pure teaching help to set the tone in the OR and provide lasting educational lessons, respectively. Being mindful of these different forms of operative interactions and striving to balance their use can enhance the learning experience in the OR.

Operative performance assessments
A variety of rating scales, procedure-specific checklists, and indices of surgical competency have been developed in the last few decades and provide a standardized means of assessing learner performance. Examples include the Objective Structured Assessment of Technical Skills and the Global Operative Assessment of Laparoscopic Skills.

Although many assessment scales focus primarily on technical skills, the mark of a proficient surgeon includes not only mastery of the technical elements but also an ease and efficiency of movement and a situational awareness that promotes the efficiency of the entire surgical team. Therefore, scoring systems, which aim to evaluate overall surgical competence and incorporate all of these elements, are an ideal tool for this setting. One example is the Ottawa Surgical Competency Operating Room Evaluation (O-SCORE), which evaluates residents’ pre-procedure plan, case preparation, knowledge of specific procedural steps, technical performance, visuospatial skills, post-procedure planning, efficiency and flow, and communication with the surgical staff. When this tool was piloted in the division of orthopaedic surgery at the University of Ottawa, ON, faculty indicated that the tool made trainee assessment easier. Post-hoc analysis proved that the tool was able to differentiate between junior and senior residents, thereby validating the model. As objective measures of resident competence become increasingly important in education,

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models such as the O-SCORE may take a central role in resident assessment and teaching.

**Video-based assessments**

Video-based post-procedural analyses of residents’ operative performances provide yet another method for assessing residents’ surgical competence and for providing instructive feedback. Video assessments add flexibility to both the evaluation and the instruction process. Skills, performance, and operative technique may be viewed and rated at a later date, allowing for more extensive debriefing and analysis.

A video assessment system has been implemented recently at a tertiary care training institution in Pennsylvania. In this model, residents are videotaped while performing selected index cases. Feedback is given in the form of two separate rating systems, assessing both the residents’ performance and level of autonomy in the OR using the Zwisch model, as well as nontechnical criterion including situational awareness, decision making, communication and teamwork, and leadership. Such models, which evaluate multiple aspects of overall surgical competence, are another way to facilitate resident development.

**Conclusion**

Surgical training and education has evolved substantially over the last several decades in response to new technologies, regulations, and practices. In an effort to address these changes, a multitude of teaching and assessment methods were created to maximize teaching opportunities in the OR. Educators and institutions that embrace these new methods of teaching place themselves in an optimal position to train the next generation of surgeons. Each of these methods varies in terms of focus and mode of implementation, but they all share a common goal of maximizing the development of the surgical resident by encouraging proficiency in surgery.

REFERENCES (CONTINUED)

Feedback fundamentals in surgical education:

Tips for success

by Rebecca L. Hoffman, MD; Jacob A. Petrosky, MD; Mariam F. Eskander, MD; Luke V. Selby, MD; and Afif N. Kulaylat, MD

HIGHLIGHTS
- Reviews key concepts in the delivery and receipt of feedback
- Offers suggestions on best practices in providing feedback to students and trainees, including how to set the stage and signposting
- Provides insights into how to tailor feedback for different audiences

Humans are notoriously poor at assessment. Acknowledging areas for personal improvement can be onerous and humbling, whereas identifying and informing others of their strengths and fallibilities can be daunting and uncomfortable. However, an understanding of one’s weaknesses and limitations is essential for growth.

Formative feedback is defined as information communicated to a learner with the intention of modifying his or her thinking or behavior to improve learning. This process provides the framework by which non-evaluative, supportive, timely, specific, and actionable feedback can result in measurable improvements in the learner’s knowledge, skills, or behaviors. Identified as one of most important influences on learning, feedback alleviates uncertainty and illuminates a pathway to success.1,2

Formative feedback is especially important for the surgical trainee. For the safety of the patient, positive technical and non-technical behaviors must be reinforced, while negative behaviors need to be modified before the surgeon begins independent practice. Formative feedback contrasts sharply with common, non-specific evaluations such as “good job” or “needs to read more,” which are unlikely to motivate the recipient to improve performance. This article reviews critical concepts in the delivery and receipt of feedback to optimize success in surgical practice.
Feedback and improved performance

Providing feedback to students and trainees is a time-honored tradition in medicine, and in light of the challenges brought on by duty-hour restrictions and limited operative autonomy, this type of assessment has become increasingly recognized and valued. Numerous strategies have been developed to ensure timely delivery of feedback, including deliberate practice, debriefing, and coaching. While the transferability of other educational strategies, such as surgical simulation, has been well established, less is known about the attributable impact of feedback on operative performance.

Improvements in time to completion of laparoscopic cholecystectomy, reduction of technical errors, and enhancements in the economy of movement have all been demonstrated by surgical trainees randomized to groups receiving constructive feedback compared with those receiving none. In addition, feedback during and following deliberate practice in virtual reality training simulators has resulted in superior technical performance in porcine laparoscopic cholecystectomy models as well as in the operating room (OR). A recent randomized-controlled trial evaluating the influence of coaching and feedback on the performance of the jejunojejunostomy during laparoscopic Roux-en-Y gastric bypass revealed that residents who received comprehensive coaching, including performance analysis, debriefing, feedback, and behavior modeling, scored higher on a procedurespecific skill scale and made fewer technical errors than trainees who did not receive coaching.

Often, it can be difficult to find the time for structured, meaningful, and comprehensive feedback sessions. Hence, it is imperative that both the surgeon educator and the learner recognize the value of smaller quanta of feedback delivered in less structured or impromptu interactions throughout the course of a day. The following approaches may be useful in facilitating the delivery of effective feedback.

Recognizing feedback: Setting the stage and signposting

To optimize educational value, both educator and learner must recognize when feedback has actually occurred. This has traditionally been challenging for surgeons given the pressures of running an efficient day and the nature of the intraoperative teaching environment. A number of studies have demonstrated that although faculty and residents agree on the importance of feedback, they often have a different perception of how to best convey this information. For instance, research conducted by Hutul and colleagues suggests that faculty think they provide feedback 91 percent to 97 percent of the time, while residents consistently report receiving useful feedback only 17 percent to 30 percent of the time. To ameliorate this discrepancy, the educator can adopt two important strategies: setting the stage at the beginning of an interaction, and signposting.

Setting the stage

This strategy requires a more active effort on the part of the educator and is critically important for building a constructive relationship with the learner. Find a place that is relatively private and quiet (including right outside the OR) to facilitate a constructive exchange. Take a moment to establish goals that both

**Take-home points for success with feedback**

- View feedback as an opportunity, not as a criticism
- Use feedback to develop a collegial and positive educational relationship
- Thoughtful and actionable feedback is most useful for improving performance
- Feedback can be bi-directional
- Well-executed feedback produces measurable improvements in technical skill
educator and learner identify. For example, consider what your expectations are for the learning interaction (short-term, long-term, or both). Perhaps set a mixture of goals—some of which are easily attainable and others that are more challenging. Setting the stage prior to a scenario that may be stressful or technically difficult may also minimize anxiety. Most importantly, take this opportunity to establish an expectation of ongoing feedback and to identify what forms that feedback might take (structured, impromptu, written evaluations, and so on).17

Signposting
This strategy involves alerting the learner that feedback is about to occur by using the word “feedback.”17 The word makes it clear to both parties that this is a learning opportunity, which should diminish potential discrepancies in perceptions of feedback. While signposting is easy to do in a more structured setting, using this strategy for impromptu feedback that occurs in the OR is more difficult and the lesson is less likely to be retained by the learner. Feedback in the OR is also often disguised as technical tips or disapproving (or approving) speech and/or body language.

Surgeon educators may get acknowledged for, and learners may more easily recognize, these common OR interactions as feedback if retrospective signposting is used. Retrospective signposting refers to the acknowledgment that feedback has occurred after the fact. Retrospective signposting might occur after an exchange between instructor and learner. The educator could state, “I hope that the feedback on your initial approach to the gallbladder was useful.” Or the senior surgeon might say something like, “During the case, I gave you some feedback on the best way to skeletonize the cystic duct. I would like to suggest that for the next laparoscopic cholecystectomy, we establish a new goal based on that feedback.”

Providing effective feedback: The important components
Many educators struggle with providing useful, honest, and specific feedback. Traditional post-rotation assessments are fraught by the long latency period between the subject of the feedback and end of the rotation. Additionally, they are typically overly broad or generic and are neither actionable nor specific. To be effective, feedback should be timely, concise, actionable, and specific. In one example, residents generally regarded feedback as inadequate, vague, and non-specific, whereas the faculty providing the feedback felt it was useful.18

Ideally, feedback should be provided shortly after the event, for maximal impact, but it does not necessarily need to be provided during an interaction. For example, in a stressful situation, it may be difficult for the teacher to provide and the learner to incorporate the feedback, so a debriefing session afterward may be more appropriate. Feedback should be specific, referring to precise behaviors or points of knowledge. It should be concise and focus on only one or two points. It should be clear and actionable, and the educator should be able to explain how the feedback can lead to improvement.

Tailoring feedback to the audience
The general strategies highlighted in this article for providing effective feedback are independent of the level of the learner. However, it is important to recognize that medical students, residents, and attending surgeons all have different expectations for delivery and receipt of feedback.

Medical students
A medical student rotating on surgery has specific feedback needs. Students are often assigned concrete tasks that may not require extensive feedback, such as collecting vital signs before rounds, changing dressings,
Effective formative feedback provides the opportunity for self-assessment and usually ends with a plan for improvement.

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Retracting tissue, or holding the laparoscope. These tasks expose the student to different components of surgical care, and it is the student’s understanding of these components that should be assessed. For example, students pre-rounding and recording vitals do not want and should not need feedback on whether they copied the numbers correctly. Instead, their understanding of the importance of the vital signs they recorded can and should be evaluated. Tachycardia in a postoperative patient, for instance, should lead to a brief discussion of the normal range of vital signs and a longer discussion of the differential for postoperative tachycardia.

Residents

Surgical residents are primarily concerned with two main tasks: mastering technical operative skills and patient management. The feedback they receive should focus on those two domains and should be specific to the level of training. Expecting a surgical intern to perform any laparoscopic procedure skin-to-skin with minimal guidance may be possible for only a few select individuals, as most interns have yet to attain the skills and confidence needed to succeed. In contrast, a senior surgical resident at many programs would be expected to perform all aspects of the surgical encounter from consent, positioning, and setup (including the ability to troubleshoot the oft malfunctioning laparoscopic instrumentation), and safely perform the critical aspects of the procedure with minimal coaching.

Attending surgeons

Many medical students and residents shy away from providing feedback to their attending surgeons, but their hesitation may be unwarranted. The surgeon who takes a job at an academic hospital and is involved in resident education does so knowing that medical student and resident education is a vital responsibility. Although potentially intimidating, it is appropriate for a resident to approach an attending and provide feedback after an operation. In fact, this dialogue is necessary for all parties to gain the most from an experience. Importantly,
“upward feedback,” as it is known, should be used to enhance the educational benefit of the learner.21 This type of feedback should be used to reinforce the positive aspects of the interaction and serve to enhance the collegial and educational relationship between the learner and educator. For example, the resident might make the following statement: “I like when you let me decide which stapler to use.” It can also be used to communicate what isn’t working for the learner, with a statement such as, “I don’t understand what you mean when you say….”

Conclusion
Effective formative feedback provides the opportunity for self-assessment and usually ends with a plan for improvement. When delivered consistently and appropriately, feedback can lead to more a productive instructor-trainee dynamic.19 In surgery, specifically, good instructors are identified as those educators who challenge trainees to think, provide useful feedback for their work, communicate ideas well, and express a positive attitude toward trainees and teaching.22 At the fundamental level, the medical student, the resident, and the attending all share the same goal—to provide the best care for the patient. Well-executed feedback provided at all levels of training and/or practice should be recognized as essential to this most basic mission.
Surgical care does not take place in a vacuum. Social, economic, legislative, and regulatory issues all affect our ability to provide optimal care to each patient, to promote the best interests of all our patients, and to thrive as a profession. Working through these issues requires us to act as advocates for the science and profession of surgery. An advocate is defined as “a person who works for a cause or a group.” As surgeons, we work for our patients. Surgeons exist for the purpose of caring for patients; patients don’t exist to give surgeons opportunities to wield scalpels. By definition, that makes all of us advocates for our patients.

On an organizational level, the American College of Surgeons (ACS) Division of Advocacy and Health Policy provides surgeons with numerous advocacy-related resources, including the annual ACS Leadership & Advocacy Summit, the Health Policy Research Institute, and online educational tools. The passage of H.R. 2, the Medicare Access and CHIP (Children’s
Health Insurance Program) Reauthorization Act, in April is a recent example of the impact of political advocacy efforts. The permanent repeal of the sustainable growth rate (SGR) through H.R. 2 had been at the top of the ACS’ health policy agenda for several years. The College’s advocacy efforts, together with other medical societies, were crucial to the SGR’s demise.

Numerous individual surgeons have had prominent roles in health care policy and patient advocacy, including the following: C. Everett Koop, MD, FACS, shaped the landscape of patient advocacy by serving as the U.S. Surgeon General under President Ronald Reagan; Atul Gawande, MD, MPH, FACS, awakened public consciousness through books and articles on a variety of health care topics; and countless other surgeon advocates have represented their constituents in the U.S. and state congresses. In the 114th U.S. Congress, six members of the House of Representatives—Dan Benishek, MD, FACS (MI-R); Charles Boustany, MD, FACS (LA-R); Larry Bucshon (IN-R); Michael Burgess, MD (TX-R); Tom Price, MD, FACS (GA-R); and David “Phil” Roe, MD (TN-R)—and two senators, John Barrasso (WY-R), and Rand Paul (KY-R), are surgeons.

A tale of two surgeons

Two surgeons who have helped to shape the practice of health care on a national level through their advocacy efforts are Kristen Zarfos, MD, FACS, and Todd Wider, MD. Their passion for patient care, their refusal to accept subpar treatment for their patients, and their unrelenting drive to promote patient well-being is exemplary. The complete interviews with Drs. Zarfos and Wider will be available on the RAS-ACS Advocacy and Issues Community website later this month; however, the salient comments from these interviews are summarized in this article.

Kristen Zarfos, MD, FACS

Dr. Zarfos first became interested in advocacy work when insurance companies stopped covering overnight stays for mastectomies—a policy the media once referred to as drive-through mastectomies. “I was concerned that…patients could not be treated as individuals in the context of what procedure they were having and their comorbidities and their family setting,” said Dr. Zarfos, a general surgeon specializing in breast and thyroid surgery, Hospital of Central Connecticut, New Britain.

She started by asking her patients for their opinions and by gathering objective data. “In an informal way I was surveying all of my patients,” Dr. Zarfos said, and they “replied with passion. The credit [also] goes to the patients who were willing to come forward and speak to the press.” She said working with the media afforded her the opportunity to contact individuals who were willing to come forward and reveal details about their personal experiences.

Dr. Zarfos also found allies in local legislators and policymakers. “I was told by a friend that [Rep. Rosa DeLauro (CT-D)] was someone who had had ovarian cancer—she was a survivor and interested in women’s health issues,” Dr. Zarfos said. “If you want to work with a legislator, you have to do your homework,” she advised. “You have to be completely factual and you have to learn to speak publicly [and to] not get too emotional.”

Eventually Dr. Zarfos’ efforts paid off. In 1997, Representative DeLauro sponsored H.R. 135, the Breast
Cancer Patient Protection Act of 1997, which stated that health insurance plans must cover at least a minimum hospital stay for mastectomies and lymph node dissections performed for breast cancer. H.R. 135 was referred to a subcommittee, but it was not signed into law. However, several large national health insurance companies did agree to change requirements for outpatient mastectomies, and currently 21 states have legislation to prevent patients from being forced out of the hospital before they are ready for discharge. Today, outpatient mastectomies are common, but they are not mandatory.

Todd Wider, MD

Dr. Wider, a plastic surgeon at St. Luke’s Roosevelt Hospital in New York, NY, became active in advocacy when he realized breast reconstruction was considered cosmetic surgery and therefore not covered by a patient’s insurance. “First of all, it’s not a cosmetic operation, and in this case, we can’t even close the wound primarily, so I have to bring tissue in,” Dr. Wider once told a medical director at an insurance company. “He suggested I perform a skin graft. I answered, ‘That might have been okay in 1935, but not in 1998.’ I told him that it was medieval, and I wouldn’t do that. He answered that the insurance company would not pay for a transverse rectus abdominal muscle [TRAM] flap, but I was not going to lie down and accept this.”

While Dr. Wider was accustomed to having discussions with insurance companies about reimbursement, this case involving Janet Franquet, a young nurse with aggressive inflammatory breast cancer, was particularly memorable. When the patient’s insurance company refused to cover breast reconstruction with a TRAM flap after a radical mastectomy, arguing that it was a purely cosmetic operation, Dr. Wider was outraged and performed the reconstructive procedure for free. This experience served as a catalyst for his interest in patient advocacy and social justice in general.

Dr. Wider’s next course of action was to reach out to various lawmakers, including Sen. Alfonse D’Amato (R-NY), who gave press conferences and speeches to raise public awareness regarding proper insurance coverage for breast reconstruction before presenting this issue to the U.S. Senate. A bill was eventually passed in both houses and President Bill Clinton signed the Women’s Health and Cancer Rights Act in 1998. The law mandates that health plans offering mastectomy coverage also have to cover reconstructive options as well as complications that may arise from the operation. “It was a very rewarding experience to advocate for your patient and have a real impact[...] I was bitten by the social advocacy bug because I thought I could actually have an impact on the society we live in, and that led to my film career,” said Dr. Wider, who is also a nationally acclaimed filmmaker of documentaries on social justice issues. He advises surgeons interested in advocacy to follow their moral compass. “My advice is to never lose sight of one’s own integrity. Practice with integrity. You always know in your heart what the right thing to do is—always.”

Five steps to success in advocacy

Drs. Zarfos and Wider are nationally recognized health care policy advocates, but not every surgeon needs to achieve this degree of success to effect change. In a time of increasing political and financial
The two surgeon advocates featured in this article had relatively few resources when starting out. Today, surgeons can receive support from the ACS, which offers educational materials, including webinars and brochures, talking points to refer to when e-mailing or calling legislators, legislative updates at the regional and federal level, and more.

pressure, decreasing physician autonomy, and profound changes to the health care system, an active interest in our health care system is more important than ever.

The two surgeon advocates featured in this article had relatively few resources when starting out. Today, surgeons can receive support from the ACS, which offers educational materials, including webinars and brochures, talking points to refer to when e-mailing or calling legislators, legislative updates at the regional and federal level, and more. In addition, the ACS hosts the annual Leadership & Advocacy Summit in Washington, DC, which offers in-depth advocacy training and in-person opportunities to meet with legislators on Capitol Hill.

Surgeons interested in advocacy should also review the advocacy section of the ACS website and, in particular, information pertaining to the ACS Professional Association Political Action Committee, which is accessible to all ACS members. These resources offer concise information on current health policy topics and highlight opportunities to get directly involved in local and national advocacy efforts. Subspecialty organizations and local chapters have recognized the importance of political advocacy and offer numerous resources geared toward grassroots advocacy efforts.

The following are suggested guidelines for surgeon advocates:

• Get objective data, and be prepared. Advocating for our patients is personal and can be emotionally charged. However, in political advocacy, numbers and verifiable data count. Every successful advocacy effort starts by knowing the facts. Be up-to-date on health policy issues and prepare objective data, which may come from a variety of sources including patient surveys, medical literature, national databases, as well as from such entities as the ACS Health Policy Research Institute and the Kaiser Family Foundation. More information on these groups can be found on their respective websites at www.facs.org/advocacy/hpri and www.kff.org.

• Connect with local advocacy groups and grassroots organizations. In many states there are local advocacy groups and grassroots organizations. Be sure to tap into the ACS chapters and other surgical societies for resources and opportunities for collaboration. Think outside the box—allies don’t have to be exclusively medical organizations.

• Harness the power of the media. Members of the media can be important allies, as their ability to reach people allows surgeon advocates to reach a wide audience and disseminate important health care-related information. Letters to the editor and guest editorials on a variety of key health care policy topics may be published in local newspapers. Be sure to reach out to journalists who may have access to legislators and who may be able to connect you with like-minded advocates.

• Contact local legislators after doing your homework. Preparation is key before approaching politicians about an issue. Look for legislators who may have a personal connection to a particular issue or who may have a special reason to work with you. Obtain objective, verifiable information, discuss issues in a professional manner, and be bipartisan. Support can come from unexpected places and from both sides of the aisle.
The most important piece of advice both Dr. Zarfos and Dr. Wider had to offer is that health care policy advocacy is a worthwhile and noble cause. We became physicians to help patients in need, and this moral compass is the best guide for successful and honest political advocacy.

Don’t discount the knowledge and influence of your legislator’s staff. They have your elected official’s ear and can move your issue to the top of the priority list.

• Never lose sight of your integrity. The most important piece of advice both Dr. Zarfos and Dr. Wider had to offer is that health care policy advocacy is a worthwhile and noble cause. We became physicians to help patients in need, and this moral compass is the best guide for successful and honest political advocacy.

Advocacy matters
Professional success is commonly viewed in terms of academic or clinical achievement, but the health care policy-related triumphs led by surgeon advocates deserve more attention.

The experiences of the surgeon advocates described in this article may motivate some surgeons to become more active in health care policy and provide a template for any surgeon interested in taking up an issue affecting patient care. In this time of increasing non-medical influences on daily medical practice, active involvement in health care policy initiatives may ensure that we, as surgeons, can shape our practice environment and continue to provide the best possible care to our patients. ♦

REFERENCES
Surgeons and social media:

by Said C. Azoury, MD; Lindsay A. Bliss, MD, MPH; William H. Ward, MD; Amy E. Liepert, MD; and Stefan W. Leichtle, MD

Threat to professionalism or an essential part of contemporary surgical practice?
Editor’s note: The subject of this article—whether social media is a threat to surgery or an essential part of contemporary practice—will be debated at this year’s Resident and Associate Society of the American College of Surgeons (RAS-ACS) Symposium on Sunday, October 4, at the 2015 Clinical Congress in Chicago, IL. The Advocacy and Issues Committee of the RAS-ACS sponsors the debate.

Over the last decade, social media has become the preferred method of communicating and exchanging ideas among younger generations. The most popular platforms include Facebook, Instagram, and Twitter; additionally, professional networking sites, such as LinkedIn, Doximity, and ResearchGate, have gained prominence in the business and health care worlds. Of the more than 7 billion people on Earth, approximately 3 billion are active Internet users, and more than 2 billion have active social media accounts. In addition to millennials (individuals born between 1986 and 1997), older generations are avid users of social media. In fact, a recent report noted that approximately 56 percent of online adults ages 65 and older use Facebook.

Patients increasingly use the Internet and social media to obtain health care information, and many hospitals, medical practices, and health care organizations, including the College, use social networks for marketing initiatives, to announce events, and to provide educational material regarding research and health care topics. A recent survey of 2,070 respondents by the ACS indicated that 48 percent of surgeons use LinkedIn, 55 percent use Facebook, and 82 percent regularly access YouTube. In fact, surgeons increasingly rely on online platforms to access educational material and to connect with colleagues on multiple levels—locally, nationally, and even globally. With the rigorous demands of surgical training limiting the time available for personal interaction, surgical residents also use social media and networking websites to keep in touch with friends and family.

The ability to disseminate information as well as personal opinions to a global audience provides unprecedented opportunities to share information but, at the same time, poses serious risks to physicians’ careers and personal privacy, as well as to the reputation of our profession in general. How should surgeons respond when they get “friend requests” from patients? Should attending surgeons be online friends with their residents? How much information about their private lives should physicians publicly disclose? Are there official rules that can guide physicians and help them avoid legal trouble?

Social media: An essential communication tool

Surgeons today find their time split between clinical practice, administrative and research pressures, travel for and engagement in professional societies, and family and personal commitments. Fortunately, social media allows for professional engagement during the brief pauses in a busy day’s schedule—waiting for an elevator in the hospital, having a snack in the operating room lounge between cases, and riding the stationary bike at the gym all become opportunities to engage in social media.

Social media also is taking on a greater role at regional and national health care meetings and allows for medical advancement and research to be disseminated in a rapid and accessible manner. The results from an groundbreaking abstract presented at a conference in Tokyo, Japan, for example, could be tweeted by attendees, re-tweeted by colleagues, and read in a surgeon’s Twitter feed between operative cases. Before the widespread adoption of smartphone apps, a surgeon in Illinois might have to wait a year to see these results published in a journal. This swift spread of information can help decrease the 17-year health research implementation curve and enable innovative treatments to get to patients sooner. The use of unique meeting and session-specific hashtags—for example #ACSCC15, the hashtag associated with all of this year’s Clinical Congress tweets—allows surgeons to discuss ideas in real time as they are presented to session attendees. A live
Twitter feed also can ensure that a question is shared with the moderator, particularly in large sessions with numerous attendees, and it can allow a speaker to provide clarification. Networking is more easily accomplished and supplemented with tools like Doximity or LinkedIn. A chance meeting in a hallway can be solidified with basic professional information obtained through these sites while also providing a means of communication between participants. These relationships can lead to lasting partnerships or research and clinical collaborations. New collaborators and clinical trial sites can be identified through professional forums such as the ACS Communities or Facebook groups; even local collaborations can be enhanced via social media in a way that is already integrated into established social routines.

Social media platforms can play an important role in the critical assessment of medical literature. Established in 2014, the International General Surgery Journal Club (@igsjc) uses Twitter to facilitate discussions about a selected article over the course of several days. By partnering with publishers, articles can be made available outside of paywalls. Geographically isolated surgeons no longer have to travel to participate in scholarly exchange—they only need a mobile phone signal. Furthermore, access to the Internet and social media platforms via mobile devices can be used to demonstrate ongoing professional development, such as participation in continuing medical education activities through platforms such as Medscape, Epocrates, and QuantiaMD.

The educational benefits of social media extend to current students and trainees. Residents can learn from the wisdom shared by attending surgeons on ACS Communities, and online discussions around practice management may provide a glimpse into aspects of professional development not taught on the wards. Recent topics included tips for contract negotiations, advice on billing and coding, as well as discussions about recognizing and avoiding burnout. Medical students considering a career in surgery can see the inclusive, diverse make-up of practicing surgeons by viewing the Facebook profiles of the more than 11,000 individuals who “like” the ACS page. Trainees also can find resources to enhance their clinical education and improve their academic performance. Residents following @SCOREsurg on Twitter receive “This Week in SCORE (TWIS)” assignments to help keep reading habits comprehensive, which should help them to prepare for clinical care duties as well as the American Board of Surgery In-Training Examination. Medical students and residents can prepare for cases using YouTube video reviews, and preclinical students can use Facebook groups to work through problem-based learning assignments.

The advantages of social media become increasingly apparent as surgeons become more involved in advocacy and health policy work, as well. These platforms provide a fast, direct means of interacting with professional organizations and legislative staff. Social media also has the potential to mobilize a large group of people with little effort when calls to action are needed and to provide a direct route for grassroots communication to legislative offices. Similar benefits can be extended to patient advocacy and disease-specific groups. A surgeon who joins a Crohn’s disease-focused Facebook group or follows the Twitter hashtag #CrohnsLife will have a better sense of the daily challenges his or her patients manage. These social media tools may lead to meaningful collaborations, identify patient advocates and champions, and may facilitate financial support for research efforts or programs to enhance patient care.

Social media can be used to communicate directly with patients. A Facebook page can help promote a surgeon’s services and expertise, and a Twitter account using a disease-specific hashtag can help raise the profile of a surgeon among potential new patients. While plastic and reconstructive surgeons have led the way in marketing and branding their services through social media, surgeons in other market-driven fields, such as bariatric surgery, also have used social media to reach patients considering surgery. Participating in research discussions or clinical debates via these platforms can
suggest professional expertise to potential patients who may be unfamiliar with peer-reviewed publications. Similarly, patients look for physician reviews on social media in the same way they might look for reviews when evaluating a contractor or a caterer.

Social media is uniquely positioned to enhance a surgeon’s professional life. It can be leveraged for education, collaboration, research dissemination, and patient recruitment. Mobile platforms allow users to engage one another via social media, allowing for communication in small, productive bursts. Social media breaks down geographic and practice setting barriers and makes surgeons more accessible to patients, advocates, and each other.

Social media: A threat to professionalism
On the down side, social media also can erase the boundaries between surgeons’ professional and private lives. As the growth in social networking sites continues, many questions remain regarding how these developments will affect surgeons. The difficult situations that can arise through the use of social media add layers of complexity to traditional ethical issues, and despite social media’s widely touted advantages, many critics believe that social media use by physicians and surgeons can be a precarious endeavor.

Frequent posting of unprofessional online content by medical students and residents is an example of questionable use of social media. The variability of unprofessional online commentary found in multiple studies ranges from Health Insurance Portability and Accountability Act (HIPAA) violations and sensationalistic reporting of traumatic patient injuries to anecdotal bragging about episodes of inebriation and descriptions of sexual encounters. These lapses in judgment not only undermine generally accepted tenets of professional behavior, but they may create public mistrust of the medical profession. As a result of such activity, medical education administrators have begun advocating for screening of an applicant’s online activity.

While the inappropriateness of these public lapses in judgment on social media may seem obvious, part of the challenge regarding appropriate online communication stems from the absence of a widely held standard of professionalism. The presumed anonymity of online posting and social media interactions lowers the threshold for unprofessional behavior, and well-established guidelines on what constitutes appropriate behavior can be hard to find. The barriers that separated a surgeon’s professional life from his or her personal affairs are much more susceptible to breaches. Social media allows for virtually all facets of an individual’s life to be interconnected.

It should not be surprising that, with this paucity of boundaries, interactions between physicians and patients have transcended the former limitations of the physician-patient relationship. One example of this newly available interaction occurs when a patient delivers a “friend request” to his or her physician. Inevitably, the physician is placed in the awkward position of trying to appease a friendly request while guarding against privacy endangerment. Acceptance of a patient’s invitation to formally establish a more social relationship can diminish the professional limitations of an acquaintance, exposing the patient to the online personal life of his or her health care provider. Aside from the challenges this situation may create during office-based consultations, such a relationship also can expose a surgeon to risk if the patient has maladjusted behavioral patterns. Vulnerability to criminal activity of varying degrees is certainly increased—multiple accounts have been published by the lay press involving health care professionals who have been stalked or even assaulted by patients or their associates as a consequence of learning and acting on information easily accessed via social media. Given the personal time and family interests that surgeons sacrifice throughout their training and careers, it seems remarkable that some feel inclined to give even more of themselves through social media.
Patient privacy issues
One of the most significant concerns associated with active physician participation in social media centers on the potential medicolegal breaches involving patient privacy. Chief among them are outright violations of HIPAA—recent literature is replete with examples of patient privacy violations.16,17 Despite significant advances in patient privacy protection in the decades since HIPAA was implemented, online publishing of sensitive patient information still occurs on social media, particularly Twitter and Facebook. Among surgeons-in-training and medical students, these posts rarely provide patient names and identification numbers directly; however, detailed anecdotes of patient encounters, which can be easily traced, are sometimes shared. The content of these posts range from simple personal reflection concerning a tragic diagnosis to outright ridicule and amusement at a patient’s unfortunate injury or circumstance.16 Such behavior, facilitated by the obscure professional boundaries characteristic of online forums, is susceptible to serious legal ramifications, as these violations of privacy may lead to prosecution, professional censure, and loss of certification or licensure.

Whether intentional or accidental, these missteps within the realm of social media are widely considered unethical and below the professional standards to which we as surgeons adhere. As LaMar S. McGinnis, Jr., MD, FACS, remarked in his 2009 ACS Presidential Address, the “precepts of professionalism extend beyond the operating room, the clinic, and the hospital, to your family, your peers, and other professional associates, your casual contacts, your community, and wherever you venture.”20 Many surgeons would do well to remember Dr. McGinnis’ advice, especially while logged in to their preferred social media account.

Guidelines and recommendations
In general, common sense is a good guide for how to behave when using social media. Many hospitals and health care organizations have issued official social media guidelines that also act as the basis for legal action if violated, and it behooves physicians to be familiar with these policies for this reason.

American Medical Association (AMA)
The AMA’s Council on Ethical and Judicial Affairs issued a report, Professionalism in the Use of Social Media, extending its comprehensive Code of Medical Ethics to online behavior.21,22 Important guidelines in this report include the following:

- Be aware of the potential dangers of social media and Internet use, which has the potential to compromise both an individual physician and the medical profession as a whole
- Apply confidentiality, privacy, and professionalism policies and guidelines that pertain to offline behavior and practices to online interactions
- Use the highest privacy settings on all social networking sites, and be aware that these settings do not guarantee absolute privacy
- Monitor online content regarding your identity at regular intervals, which may include verifying the accuracy of contact and other information on professional websites or reviewing images and postings of yourself appearing on social networking sites
- Establish two different personas online—one for professional and one for private interactions
- Notify medical colleagues about potentially unprofessional content online and report it to the appropriate professional organizations if the content is severe or persistent

The Federation of State Medical Boards (FSMB)
The FSMB Special Committee on Ethics and Professionalism has issued comprehensive social media guidelines in its Model Policy Guidelines for the
Appropriate Use of Social Media and Social Networking in Medical Practice.23 The positive aspects of social media use in physicians’ private and professional lives are acknowledged in this guide, but it also includes warnings about the potentially severe negative consequences of inappropriate use. In a survey of 48 state medical boards, 92 percent (44) reported online-related issues, with serious disciplinary consequences including license restriction, suspension, or revocation occurring at more than half of the boards (27 of 48 medical boards).24 The FSMB’s guidelines emphasize the following:

- Maintain proper online boundaries between physician and patient, similar to any person-to-person interaction in the hospital or office.
- Avoid any online contact with past or current patients, particularly on social media sites with a largely personal focus, such as Facebook.
- Establish separate personal and professional profiles on social networking sites.
- Use different e-mail addresses for private and professional communications to avoid confusion about individual and institutional representation.
- Report unprofessional behavior to regulatory authorities.
- Learn an employer’s social media or social networking policy, if applicable.
- Avoid text messaging or e-mailing patients for medical purposes.

Actively manage one’s online presence by establishing profiles on social media and professional networking sites. This recommendation can be considered a reminder to social media skeptics that ignoring this technology is not the best response to concerns about professionalism.

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Council of Emergency Medicine Residency Directors (CORD)
Noting that emergency medicine physicians appear to be among the most avid physician users of social media, the CORD board of directors published guidelines for social media in 2014, taking into account existing guidelines at medical and nonmedical institutions. They also encourage every residency program and institution to develop its own social media policy and to educate employees about proper use of social media. Echoing the sentiments of other organizations, physicians should uphold the same standards of professionalism and confidentiality online as they would in person. The CORD guidelines highlight several points specifically aimed at residents, such as how senior residents or faculty need to be consistent in their approach to accepting or rejecting friend requests from co-residents to avoid the impression of bias or favoritism.25

How to use social media
In 2015, the issue is not whether physicians should use social media, but how they should use it. The ubiquity of social media makes ignoring the technology nearly impossible and certainly ill-advised. The Internet and social media offer tremendous opportunities for physicians but invariably create serious challenges and potential conflicts. Applying common sense and adhering to “professional offline standards” while online are among the most helpful recommendations for physicians who engage in social media. Fortunately, an increasing number of national physician organizations and health care institutions are issuing guidelines on the proper use of social media. These recommendations can provide valuable guidance and may also serve as the basis of legal action; all physicians should be aware of how the rules apply to them in their respective professional environments. In 2015, what happens online can no longer be ignored offline. ♦

Disclaimer
The views expressed in this article are those of the authors and do not necessarily reflect the official policy or position of the Department of the Navy, Department of Defense, or the U.S. government.

REFERENCES (CONTINUED)
No quality without access:

ACS and NIH collaborate to ensure access to optimal care

by Diane Schneidman

HIGHLIGHTS

• Describes the purposes of the NIH-ACS Symposium on Surgical Disparities Research
• Summarizes comments on the causes and possible solutions to resolving disparities in health care from notable surgical leaders
• Recaps presentations offered by leaders at the NIH, PCORI, and other stakeholders
• Presents findings and current knowledge regarding health care disparities as described by surgical residents and experts in the field
• Outlines an agenda for moving forward to address disparities in care

When L.D. Britt, MD, MPH, DSc(Hon), FACS, FCCM, FRCSEng(Hon), FRCSEd(Hon), FWACS(Hon), FRCSI(Hon), FCS(SA)(Hon), FRCSGlasg(Hon), was President of the American College of Surgeons (ACS) from 2010 to 2011, he noted that the organization has historically devoted its resources to advancing quality and patient safety. However, he observed, “There is no quality without access.”

This bold statement led to the establishment of the ACS Committee on Optimal Access (recently renamed the ACS Committee on Health Care Disparities), which Dr. Britt chairs, and which developed an ACS Statement on Optimal Access.* The committee was charged with several tasks, including the development of specific strategies for addressing health care disparities and the production of resources that could be used as part of these strategic initiatives.

With the establishment of the committee and its charges, the stage was set for the College to develop a collaborative relationship with the National Institute on Minority Health and Health Disparities (NIMHD)—one of the National Institutes of Health (NIH). Given the College’s history with quality improvement programs and the NIMHD’s considerable research and scientific resources, the organizers of this effort saw the potential for a formidable partnership that could substantially expand access to surgical care.

To launch this collaborative effort, approximately 50 thought leaders from the ACS, NIH, other government agencies, and academic institutions gathered for what several participants described as a historic event—the NIH-ACS Symposium on Surgical Disparities Research, May 7–8, in Bethesda, MD. The purpose of this meeting was to create a national research agenda for use by scientists as they pursue future investigative initiatives, and (2) a list of priorities to assist the NIMHD and other funding partners as they establish funding streams for this research.

A broken system
“The American health care system, by any metric, is broken,” Dr. Britt, Brickhouse Professor of Surgery, Eastern Virginia Medical School, Norfolk, said in his opening remarks. “For some, it is the best health care system in the world, but for many others, that is not the case.”

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“The question is, how do we fix it?” asked Dr. Britt, noting that traditional approaches, such as increased entitlement spending and health care reform, have failed. “Albert Einstein said, ‘You should not use an old map to explore new territory,’ but that’s what we’ve been doing in health care,” he observed, adding that the symposium should be useful in generating a new charter for overcoming health care disparities. Given the College’s and the NIH’s records in health care research and innovation, Dr. Britt said, “If we can’t solve this, I don’t know who can.”

Dr. Dankwa-Mullan said the conference and collaboration with the ACS are “timely and encouraging for all of us at the NIH.” She noted leaders of both entities are deeply committed to ensuring that all patients receive quality care. She added that in her years of working in the health care sector, she has witnessed “the power of identity—the power of group identity—to really make an impact in our communities,” as well as the power of passion. “I’ve learned that if you are a teacher, your words can be meaningful, but if you are a passionate speaker, they can be especially meaningful. If you’re a nurse or clinician, you can do some good things, but if you’re a passionate clinician, physician, or caregiver, you can really make a difference for the patient and for the community.”

Where the College stands
ACS Executive Director David B. Hoyt, MD, FACS, gave a presentation on systems-based approaches to addressing health care issues, including the development of the U.S. trauma care system. Dr. Hoyt noted that the 1960s was a period of strife in the U.S., leading to an escalation in traumatic injury. In response, the government called for the development of a more systematic approach to resolving the nation’s “neglected epidemic.”

To develop a systems-based approach to trauma care, “we highlighted leadership and legislation,” Dr. Hoyt said. “We cannot do all of this just through goodwill. We’ve got to have leadership, we’ve got to have commitment, and we may need to have legislative oversight over some of the expectations that we hold.”
Dr. Hoyt outlined the four-step process that the ACS has used as the model for its trauma and other quality improvement programs. “You start by setting standards—what you expect to happen at a certain point. You then build out the infrastructure, you measure performance through the analysis of data, and, finally, you subject yourself to external verification,” he said.

In addition, Dr. Hoyt commented on the Affordable Care Act (ACA). “What [the legislators who crafted] the ACA hoped to do was improve access to care through insurance reform, control costs through payment reform, and create delivery system redesign through performance measurement and incentives,” he noted.

“So how have we done? The good news is that insurers can no longer deny patients coverage due to preexisting conditions, and patients have more coverage options,” Dr. Hoyt said. For instance, the ACA led to the expansion of Medicaid in most states. As a result, the percentage of uninsured Americans dropped from 18 percent in 2013 to 13 percent in 2014.

“Have we bent the cost curve? I would argue that we have,” Dr. Hoyt said. Although health care costs are still rising faster than inflation, the cost of care per worker in 2014 rose just 4.6 percent from 2013, he said. Previously, health care spending was increasing by more than 6 percent annually.

A transformation in how policymakers view health care reform has been a shift in focus “from volume to value,” Dr. Hoyt noted. This changing focus is central to H.R. 2, the Medicare Access and CHIP (Children’s Health Insurance Program) Reauthorization Act and its Merit-based Incentive Payment System.

To truly eliminate disparities, however, the health care system must ensure that all patients have optimal access. “I would argue that verifying access has not been a priority in the United States. It has not been an adequate priority at the American College of Surgeons, and we can start today to change that,” Dr. Hoyt said.

NIH commitment

Providing an overview of the NIH’s efforts to address health care disparities were Lawrence Tabak, DDS, PhD, Principal Deputy Director, NIH, and Yvonne T. Maddox, PhD, Acting NIMHD Director.

Dr. Tabak noted that the NIMHD recently announced funding with intent for research that would focus on health care disparities with precision in medicine. He added that the NIH is excited to be partnering with the College on this initiative. “These types of collaborations assist in the development of the solutions needed to resolve these types of multidimensional problems,” he said.

Dr. Maddox described the NIMHD as “the entity within the NIH that is responsible for leading scientific research to improve minority health and eliminate health care disparities. Most importantly, we are responsible for translating and disseminating the research results that are created across the NIH,” Dr. Maddox said.
Dr. Maddox provided background information on the NIMHD and other federal efforts to address health care disparities, including the 1985 release of the U.S. Department of Health and Human Services (HHS) Report of the Task Force on Black and Minority Health. Several years later, during the Clinton Administration, HHS launched an initiative to address health disparities with a focus on the following:

- Cancer
- Diabetes
- Human immunodeficiency virus (HIV)
- Cardiovascular health
- Immunization
- Infant mortality

“Have we had success in these six areas? With respect to cancer, we see about a 1 percent reduction in cancer deaths each year. When it comes to cardiovascular disease, we’ve seen about a 60 percent reduction overall and about a 70 percent reduction in stroke,” Dr. Maddox said. Across all populations, infant mortality also has declined, but when the rates in the African-American population and various subpopulations of the Hispanic community are compared with the Caucasian population, the gap remains. “Over the last 30 years, infant mortality has dropped significantly in all populations, but it will take another 39 years for infant mortality in the African-American population to get to where it was 39 years ago for the Caucasian population, if we continue to track the way we’re tracking today,” she said.

Dr. Maddox emphasized the importance of examining health care disparities not only among racial and ethnic minority populations, but among other subpopulations as well. Examples include the lesbian, gay, bisexual, transgender, queer (LGBTQ) community; rural Americans; people who live in low-income, inner-city neighborhoods; and people with disabilities or special needs.

“We need to be mindful that when you’re going to do health care disparities research, you need to look at it from various domains. It’s at the individual domain, it’s at the community domain, it’s at the provider domain, and it’s at the health care systems domain,” Dr. Maddox said.

The science of systems

Atul Gawande, MD, MPH, FACS, professor of surgery, Harvard Medical School; professor, Harvard School of Public Health; general surgeon, Brigham and Women’s Hospital; and executive director, Ariadne Labs, Boston, reinforced some of the concepts that Dr. Hoyt and Dr. Maddox brought forth, adding his own insights on global health care disparities in a keynote address on “the science of systems.”

Dr. Gawande spoke about the increasing interest in addressing global disparities in surgical care as evidenced by the formation of The Lancet Commission on Global Surgery (LCoGS), on which he serves. He noted that “surgery was not on the map” in the global health care community until the World Health Organization (WHO) released a report containing a chapter by Haile T. Debas, MD, FACS, professor emeritus, University of California-San Francisco, on surgery’s effect on lifespan. Dr. Debas offered evidence that surgery contributed as significantly to lifespan as many public health activities, such as vaccinations. “That gave us an opportunity to approach the World Bank and tell them [surgical disease] needs to be on the [research] map along with HIV, along with tuberculosis,” and other health care issues.
“Now the reality is that there are enormous disparities in access to care and in the quality of that care,” he added. The LCoGS found that approximately 5 billion of the more than 7 billion people in the world today lack access to safe, affordable surgical care when they need it. The LCoGS defines “affordable” as less than 40 percent of a patient’s annual disposable income.

Just as there are global disparities, “within every country there are disparities, the U.S. clearly very much included,” Dr. Gawande said. He suggested that a scientific approach was used to promote public health improvements in the U.S. and would be useful in expanding access to surgical care as well. “The only way I see to change that is through scientific discovery—scientific discovery of how you drive systems to produce these kinds of changes,” he said.

More specifically, Dr. Gawande noted that many scientific discoveries and innovations that occurred in the 19th century began to bear fruit in the 20th century with the advent of penicillin, insulin, new surgical procedures, and so on. As a result, “we started the 20th century with an average life expectancy of 47 years and ended it at 79 years,” Dr. Gawande said.

While life expectancy has increased and mortality has remained relatively flat since 2000, health care costs have continued to rise, leading the public to question the value of the care they receive. Value is determined on the basis of outcome in relation to cost. “There is a huge difference in quality of care depending on where you go and your community, and there are huge differences in the costs of care depending on where you go,” Dr. Gawande said.

“The best places behave most like a system. A system has diverse components that are able to work together to achieve a successful outcome. It’s like a car in that way,” he said. “We, in medicine, have been obsessed with having the best components—with having the best drugs, the best devices, the best specialists—but the real question is how they fit together.”

Dr. Gawande added that unlike most research conducted at the NIH, investigations into health care disparities and the development of systems-based approaches “is not a cure for pneumonia. It’s a cure for failure.”

Comparative effectiveness research
According to Romana Hasnain-Wynia, MS, PhD, disparities program director, Patient-Centered Outcomes Research Institute (PCORI), Washington, DC, the 2003 release of the Institute of Medicine report, Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care, “was kind of the pivotal point for stakeholders to recognize that disparities are real—that they exist.” More specifically, the report, which is based on more than 600 studies, demonstrates that racial and ethnic minorities consistently receive poorer-quality health care for a range of conditions, even after accounting for socioeconomic status (SES) and access-related factors, such as insurance coverage.

Like Dr. Gawande, Dr. Hasnain-Wynia said where patients receive care affects quality of care. “Are disparities driven by who you are or where you go? We discovered that who you are matters, but where you go really matters—I mean really matters. Disparities are driven by minority patients receiving care from different hospitals, clinics, and physicians than their white counterparts.”

Dr. Hasnain-Wynia’s agency, PCORI, is an independent research institute authorized by Congress in 2010, which funds comparative effective research (CER) aimed at discovering which health care options
work for which patients under which circumstances. “We have about $1.3 billion to disperse to conduct clinical research through 2019,” she said. PCORI’s disparities program does “not fund studies that describe disparities or even studies of what drives disparities,” Dr. Hasnain-Wynia said. “We are very focused on observational studies that can really help us get to the solutions,” particularly research that would assist in addressing notable gaps in clinical therapeutic evidence.

“Disparities are caused by multiple factors at multiple levels,” she added. “So there is no quick fix. If there were, I think we would have made it long ago.”

Plotting the agenda
A central purpose of the symposium was to develop a research agenda for the five cross-cutting themes mentioned earlier: patient factors, systemic factors and access, clinical care and quality, provider factors, and postoperative care and rehabilitation. Dr. Dankwa-Mullan set the tone for the thematic presentations, noting, “In the health care setting, disparities often present as a difference in the quality or quantity of care, but there are really several other dimensions that may influence disparities.” Health care disparities exist across many clinical conditions and many health care settings, she said. “Across the NIH, we are really interested in measures. What will actually reduce disparities?”

To help answer this question, Dr. Haider explained that surgical residents were invited to present summaries of existing literature relating to each theme, followed by commentary from experts as to what should be studied.

Provider factors
Navin R. Changooor, MD, a general surgery resident at Howard University Hospital, Washington, DC, said provider level factors refer to variations in practice patterns, such as provider bias, competencies, and awareness, which may influence quality of care and outcomes. Dr. Changooor also spoke about the lack of diversity in the surgical workforce.

Olivia D. Carter-Pokras, PhD, associate professor in epidemiology, University of Maryland School of Public Health, Baltimore, said that little research has been conducted on the impact of cultural competency education. Current efforts to teach cultural competence to physicians often reinforce stereotypes, she added.

According to Dr. Carter-Pokras, some of the existing literature on provider factors indicates that it is possible for people to unlearn implicit biases.

“What we really need cultural competency education to evolve into is teaching skills that actually can be applied to improve care, such as learning to work with translators effectively,” she said.

Patient factors
Lisa Kodadeck, MD, a surgery resident at Johns Hopkins Hospital, said patient factors that affect surgical disparities include demographics, physiology, SES, and culture. According to Dr. Kodadeck, blacks are less likely than whites to receive appropriate surgical services and have higher operative mortality rates and morbidity. Hispanic patients, on the other hand, experience similar or better operative mortality in comparison with white counterparts. In addition, patients of lower SES are less likely to receive surgical services and more likely to experience operative mortality.
Dr. Kodadek said patient education and systematic changes may help to mitigate health care disparities and suggested that future disparities research efforts address outcome variations among racial and ethnic subgroups and look more closely at SES data.

James Rodrigue, PhD, professor of psychology and surgery, Harvard Medical School, said two patient factors that significantly affect access to surgical services are net economic resources and geographic/social isolation. He suggested that studies on patient factors are needed to better understand and then eradicate disparities.

John Rose, Jr., MD, a surgery resident at University of California, San Diego, spoke about systemic factors and access issues. Systemic factors that affect disparities include public policies, insurance status, management protocols, data systems and electronic health records, triage, and referrals. Access issues influence the likelihood of operation versus no operation, cancer resection, delays in presentation, diagnosis to treatment time, and receipt of care from high-volume providers, Dr. Rose said.

Joel Weissman, PhD, deputy director, chief scientific officer, CSPH, explained how insurance and payment affect access to care, noting that in states where surgeons receive lower Medicaid reimbursement patients have longer wait times for breast-conserving operations. He suggested that researchers study how payment affects referrals and outcomes and whether enrollment in accountable care organizations affects disparities.

Peter A. Najjar, MD, a Harvard Medical School fellow in patient safety and quality and Arthur Tracy Cabot Fellow in Health Services Research, CSPH, presented on the topic of disparities in clinical care and quality. He offered a health care quality framework based on the Donabedian model centered on the interconnectedness of structure, process, and outcomes. Dr. Najjar suggested that future research focus on the causes and impact of structural differences associated with race.

Otis Webb Brawley, MD, chief medical and scientific officer and executive vice-president, research, American Cancer Society, spoke about disparities in cancer care. He noted, “We spend a lot of money on health care, and costs are still going up,” adding that “part of the problem is that some people get too much care,” while others receive too little care or receive definitive care after their condition is too advanced.

Elizabeth Lilley, MD, MPH, a general surgery resident at Rutgers-Robert Wood Johnson Medical School, New Brunswick, NJ, and postdoctoral fellow, CSPH, spoke on postoperative care and rehabilitation. She described racial/ethnic disparities in timing and follow-up care for cancer patients, in long-term functional outcomes for patients with traumatic brain injury, and in palliative/end-of-life care.

David C. Chang, PhD, MPH, MBA, director of health care research and policy development, Codman Center for Clinical Effectiveness Research in Surgery, department of surgery, Massachusetts General Hospital, Harvard Medical School, said postoperative care and rehabilitation “is really about quality of life.” Dr. Chang added that “culturally competent care begins with culturally competent science. To truly address disparity problems, not only do we need to continue our efforts and recruitment of minorities in the making of science, but also promote participation of minorities in the setting of agendas to help break the glass ceilings.”

Creating a national research agenda

To generate a research agenda, symposium attendees participated in a thematic ranking exercise. Following each of these thematic presentations on the first day of the conference, attendees were asked to submit three
to five free-response research questions or recommendations of interest for each theme. These recommendations were then collected, sorted by theme, and collated by a group led by Allysha Robinson, PhD; Maya Torain; and Cheryl Zogg, MS, qualitative researchers at the CSPH. More than 400 research questions and ideas were generated through this exercise. The collated and thematically sorted materials were then used by breakout groups on day two of the conference to determine the most important research questions for each theme. (Details are provided later in this article under the subhead “Moving forward.”)

**From disparities to parity**

ACS Immediate Past-President Carlos A. Pellegrini, MD, FACS, FRCSI(Hon), The Henry Harkins Professor and Chair, department of surgery, University of Washington, Seattle, kicked off the second day of the symposium with a keynote address, From Success to Significance: A Call for Leadership. “Eliminating health care disparities requires acknowledging and recognizing all people equally and recognizing social injustices, many of which are still present today,” he said.

Using treatment for end-stage renal disease as an example of unequal care, Dr. Pellegrini noted that this condition disproportionately affects blacks and Latinos, yet these patients are generally underrepresented on wait lists for kidney transplants.

According to Dr. Pellegrini, racism is at the core of health care disparities. “I say racism plays a major role. I believe it is alive and well, and unless we understand it, and we change it, we cannot eliminate disparities,” he said.

Dr. Pellegrini defined racism as a system of structuring and assigning value based on the social interpretation of appearances. “I think of racism as including all forms of human differences,” he said, because all of these differences—race, religion, ethnicity, and so on—are used to place some people at a disadvantage, while placing others at an unfair advantage.

Multiple forms of bias affect health care disparities, Dr. Pellegrini said. Institutional racism results in patients having less access to health care facilities and other resources. Personally mediated biases include consciously held beliefs about a group based on gender, race, or other characteristics. Internalized bias occurs when people accept the negative perceptions about their own abilities and intrinsic worth, which results in self-devaluation. “You see it when, for example, a Hispanic patient asks to be treated by a white physician,” Dr. Pellegrini said.

“We are all biased,” Dr. Pellegrini said. “We bring our prejudices every single time into every single interaction, and if you’re conscious of that, and you accept the fact that you are imperfect, then you can try and correct your actions and mitigate [them].”

For a capitalistic society to truly embrace diversity, it is time to stop emphasizing equality as a moral imperative—“something we do because we’re good people”—and start to sell it as marketable product—“as part of the value-driven proposition,” he said. The new strategy focuses on inclusion—the act of recognizing, embracing, and maximizing diversity. “Without diversity, we can’t have excellence. Diversity brings new ways of thinking, different ways of thinking, and diversity brings innovation.”

Dr. Pellegrini concluded that cultural change is needed to move from disparities to parity. “Going from to success to significance will require moving from knowing to doing.”
Military health system

Jonathan Woodson, MD, FACS, Assistant Secretary of Defense for Health Affairs, gave a special keynote address on the military health system (MHS), describing the resources and experience that the MHS brings to efforts to improve diversity in health care.

“I believe the military health system is in a particularly good position to be a collaborator because of whom we take care of and what we have at our disposal,” Dr. Woodson said. “We can help to define and answer some of the questions because we level the playing field on a number of issues.”

The MHS comprises 54 hospitals and more than 600 medical and dental clinics. The MHS educates health care professionals at approximately 217 graduate medical education programs and runs a robust research and development program, Dr. Woodson noted. The system provides health insurance to approximately 9.5 million Americans.

The military’s demographics reflect a microcosm of America and has largely succeeded in ensuring equal access for all patients. “In the military, it doesn’t matter if you’re black, white, or Hispanic, you are going to get the same health care as everyone else,” he noted.

“We consider ourselves an undiscovered laboratory for health services research,” Dr. Woodson added. “We’ve got amazing repositories of data and are working with the Brigham and Women’s Hospital to refine those databases so we can ask difficult questions and find solutions and answers.”

In addition, the MHS has a memorandum of understanding with the NIH across a number of programs. Furthermore, the MHS has been strengthening its ties with the ACS. MHS hospitals participate in the ACS National Surgical Quality Improvement Program, and last October, the MHS signed a collaborative agreement with the ACS that will benefit both parties in the areas of education, systems-based practices, and research.

Other stakeholders and potential partners

Representatives from other federal agencies described the role these entities play in addressing health care disparities.

J. Nadine Gracia, MD, Deputy Assistant Secretary for Minority Health and Director, Office of Minority Health, HHS, said her team is charged with raising awareness about minority health and is forming partnerships and networks with community-based organizations, faith-based organizations, and other groups to address health care disparities. The agency also funds research into factors that contribute to health care disparities and is “interested in promoting cultural competence, including the development and promotion of national standards,” she said.

Uchenna S. Uchendu, MD, Executive Director, Veterans Health Administration (VHA), Office of Health Equity, said that approximately 22 million veterans live in the U.S., and that number is expected to grow as troops continue to return home from the wars in the Middle East. Many of these individuals will transition back into the civilian workforce and, consequently, may receive health care coverage through the private sector. Hence, the VHA is interested in partnerships that will ensure that community-based providers understand veterans’ unique needs and challenges.

Darryl Gray, MD, Medical Officer, Center for Quality Improvement and Patient Safety, Agency for Healthcare Research and Quality (AHRQ), said the agency has a considerable grant portfolio that may be expanded to support partnerships in this area. AHRQ has published reports on health care disparities and inequities and has developed a disparities analytic file.

Jonca Bull, MD, an ophthalmologist and Director of the Office of Minority Health, Food and Drug Administration (FDA), highlighted a recent congressional mandate that the agency examine demographic subgroups and develop an action plan to ensure all populations have better access to medication and

“Eliminating health care disparities requires acknowledging and recognizing all people equally and recognizing social injustices, many of which are still present today.”

—Dr. Pellegrini
technologically advanced procedures. In August 2014, the FDA issued an action plan that has three priority areas: (1) improve data collection and coding of data, (2) advance clinical trials, and (3) improve transparency.

Moving forward
Rounding out the program, the participants broke into small groups to discuss areas for future research and collaboration based on the questions and comments raised in the previous day’s overview of the meeting’s five core themes.

Ali Salim, MD, FACS, chief, division of trauma, burns, and surgical critical care, Brigham and Women’s Hospital, and professor of surgery, Harvard Medical School, stated that improving health literacy was the major concern of the group that discussed patient factors. The group called for better engagement with primary care professionals and improved patient education.

ACS Regent Henri Ford, MD, MHA, FACS, vice-president and chief of surgery, Children’s Hospital Los Angeles; and professor and vice-chair for clinical affairs, department of surgery, Keck School of Medicine, University of Southern California, said the group that looked at provider factors called for improving cultural dexterity, improving patient-provider communication, and addressing implicit biases through mindfulness and empathy.

Steven Stain, MD, FACS, a member of the ACS Board of Governors Executive Committee, and the Henry and Sally Schaffer Chair, department of surgery, Albany Medical Center, NY, said the group focused on systemic factors identified the following areas for research: (1) the effect of payment strategies in the context of policy reform; (2) care coordination, integration, and tailored guidelines; and (3) regionalization of care.

Shadid Shafi, MD, MPH, FACS, clinical scholar, Baylor Scott & White Health System, and director, Research Institute at John Peter Smith Hospital and Health System, Baylor University, Houston, TX, led the panel on clinical care and quality, which emphasized leveraging the electronic health record to improve adoption of evidence-based care.

ACS Regent Beth H. Sutton, MD, FACS, a general surgeon in private practice, Wichita Falls, TX, and clinical professor of surgery, University of Texas Southwestern Medical School, Dallas, led the postoperative care and rehabilitation group, which identified the need to leverage existing databases, long-term strategies for communication with patients, and how postoperative care affects patient perceptions of satisfaction and quality of life.

Each of the five group leaders also presented the top research questions and topics for their theme. These are now being written up for peer-reviewed publication and approval by the various federal and institutional participants.

Overall, the symposium set the stage for the ACS, NIH, and other partners to work together to ensure that surgical patients have better access to care, regardless of race, gender, ethnicity, geographic location, and other characteristics.

“I’ve heard nothing but positive feedback from the speakers, attendees, and colleagues at the ACS and the NIH,” Dr. Haider said at the conclusion of the symposium. “We have accomplished our goal of creating a national research agenda, and I anticipate that it will be widely adopted by researchers and funders alike as we continue to produce research that moves us closer to eliminating disparities.”

Dr. Britt added, “I can’t say it enough—I think this is historic. I think we can advance the science and move the needle a little bit more.” Dr. Dankwa-Mullan agreed, noting, “There is enormous, tremendous work to be done. We look forward to working together and collaborating on this effort.”

Note
To view a video featuring key participants at the symposium, go to www.facs.org.

“...I believe the military health system is in a particularly good position to be a collaborator because of whom we take care of and what we have at our disposal.”

—Dr. Woodson
The importance of detailed documentation in ICD-10

The 10th revision of the International Classification of Diseases (ICD-10) takes effect October 1. The good news is that surgeons still have some time to make changes in their documentation practices to prepare for the transition to ICD-10. Following are some guidelines for ensuring a smooth transition.

Transitioning
Transitioning from ICD-9 to ICD-10 will affect the way many surgeons practice. Most of the information coders will use will come from accurate and thorough documentation in the medical record. The biggest difference between ICD-10 and ICD-9 is the addition of numerous codes. There are 68,000 codes in ICD-10 versus 13,000 in ICD-9. In addition, the inpatient procedure code set (PCS) will evolve, bringing the entire set of new codes to 141,000.

Clinical documentation implementation
Clinical documentation implementation (CDI) programs can be beneficial in this transition. CDI programs may comprise coding and/or nursing specialists assisting physicians on documentation in order to allow for timely and accurate coding. The success of CDI programs relies on a cooperative effort between physicians, health information management, coders, and clinical documentation specialists. Documentation queries may be helpful in clarifying diagnosis codes. Surgeons will need to respond quickly and accurately to documentation queries to aid in the transition. In addition, they must become familiar with the increased granularity of these coding sets. For example, documentation should indicate whether one lymph node or an entire chain of lymph nodes was removed; or the documentation should describe whether a patient’s anemia is chronic or acute blood loss anemia.

Importance of documentation
The increasing complexity of medicine has been met with a corresponding increase in complexity of medical documentation. The purpose of developing the ICD-10 coding set...
Documentation in the patient’s record will be integral to accurate coding with the new system. As surgeons, we must ensure that our documentation covers laterality, severity of disease, time of onset, and so on to provide the necessary details for accurate coding within the ICD-10 code set.

was to reflect these intricacies. New devices and advanced procedures are now included and can be accurately coded in the health record. The transition aids in data collection to accurately reflect the condition that is being treated, as well as the outcomes for that treatment. For example, similar injuries on opposite limbs cannot be accounted for in ICD-9. With ICD-10, different injuries or different severities of medical conditions now can be coded.

Thorough, detailed documentation leads to accurate coding, and accurate coding leads to appropriate and timely claims payments for hospitals and physicians. Most importantly, accurate documentation can lead to better, more effective patient care. It can provide more detailed information to other health care providers performing subsequent care or services on patients.

Documentation in the patient’s record will be integral to accurate coding with the new system. As surgeons, we must ensure that our documentation covers laterality, severity of disease, time of onset, and so on to provide the necessary details for accurate coding within the ICD-10 code set.

Quality and safety measures
Many of our quality and safety measures are risk-stratified. Thorough documentation with the appropriate coding of the problem list will accurately reflect the overall state of the patient. The quality and safety measures affect payments directed to hospitals. As requirements for surgeon-specific data increase, clear documentation with ICD-10 could affect potential future pay-for-performance programs. If certain conditions were present on admission or certain co-morbid conditions exist and are not documented, it could affect the observed-to-expected death ratio for morbidity and mortality. If a surgeon under-codes a case, then the observed ratio may fall below the expected average of his or her colleagues.

If your practice has not yet started the transition, now is the time to get ready for ICD-10. As surgeons, we must enhance our clinical documentation to reflect the more detailed changes with ICD-10. For more information, visit the ACS ICD-10 resource website at www.facs.org/advocacy/practmanagement/icd10.
Resources for optimal patient care: EBDS and patient education programs

by Sapna Dalal, MHSA; Lewis Flint, MD, FACS; and Kathleen Heneghan, MSN, RN, CPN

In our continuing effort to provide information about all the benefits of membership in the American College of Surgeons (ACS), this month’s column spotlights two resources that may contribute to your daily practice and the delivery of optimal patient care: Evidence-Based Decisions in Surgery (EBDS) and the College’s patient education programs.

EBDS

Since its inception more than 100 years ago, the ACS has been dedicated to helping surgeons obtain the knowledge needed to provide the highest quality care to their patients. High-quality surgical practice is both a science and an art. The art emerges through dedication to ethical practice, empathy and respect for the patient and his or her preferences, and the delivery of compassionate care. The science of surgery requires a lifelong commitment to learning.

An increasing emphasis is being placed on the use of evidence-based practices in the delivery of health care. Clinical practice guidelines offer high-quality evidence that surgeons can apply in daily practice. Guidelines often are developed by government agencies, professional medical organizations, and research groups to facilitate the implementation of evidence-based practice by individual practitioners, practice groups, and health care institutions. The ACS, for example, has developed practice guidelines for use in surgical practice—the EBDS program.

What are clinical practice guidelines?

The core objective of evidence-based practice is to standardize the application of scientific knowledge at the point of care. Standardization is a process that is intended to decrease the inappropriate variation that negatively affects quality, safety, and cost-effective surgical care; decreasing this variation should be synergistic with promoting, not stifling, innovation. One important function of clinical practice guidelines is to add ease to the process of reducing variation in practice.

Clinical practice guidelines are developed by government agencies, such as the U.S. Preventive Services Task Force and the National Institute for Health Care and Excellence, UK. Most practice guidelines are developed by professional medical organizations, including the American Heart Association, the National Comprehensive Cancer Network, the Society of American Gastrointestinal and Endoscopic Surgeons, the Society for Surgery of the Alimentary Tract, and the Eastern Association for the Surgery of Trauma. Independent research groups, including the Surviving Sepsis Campaign, also produce practice guidelines.

Producing clinical practice guidelines begins with identification of the clinical problem(s) to be addressed, followed by assembling the evidence. In this stage, the focus is on available prospective randomized trials, meta-analyses of multiple trials, and strong observational studies. When the evidence available in the literature is insufficient, expert opinion is gathered from the proceedings of meetings designed to gather, evaluate, and publish expert opinion. The evidence is then graded using...
systems such as those developed through the U.S. Preventive Services Task Force, the Centre for Evidence-Based Medicine (University of Oxford), and the American College of Physicians Grades of Recommendation, Assessment, Development and Evaluation (GRADE) system.

After the evidence is assembled and graded, a list of recommendations is produced. Accompanying each recommendation is a statement on the grade of evidence that supports the recommendation and a statement regarding the strength of the suggestion; the latter statement is formed from the judgments of the clinical importance of the recommendation made by the guidelines production group assembled by the sponsoring organization.

When the list of recommendations is complete, they are supplemented by a review of the supporting evidence from the medical literature, along with an extensive bibliography, is published. Guidelines may be published in a peer-reviewed journal, housed on an organization’s website, or both. Usually, the full guidelines are available at no charge from the sponsoring organization’s website.

Despite the care and effort invested in producing guidelines, there are sometimes problems with the evidence used, including a shortage of acceptable randomized controlled trials, especially for surgical conditions. Available randomized trials test hypotheses in carefully selected groups of patients, which raise the possibility that selection bias may reduce the generalizability of the findings. The outcomes observed in prospective randomized trials demonstrate the ability to achieve a result (efficacy). In daily surgical practice, it would be preferable to be confident that the desired outcome would be produced repeatedly in different patients (effectiveness).

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Although guidelines supported by evidence from high-quality observational studies (cohort or case control designs) may be as useful as guidelines supported by randomized trials, these studies are scarce. That said, results of prospective cohort studies involving large numbers of patients from multiple institutions may offer insight into outcomes that can be expected in “real world” experience. The final problem worth mentioning in this context is that research studies performed to validate the effectiveness of guidelines are published infrequently.

50 percent of patient care encounters, for myriad reasons. For example, there may be significant variation in the clinical picture an individual patient presents. Application of the guideline may be futile or inappropriate because the patient’s problem varies significantly from the problem described in the guidelines. Implementation of guidelines may be hindered by lack of agreement (buy-in) among all members of the surgical staff. Of equal importance is failure of the health care institutions to provide resources to ensure adequate compliance with the guidelines and that the data are gathered to confirm the guidelines are having the desired result. A barrier particularly pertinent for surgeons is the simple fact that guideline documents are lengthy (sometimes exceeding 250 pages) and the portions that are pertinent to surgical practice may be difficult to locate.

EBDS: A first step
The EBDS provides sets of recommendations based on existing practice guidelines supplemented with input from experts in the area of practice addressed by the module. The modules are developed at the ACS and are peer-reviewed by six to 10 members of the ACS Board of Governors and the
ACS Advisory Councils. Each module summarizes guideline recommendations pertinent to surgical practice along with the grade of evidence supporting the recommendation. Advice is provided relevant to the resources needed to implement the guideline in practice; a listing of the types of data needed to document guideline compliance and effectiveness also is provided. Patient education links and lists of supplementary recommendations from module reviewers are presented.

The modules conclude with a list of references that may help the user better understand the guideline and the problem addressed in the module.

The modules are available on the ACS website on the Division of Education page, located at www.facs.org/education/resources/ebds-guidelines. The modules can be opened by signing in with an ACS ID. The EBDS can also be accessed at ebds.facs.org.

After signing in, the user can select a topic. The user is then taken to the opening page for the topic. The next page contains a review of the guideline recommendations and describes the supporting evidence. Illustrative examples are shown. Some modules include a clinical decision pathway. (See sample screens in Figure 1, this page.)

The modules are housed in a mobile-optimized website. The modules are designed to assist with and improve communication between the surgeon and other health care professionals. Modules also have been useful in facilitating conversations with patients and patients’ families.
With more than 50,000 kits distributed, patients have rated this [Surgical Home Skills Prep Program] service, developed in collaboration with multiple associations, as more helpful than any other resource in preparing them for discharge to home.

Finally, the information may be used to support clinical decisions. Currently, 39 modules that have been chosen because of their relevance to the diagnoses related to the 20 most common operations general surgeons perform. The modules are revised based on annual reviews and are updated whenever guideline revisions or modifications are published.

The EBDS is a resource of great potential value in surgical practice. Our objective is to make evidence-based practice easier for surgeons by providing accessible and easy-to-use guidance that can be employed at the point of care.

**Patient Education Program**

The ACS Surgical Patient Education Program encompasses a range of patient education interventions and resources. These programs are aimed at improving the quality of patient care and promoting patient safety through educational efforts that recognize patients as integral members of the surgical team. The goals of the program support excellence in surgical care and address a range of national mandates, including reduction in complications, prevention of readmissions, improved satisfaction scores, and decreased health care costs.

The surgical prep home skills program provides the surgical team with simulation-based patient training designed to preoperatively teach patients and families the necessary skills for at-home care and to recognize complications. With fast-track options and early discharge, more patients recover at home, making a surgical home prep program an essential component of their care. Each kit contains an instructional booklet, DVD with step-by-step instructions, equipment and a practice model, a checklist to guide and validate skill acquisition, website references, and a self-evaluation.

With more than 50,000 kits distributed, patients have rated this service—developed in collaboration with multiple associations—as more helpful than any other resource in
preparing them for discharge to home. The use of the kit resulted in higher patient confidence scores (which was associated with fewer complications), increased satisfaction, and fewer readmissions. Adult ostomy (Spanish and English-language versions), pediatric ostomy, feeding tubes, and central line kits are available at www.facs.org/education/patient-education/skills-programs. A wound and drain skills program, as well as a tracheostomy program, are currently in development.

The Informed Surgical Prep brochure and e-learning materials prepare patients for their operation. The electronic materials also can be used to address meaningful use criteria. In addition to medications and surgery, the new Quit Smoking before Surgery brochure graphically illustrates the potential surgical complications of smokers versus nonsmokers in the areas of cardiovascular and wound health, as well as cancer recurrence. Preoperative smoking cessation counseling is a reimbursable item, and the brochure with the Quit Smoking Action Plan helps surgeons meet that coding requirement. A 1.0 continuing medical education program on the codes and implementation also is available. The eight-page color procedure brochures meet the ACS guidelines for informed consent and current Joint Commission patient safety requirements. Procedure options with images, discharge instructions, procedure-specific risks, and potential complications using the risk calculator are included. They are available free on the ACS website at www.facs.org/patienteducation, with a print and electronic purchase option. New to the series are colectomy and colonoscopy, along with six different prep options.

Other services
The Surgical Cancer Series continues to offer the Lung Cancer Program developed in collaboration with the American Association for Thoracic Surgery, Society of Thoracic Surgeons, Association of PeriOperative Registered Nurses, and Commission on Cancer. The program covers the entire perioperative period, including preoperative exercise and smoking-cessation plans, tests and cancer staging with images, hospital safety and guidance for active recovery, discharge instructions, and a survivorship plan. The DVD and 20-page booklet are available on the ACS website at www.facs.org/education/patient-education/skills-programs/lung.

The ACS Patients as Partners website can be accessed at www.facs.org/patienteducation. Materials can be viewed at no charge with minimal fees for print and digital access. A new option is a digital access version of ACS patient education brochures and videos, with the ability to efficiently deliver and send evaluations to patients. The materials can be printed in the office, viewed on the surgeon’s practice website from a mobile device, or sent via e-mail or to the patient’s portal. New government, cancer, medication, and lab resources are also available as part of this package.

The ACS has teamed up with Dialog Medical iMedConsent to offer more than 2,000 informed consent documents, featuring pre- and postoperative instructions. Documents can be individualized and are compatible with all electronic medical records and are located at www.facs.org/education/patient-education/medical-professionals/informed-consent.

Contact Sapna Dalal, MHSA, at sdalal@facs.org or Lewis Flint, MD, FACS, at lflint@facs.org with any questions, comments, or recommendations regarding the EBDS program, and Kathleen Heneghan, MSN, RN, CPN, at kheneghan@facs.org with any questions about the Patient Education Program.
PACES trial: Evaluating the effectiveness of efornithine and sulindac in preventing colon adenomas

by Jason Zell, MD; Y. Nancy You, MD, MHSc, FACS; and Judy C. Boughey, MD, FACS

There are more than 1 million survivors of colorectal cancer in the U.S. today, and the number continues to grow. After completing treatment for colorectal cancer and being deemed cancer-free, these patients remain at higher risk of developing precancerous polyps or a second colorectal cancer than the general population. Prevention is preferable to treatment, but it relies on identification of an appropriate patient population. For colorectal cancer, patients who have survived their index tumor are easily identified and are motivated to participate in studies aimed at the prevention of further disease.

Polyamines are naturally occurring substances that, in excess, promote carcinogenesis within colorectal tissues. When used together, efornithine and sulindac lower colorectal tissue polyamine levels and have shown early promise in preventing carcinogenesis in mouse models and in humans. Importantly, these oral agents effectively prevent colorectal carcinogenesis when given at very low dosages, resulting in minimal toxicity.

Puting drugs through the paces
The S0820 Preventing Adenomas of the Colon with Efornithine and Sulindac (PACES) study seeks to determine whether two drugs that have shown early promise can significantly lower the risk of secondary colorectal polyp or cancer for these survivors. PACES study researchers are enrolling approximately 1,500 patients who have recently completed surgery (with or without radiation, chemotherapy) for Stage 0—III colorectal cancer. Approximately one year after resection (six–15 months), patients will be randomized to either efornithine 500mg/day alone, sulindac 150mg/day alone, efornithine 500mg/day of efornithine with 150mg/day of sulindac, or...
two placebos daily for three years. They will then have a colonoscopy (for example, at study-year three, which corresponds to postoperative year four). Audiograms are done pre- and post-intervention, and the audiology eligibility criteria used in S0820/PACES are more stringent than those used in the previous phase III trial of adenoma patients. Investigators are looking to learn whether either drug or the combination reduces the rate of high-risk adenomas or second primary colorectal cancers in these cancer survivors. Patients will then have annual check-ups for five years off drug intervention and undergo follow-up colonoscopy eight years after enrolling.

A previous phase III clinical trial in 2008 showed that 267 patients who had had adenomas removed from their colon and then took daily eflornithine and sulindac at these dosages for three years lowered their risk of developing another adenoma by 70 percent compared with those who did not take the drugs.* More importantly, the adenomas that were most likely to be prevented were the ones that are most likely to become colon cancer—that is, high-risk adenomas. Patients in this trial showed a 90 percent decreased chance of developing a high-risk adenoma. In that study, no significant differences were detected in gastrointestinal, cardiovascular, or other toxicity, including hearing loss, which has been associated with high doses of eflornithine. Subsequent longitudinal analyses, however, did reveal an 8 percent audiometric threshold deficit attributed to eflornithine after three years on-study (sub-clinical hearing loss). Otherwise, the agents were extremely well-tolerated.

Whereas this combination had substantial preventive effects in patients who had been treated for colorectal adenomas, PACES will address whether those observed benefits also extend to colon cancer survivors.

**Testing eflornithine and sulindac**

The two drugs being tested are not new, but neither has been approved by the U.S. Food and Drug Administration specifically for colorectal cancer prevention. Eflornithine (also known as difluoromethylornithine, or DFMO) has been used intravenously to treat trypanosomiasis, sometimes called “sleeping sickness,” and in a skin cream to reduce unwanted hair growth. Sulindac is a non-steroidal anti-inflammatory drug used to treat arthritis pain. It has been shown to reduce the number of colon polyps in patients with familial adenomatous polyposis, an inherited condition that leads to the development of hundreds, or even thousands, of such polyps. More than 500 U.S. health care institutions are participating in the study. Interested physicians can find the nearest participating institution online at SWOG.org, at CTSU.org, or by contacting SWOG (formerly the Southwest Oncology Group,) at 210-614-8808 or protocols@swog.org. The trial is funded by the National Cancer Institute, Division of Cancer Prevention.

We can do more to prevent cancers by targeting the groups at greater risk. Colorectal cancer survivors in particular stand to benefit from further risk reduction strategies. ♦

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Throughout my career, I have found the topic of surgeon fatigue and sleep deprivation to be intriguing and important. Unfortunately, the opinions of experts on this topic tend to gravitate from one extreme to the other. For example, a study in The Joint Commission Journal on Quality and Patient Safety found evidence to support the view that extended work shifts significantly increase fatigue and impair performance and safety,* whereas other research reported in the surgical literature finds that fatigue has a minimal effect on the development of patient complications. I believe a balanced and reasonable approach is needed in addressing this issue.

**Contributing factors**

Many factors can contribute to surgeon fatigue, including insufficient staffing, excessive workloads, extended workdays, and cumulative days of heavy work hours. Fatigue can be dangerous, causing lapses in attention or inability to stay focused, reduced motivation, compromised problem-solving skills, confusion, irritability, memory lapses, impaired communication, slowed or faulty information processing and judgment, diminished reaction time, and indifference and loss of empathy. All of these factors can affect the surgical team, directly or indirectly, resulting in potentially serious or even deadly consequences.

**Fatigue in a culture of safety**

Addressing fatigue requires leadership support and a culture of safety. Such a culture embraces the concept of reporting and addressing any factor that compromises safety. When an institution’s leadership supports a culture of safety, staff members know that their concerns will be heard and taken seriously. To aid in developing such a culture, The Joint Commission’s Sentinel Event Alert #48 from December 2011 outlines actions for leadership to consider, including the following:†

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Addressing fatigue requires leadership support and a culture of safety. Such a culture embraces the concept of reporting and addressing any factor that compromises safety.

- Assess the organization for fatigue-related risks
- Assess the organization’s hand-off processes and procedures, given that hand-offs occur at a time when staff are more likely to be fatigued
- Provide opportunities for staff to establish schedules that minimize the risk of fatigue
- Create and implement a fatigue management plan that incorporates scientific strategies for mitigation of fatigue
- Educate staff on sleep hygiene and recognition of fatigue
- Provide opportunities for staff to express concerns about fatigue
- Encourage teamwork as a strategy to support staff who work extended shifts
- Consider fatigue as a potential contributing factor when reviewing all adverse events

**Educating surgeons**

In addition to establishing a culture of safety, it is critical to provide proper training to identify the effects of fatigue on patient safety. If surgeons are trained to understand how fatigue manifests and affects their mental and physical capabilities, they can use this knowledge to determine whether to take a break or nap, postpone an operation, or carry it out with extra help. Disclosure of fatigue to a patient and obtaining consent to proceed is not an option; it is morally untenable to ask a patient permission to proceed if and when the surgeon believes that doing so could harm the individual.

The American College of Surgeons and The Joint Commission have independently devoted substantial resources to ensuring that surgeons perform operations as safely as possible. Both organizations have developed statements on fatigue and have offered strategies for recognizing and managing its effects. These recommendations include suggestions on appropriate ways to monitor fatigue as well as strategies to overcome problems that may arise from rescheduling a procedure.

Health care organizations should invite staff to offer input on designing work schedules and creating and implementing a fatigue management plan that includes strategies that are aligned with the needs of the institution and the patient population it serves.

Although these strategies will differ from institution to institution depending on location, population demographics, size, geography, availability of other surgeons in the area, and other factors, surgeons and other health care professionals should work with the leadership of the hospital to develop suitable strategies to prevent surgeon fatigue and sleep deprivation. As surgeons, we owe it to our patients.

For more information, please visit [www.jointcommission.org/assets/1/18/sea_48.pdf](http://www.jointcommission.org/assets/1/18/sea_48.pdf). If you have comments or suggestions about this or other topics, please send them to cpellegrini@facs.org.

**Disclaimer**
The thoughts and opinions expressed in this column are solely those of Dr. Pellegrini and do not necessarily represent the official views of The Joint Commission or the American College of Surgeons.

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A hot mess: Clothing-related burn injuries

by Richard J. Fantus, MD, FACS, and Edmundo A. Rivera, MD

Burns, by definition, are traumatic injuries. Burn patients must be assessed initially with a primary survey. In addition to thorough evaluation of the airway, breathing, and circulation, the evaluation must include removal of clothing to allow a direct view of the entirety of the patient. Such exposure is necessary not only to estimate burn size, but also to allow the disrobed items to be assessed and accounted for in determining the pathology and severity of thermal injury.

In the 1940s, an epidemic of pediatric burns was associated with cowboy outfits modeled after the attire worn by the popular entertainer, entrepreneur, and World War II aviator Gene Autry, also known as “The Singing Cowboy.” Between 1945 and 1953, at least 100 lawsuits were filed against those individuals involved in the manufacture and sale of these suits. In 1953, The Flammable Fabrics Act was passed to regulate the manufacture and sale of highly flammable clothing and apparel. The act was amended in 1967 to include the fabric used to produce interior furnishings such as drapes, bedding, and floor coverings.

Factors that affect flammability
Clothing-related burn injuries involve three main factors: the fabric, wearer behavior, and the heat source. Ease of ignition, flammability, and potential for thermal injury obviously depend on the fiber type. Cotton and rayon generally possess the fastest burning characteristics. Rayon is classified as a semi-synthetic fiber, as it is derived from wood pulp. Synthetic fibers vary in their burning properties, but the misconception that synthetics are more flammable than natural fibers is false. In fact, cotton/polyester blends are more flammable than pure polyester fabrics. Garments made of animal hair, pure silk, and wool pose the least danger.

In addition to the type of fabric, certain fabric characteristics affect flammability. For example, a napped surface composed of loose fibers creates air space between the fibers, which makes them ignite more readily. Conversely, denser fabrics burn more slowly.

Garment design also may affect the likelihood of ignition. When an article of clothing swings away from the body, as in the case of blouses or pajamas, more air circulates around the clothing, portending a higher rate of flammability.*

Burn casualties
Are the mechanisms for preventing clothing-related civilian burn casualties adequate? After reviewing data from the National Center for Health Statistics, the Centers for Disease Control and Prevention, and injury surveillance databases, Hoebel and colleagues discovered that more than 4,300 serious clothing-related burn injuries occurred annually in the U.S. between 1997 and 2006.† Nearly all injuries documented involved apparel that complied with the regulations set in The Flammable Fabrics Act.† In addition to implementing more stringent flammability regulations, there appears to be an opportunity to target high-risk groups and behaviors.

To examine the occurrence of clothing-related burn injuries in the National Trauma Data Bank® (NTDB®) research dataset for 2013, medical admissions records were searched using the International Classification of Diseases, Ninth Revision, Clinical Modification diagnoses codes. Specifically searched were records that contained one of

the following external cause of injury codes (E-code): E893 (injury caused by ignition of clothing), E893.0 (injury caused by ignition of clothing from controlled fire in private dwelling), E893.1 (injury caused by ignition of clothing from controlled fire in other building or structure), E893.2 (injury caused by ignition of clothing from controlled fire not in building or structure), E893.8 (injury caused by ignition of clothing from other specified sources), or E893.9 (injury caused by ignition of clothing from unspecified source). A total of 2,970 records were found, 2,320 of which contained a discharge status, including 1,573 patients discharged to home, 283 to acute care/rehab, and 239 sent to skilled nursing facilities; 225 died (see figure, this page). Approximately 68.1 percent of the patients were male, on average 45.4 years of age, had an average hospital length of stay of 13.9 days, an intensive care unit length of stay of 17.2 days, an average injury severity score of 6.4, and were on the ventilator for an average of 10.2 days. Of those tested for alcohol (984), one-third (33.7 percent) were positive.

**Avoid being a “hot mess”**
Several flame-resistant fabrics are used in various industries, including offshore drilling, petrochemical, pharmaceutical, racing, and aviation. An example is the Nomex brand fiber from DuPont. Clothing made of this material will not win any fashion contests, but wouldn’t you rather be called a hot mess because of the appearance of your clothing than because of the burn injury it may cause?

Throughout the year, we will be highlighting these data through brief reports that will be published monthly in the *Bulletin*. The NTDB Annual Report 2014 is available on the ACS website as a PDF file at [www.facs.org/quality-programs/trauma/ntdb](http://www.facs.org/quality-programs/trauma/ntdb). In addition, information about how to obtain NTDB data for more detailed study is posted on the website. If you are interested in submitting your trauma center’s data, contact Melanie L. Neal, Manager, NTDB, at mneal@facs.org.

**Acknowledgement**
Statistical support for this article has been provided by Chryystal Caden-Price, Data Analyst, NTDB.
Joseph P. Vacanti, MD, FACS, received the 2015 Jacobson Innovation Award of the American College of Surgeons (ACS) at a dinner on June 5 at the John B. Murphy Memorial Auditorium in Chicago, IL. Dr. Vacanti is the John Homans Professor of Surgery at Harvard Medical School and is the director of the Laboratory for Tissue Engineering and Organ Fabrication, co-director of the Center for Regenerative Medicine, and chief of pediatric transplantation at Massachusetts General Hospital, Boston.

The prestigious Jacobson Innovation Award honors living surgeons who have been innovators of a new development or technique in any field of surgery and is made possible through a gift from Julius H. Jacobson II, MD, FACS, and his wife, Joan. Dr. Jacobson is a general vascular surgeon known for his pioneering work in microsurgery.

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Honored for tissue engineering

This year’s Jacobson Innovation Award honors Dr. Vacanti for his work in the field of tissue engineering, which began in the early 1980s and stemmed from a long-held interest in addressing organ shortages. Working with Robert Langer, ScD, the David H. Koch Institute Professor at the Massachusetts Institute of Technology, Cambridge, Dr. Vacanti developed an approach using tissue-specific cells placed in scaffolds made of biodegradable polymers. The cells, derived from both living tissue or stem cells, are then bathed in growth factors and proceed to multiply, filling the scaffold. The cells then grow into three-dimensional tissue that, once implanted in the body, recreates its proper tissue function. Blood vessels grow into the new tissue, the scaffold degrades, and the lab-grown tissue becomes indistinguishable from its surroundings.

Dr. Vacanti also has been an innovator in pediatric surgery. In 1984, while at Children’s Hospital Boston, Dr. Vacanti instituted New England’s first successful pediatric extracorporeal membrane oxygenation program. In addition, he started the nation’s first liver transplantation program specifically for the pediatric population.

Dr. Vacanti was a founding co-president of the Tissue Engineering Society, now the Tissue Engineering Regenerative Medicine International Society (TERMIS) and which boasts 5,000 active members from 80 countries worldwide. He was also the founding senior editor of the journal Tissue Engineering, which serves the members of TERMIS. The journal can be found in 1,700 libraries in 20 countries and is provided free online to 106 developing countries.
My grandfather could barely speak English but fought in the trenches in France in World War I and gained his American citizenship. He then worked in the boiler shops of the Union Pacific Railroad and taught me the value of hard work, but also the value of using my mind to obtain an education. My father was a professor of oral surgery and endodontics at Creighton University’s dental school, and my mother was a premedical student before marrying my father after World War II. It was that influence that led me to want to become a surgeon at the young age of four.”

Dr. Vacanti also paid tribute to the mentors who encouraged his growth as a surgeon as well as those individuals who have inspired and supported him throughout his career. “My surgical heroes and mentors are Dr. William Hardy Hendren III [MD, FACS, FRCSI(Hon), FRCSEng(Hon), FRCSGlas(Hon)] and Dr. Judah Folkman [MD, FACS], both previous Jacobson Award recipients. Both taught me about surgical innovation and how to think about a problem and its definitive solution,” he said. “Dr. Folkman advised me that if I was going to devote my
The American College of Surgeons (ACS) Evidence-Based Decisions in Surgery (EBDS) program, developed and administered by the ACS Division of Education, recently released four new modules (see related story, page 65). These point-of-care modules address diagnoses and conditions most relevant to general surgeons and are derived from currently available evidence, practice guidelines, and consensus recommendations from experienced surgeons. The EBDS modules are available online via smartphones, tablets, and computers and can be used for decision support, patient-focused interactions with other health care professionals, and patient education.

The topics covered in the four new modules include:

- Enhanced Recovery after Elective Abdominal Surgery
- Surgical Management of Complicated Gastro-duodenal Ulcer Disease
- Management of Geriatric Trauma
- Lobular Carcinoma In Situ and Atypical Hyperplastic Breast Lesions

Visit ebds.facs.org to access these modules using your ACS login information. For more information, e-mail ebds@facs.org or call 312-202-5568. ♦
The American College of Surgeons (ACS), in partnership with the John A. Hartford Foundation, announced a four-year initiative aimed at improving health care for older surgical patients through a standards and verification program for hospitals. The initiative, issued June 11, features leaders who are pioneers in the field of geriatric surgery and long-time Hartford grantees, Clifford Y. Ko, MD, MS, MSHS, FACS, Director of the ACS Division of Research and Optimal Patient Care, and Ronnie Rosenthal, MD, FACS, Chair of the ACS Geriatric Surgery Task Force and chief of surgery at the Veterans Affairs Connecticut Healthcare System. The Hartford Foundation awarded a $2.9 million grant for the program.

**Growing need for geriatric care**
The U.S. geriatric population continues to grow. The Census Bureau reports that more people were 65 years and older in 2010 than in any previous census. Moreover, the largest percentage point increase for the “oldest-old population” (defined as age 85 and older) over the previous two decades was concentrated in the 90- to 94-year-old age group, which increased from 25 percent of the oldest-old group in 1990 to 26.2 percent in 2000, and 26.4 percent in 2010.*

“More than ever, 80, 90, and even 100-year-olds are undergoing surgery, and that trend will only grow. This important partnership between the John A. Hartford Foundation and the ACS to develop standards and then verify that hospitals can deliver optimal geriatric surgical care will save lives, improve outcomes, and reduce harm for older adults across the country,” said Terry Fulmer, PhD, RN, FAAN, president of the Hartford Foundation.

**Longstanding commitment**
The ACS has long been committed to quality geriatric surgical care. In 2012, the ACS, in partnership with the American Geriatrics Society, published joint guidelines in the *Journal of the American College of Surgeons* for the perioperative care of the nation’s elderly patients.† These standards apply to every surgical patient ages 65 and older as defined by Medicare regulations.

“We have worked with the John A. Hartford Foundation for many years to develop meaningful tools for improving geriatric surgical care. The current project aims to develop and integrate geriatric surgery standards that will help facilities with infrastructure, standards, processes and protocols, and the integration of data—all to improve the care of the geriatric surgical patient,” Dr. Ko said.

**Setting the standards**
The Geriatric Surgery Verification and Quality Improvement Program will produce a framework for all hospitals, regardless of size, location, or population served, to improve the quality of care they provide to older adults undergoing surgery. The project will convene experts and engage a broad set of stakeholders representing patients, families, caregivers, multidisciplinary health providers, and industry payors, with the following objectives:

- Set standards for hospitals related to the needed infrastructure for optimal care (for example, staffing, resources, and care processes).
- Select and develop measures that matter for older patients against which hospitals can be assessed and target areas for improvement. (This objective will include new patient-reported outcomes.)
“This is a great opportunity to improve the care and outcomes of geriatric surgery patients—and is relevant to nearly all fields in surgery.”

–Dr. Ko

- Develop educational resources for patients and providers.
- Build a peer-review verification program that promotes public assurance and a culture of improvement, similar to the ACS’s successful cancer, trauma, and bariatric quality programs, which have been shown to improve care and save lives.

“This is a great opportunity to improve the care and outcomes of geriatric surgery patients—and is relevant to nearly all fields in surgery. This program will involve several disciplines and be a total team effort,” Dr. Ko said.

This work builds on the ACS’ robust data collection and quality improvement infrastructure. It will draw upon the network of experts and growing evidence base in geriatric surgery that has been developed with support from the foundation over the last 20 years.

“The ACS has a long and successful track record of helping hospitals build an infrastructure for surgical quality improvement,” said Christopher A. Langston, PhD, Hartford Foundation program director.

“This new verification program will make it easier for hospitals and health systems to focus on doing their best for the large and vulnerable patient population of older adults—and receive public credit for providing them with the right kind of care.”

**SRGS is first education program highlighted in video series**

The American College of Surgeons (ACS) Division of Education is launching a video series that shares Fellows’ perspectives about ACS programs that help them embrace the joy of lifelong learning and access resources to enhance their surgical practices. The first two-minute video in the series, available at [http://bit.ly/1Kh6Wz7](http://bit.ly/1Kh6Wz7), showcases *Selected Readings in General Surgery (SRGS®)*, a premier periodical that reviews current, evidence-based surgical articles to help support a state-of-the-art surgical practice. Eight issues (in both print and online formats) are published every year on a revolving cycle of topics.

In the video, the following ACS Fellows discuss how SRGS allows surgeons to spend their time learning, not searching:

- **Lewis Flint, MD, FACS**, Editor-in-Chief, SRGS
- **Eugene Shively, MD, FACS**, general surgeon, Taylor Regional Hospital, Campbellsville, KY
- **Karen Horvath, MD, FACS**, professor of surgery, University of Washington School of Medicine, Seattle
- **John Mellinger, MD, FACS**, residency program director, general surgery, Southern Illinois University School of Medicine, Springfield

This video series celebrates education as the cornerstone of surgical excellence and will help surgeons to identify state-of-the-art, relevant, and inspiring education and training opportunities.

Henri R. Ford, MD, MHA, FACS, completed the first separation of conjoined twins in his native country of Haiti on May 22. CBS News first reported on this surgical milestone June 5. Dr. Ford, who is a member of the American College of Surgeons (ACS) Board of Regents, assembled a team of more than two dozen volunteer health professionals from the U.S. who trained for months with Haitian medical staff for the procedure. The nearly seven-hour operation separated the six-month-old girls, Marian and Michelle Bernard, who were joined at the abdomen. They left the hospital in early June, two weeks after the procedure was completed. Physicians at University Hospital in Mirebalais, Haiti, where the operation was performed, contacted Dr. Ford, chief of surgery at Children’s Hospital Los Angeles, when the mother carrying the conjoined twins was at 26 weeks gestation. With careful planning, they were able to deliver the infants 10 weeks later in November. Dr. Ford told CBS News it was “extremely gratifying” to be able to perform the operation in his home country alongside Haitian surgeons whom he helped to train.

In addition to being an ACS Regent, Dr. Ford serves as a liaison for the ACS Advisory Council for Pediatric Surgery, is a member of the ACS Ethics Committee, is Past-Chair of the Nominating Committee, and is Past-Vice-Chair of the ACS Board of Governors.

Dr. Ford left Haiti with his family as a teenager to move to New York, NY, but returned for two weeks after the 2010 earthquake to provide surgical care to children injured in the devastation. Since then, Dr. Ford has returned regularly to provide medical care to its residents. The earthquake prompted the Haitian government to team up with Partners in Health, an organization that provides modern medical care to resource-poor countries, and which opened University Hospital in 2013.

View a video clip of the CBS Sunday Morning newscast online at www.cbsnews.com/news/conjoined-twins-delicate-separation/.

Dr. Henri Ford performs first separation of conjoined twins in Haiti
Board of Regents approves new seats; nominations due September 10

The American College of Surgeons (ACS) Board of Regents, at its June meeting in Chicago, IL, approved the addition of two new seats on the Board. These new seats ensure that the Regents represent all specialty members that are certified under the auspices of the American Board of Surgery (ABS), such as trauma and vascular surgery. As a result of the change, the number of Regents increases to 14 from 12, with five members from the ABS community and one from each of the nine specialty boards. The Nominating Committee of the Board of Governors (NCBG) will be accepting nominations for surgeons to fill the new positions through September 10, 2015.

Nomination criteria
The subspecialties that fall under the purview of the ABS and from which Regents may be nominated include the following:

• Burn and critical care surgery
• Gastrointestinal surgery
• General surgery
• Pediatric surgery
• Surgical oncology
• Transplantation
• Trauma
• Vascular surgery

One new position will be filled in 2015, and the other will be filled in 2016. The NCBG will convene in fall 2015 to select the nominee for this year’s pending vacancy. The NCBG uses the following guidelines when reviewing nominees to the Board of Regents:

• Nominees must be loyal members of the College who have demonstrated outstanding integrity and medical statesmanship, along with an unquestioned devotion to the highest principles of surgical practice.

• Nominees must have demonstrated leadership qualities that might be reflected by service and active participation on ACS committees or in other components of the College.

• The NCBG recognizes the importance of Board members representing all health care professionals who practice surgery.

• The NCBG also considers geography, surgical specialty balance, and academic or community practice.

• The College encourages consideration of women and other underrepresented minorities.

• Individuals who are no longer in active surgical practice should not be nominated for election or reelection to the Board of Regents.

All nominations must include:

• A letter of recommendation
• A personal statement from the candidates detailing their ACS service and passion for the position
• The name of one reference

In addition, entities such as surgical specialty societies, ACS advisory councils, and ACS chapters that are submitting nominations must provide a description of their selection process and the total list of applicants reviewed. Any attempt to contact members of the NCBG by a candidate or on behalf of a candidate will be viewed negatively and may result in disqualification of the candidate. Applications submitted without the requested information will not be considered.

If you have nominated or been nominated this year for 2015 already, you do not need to resubmit for this year’s position. Please submit nominations to officerandbrnominations@facs.org. For more information, contact Betty Sanders, Staff Liaison for the NCBG, at 312-202-5360 or bsanders@facs.org. ♦
Dr. Pellegrini elected to Royal National Academy of Spain

Carlos A. Pellegrini, MD, FACS, FRCSI(Hon), The Henry N. Harkins Professor and Chair, department of surgery, University of Washington Medicine, Seattle, and Immediate Past-President of the American College of Surgeons, was elected a distinguished member of the Real Academia Nacional de Medicina (Royal National Academy of Medicine) in Madrid, Spain, on June 2. Dr. Pellegrini is the only person that the Royal National Academy honored on this day. In Spain, the distinction of becoming an academic at the Royal National Academy is considered in Spain to be the highest honor bestowed on physicians of all specialties. Enrique Moreno Gonzalez, MD, FACS(Hon), a 1991 Honorary Fellow of the ACS, introduced Dr. Pellegrini at the induction ceremony. ♦
Save the date: Clinical Trials Methods Course, November 6–10, in Chicago

The American College of Surgeons (ACS) Surgical Research Committee will offer the 12th biennial Clinical Trials Methods Course, November 6–10, at the ACS headquarters in Chicago, IL.

The Clinical Trials Methods Course is a five-day intensive course based on four successfully conducted and published clinical trials. The course will provide surgeons with the concepts and development of skills in the design, implementation, and analysis of randomized clinical trials; observational studies; the use of large administrative databases; meta-analysis; funding mechanisms and budget development; outcomes (medical, patient-centered, cost); and dissemination of results. Participants will work in small groups mentored by leading surgeons and biostatisticians with expertise in clinical trials research.

Course enrollment is limited to 50 participants, and preference is given to ACS members. Note that this course is offered only every other year. View additional course details on the ACS website at www.facs.org/quality-programs/about/cqi/education/clintrial, or contact Carla Manosalvas, Administrator, Committees and Educational Programs, ACS Division of Research and Optimal Patient Care, at CTMCourse@facs.org.

ACS launches home skills program for complex wound management

The American College of Surgeons (ACS) recently announced the start of a new structured teaching and verification program that uses engaging media and self-assessment checklists to educate surgical patients and their families about delivering self-care for complex wound conditions. Nearly 60 percent of all surgical wounds are managed in the home.* To ensure that patients and their families are comfortable and confident in wound care, the Surgical Patient Education Program of the ACS Division of Education will produce, distribute, and evaluate 4,000 home skills kits over the next two years with support from an educational grant from Smith & Nephew.

“Ninety percent of ACS members who completed a 2014 patient education survey reported needing wound care resources. This program provides instruction in print and digital formats, educational checklists, and home care monitoring guides for surgical professionals to use with their patients. Evaluations from both patients and professionals will identify the best methods for home wound care management,” said Kathleen Heneghan, MSN, RN, CPN, Assistant Director, ACS Patient Education Program. “The standardized training guide and education plan, objectives, and skills verification measures for professionals will also help to consistently implement best practices.”

“There is a well-defined need for evidence-based wound care education designed to improve outcomes and instill best practices,” added Glenn Warner, president of Smith & Nephew’s advanced wound management division. “We welcome the opportunity to support an ACS initiative that engages and empowers patients and their caregivers in achieving these important objectives.”

View the ACS press release regarding the home skills program at https://goo.gl/K7W2TY. For more information about the ACS home skills program, see the article on page 65.
At Clinical Congress 2014, the American College of Surgeons (ACS) announced the formation of a strategic partnership with the U.S. Department of Defense and the establishment of the Military Health System Strategic Partnership American College of Surgeons (MHSSPACS). This collaboration of military and civilian surgeons helps to contribute to the participants’ shared culture of treating patients with an emphasis on education, research, humanitarian and disaster response, and systems-based health care.

The ACS Communities invites surgeons to join the new online Military Community. As a member of this community, you will assist the College in strengthening the military health system and the joint trauma system, as well as promoting education and training for military surgeons. Surgeons also may use the site to seek advice on surgical problems they are facing in remote areas where they are deployed. Users also may find the site serves as a valuable forum for connecting with surgeons with whom they trained or were deployed.

In addition, the College is developing a new ACS Military Chapter, the Excelsior Chapter, which will hold its inaugural meeting at Clinical Congress 2015. The goal is to encourage the participation of individuals interested in military surgery, including surgeons who are on active duty, deployed, retired, separated, or in training. By logging onto this community, military surgeons will be able to contribute to the work being done through the ACS related to military surgical care, share advice on treatment of injured patients (in military or civilian settings), and assist in identifying areas where research might benefit military and civilian trauma care. Involvement in the Military Community may facilitate identification of military surgeons who might consider joining the ACS and assist those who are returning from deployment or considering separation in connecting with positions in academic or community practices.

To join the communities, log in to ACS Communities (if you have not specified otherwise in the College’s records, the default username is your eight-digit member ID, and the default password is your last name), go to “Browse All Communities” near the top of any page, and click the blue “Join” button next to the Military Community. For more information, contact M. Margaret “Peggy” Knudson, MD, FACS, Medical Director, MHSSPACS, at pknudson@facs.org.
Currently, 273 individuals serve on the American College of Surgeons (ACS) Board of Governors (B/G), including 146 Governors-at-Large, representing each U.S. state and Canadian province; 83 specialty Governors, representing surgical associations and societies; and 44 international Governors. These numbers include the newest ACS chapter, Jordan.

The Governors act as liaisons between the Board of Regents and the Fellows and serve as a clearinghouse for the Regents on general assigned subjects and local problems. The Board of Governors Executive Committee continues to meet regularly via conference call. This past June, the Executive Committee participated in a strategic planning retreat in Chicago, IL, addressing future leadership and initiatives for the Board of Governors. Three New Governors Orientations took place: two webinars in December and January and a face-to-face meeting at the April Leadership & Advocacy Summit in Washington, DC.

The pillars of work were introduced last year, giving Governors new responsibilities that are fully aligned with the ACS’ goals. Governors’ current duties include:

- Provide bi-directional communication between the B/G and constituents
- Actively participate in at least one of the 13 B/G Workgroups
- Attend the annual Leadership & Advocacy Summit
- Participate in B/G meetings, Convocation, and the Annual Meeting of Members at the Clinical Congress
- Complete the B/G Annual Survey
- Attend chapter or specialty society meetings
- Provide a report to chapter or specialty society and B/G Executive and Communications Committees
- Participate in local Committee on Applicants meetings and interviews
- Promote ACS Fellowship in state and specialty society
- Engage new Initiates/Fellows
- Welcome new Fellows from your area/organization into the ACS
- Be an active participant in the B/G online community

Following is an update on the activities of the B/G Pillars and their respective workgroups.

Advocacy and Health Policy Pillar
Steven C. Stain, MD, FACS, Pillar Lead

The Advocacy and Health Policy Pillar has advanced the following initiatives in 2014–2015:

- Directed participation with ACS leadership in the assessment and response to regulatory and legislative initiatives that will continue to unfold as health care reform progresses
- Actively collaborated with ACS Regents and other leaders to ensure that Governors are available to offer thoughts and suggestions on the formulation of College policies and positions
As the bridge between College leadership and Fellows, every member of this Pillar represents a specific constituency of practicing surgical colleagues. Members of this Pillar may receive relevant information and relay concerns and thoughts to College leadership for appropriate response and action.

The B/G has the following appointed seats on related committees:

• Health Policy and Advocacy Group—William S. Richardson, MD, FACS
• Health Policy Advisory Council—James W. Fleshman, MD, FACS; and David B. McAneny, MD, FACS
• Legislative Committee—James F. Goldszer, MD, FACS

The Advocacy and Health Policy Pillar has two workgroups. Their respective activities for the year can be summarized as follows:

Coalition Workgroup
David B. McAneny, MD, FACS, Chair
Susan K. Mosier, MD, FACS, Vice-Chair

• The College already sponsors a broad coalition among surgery specialty societies, promoting common interests and discussing challenges, such as the now-repealed Medicare sustainable growth rate (SGR), liability reform, graduate medical education, administrative burdens on physicians and surgeons, the Physician Quality Reporting System, electronic health record incentives, physician tiers, network restrictions, scope-of-practice issues, and bundling of funding for care rendered by surgeons. The Coalition Workgroup has supported this greater coalition as well as the ideal of the ACS leading the “House of Surgery.”

• Organizes the legislative priorities of its constituent specialty societies. These concerns were reviewed to establish common themes.

• Collaborates with the Chapter Activities Domestic Workgroup to foster chapter activities that appeal to a variety of surgery specialists, including resident paper competitions and lectures about surgical sciences and socioeconomic issues.

Health Policy and Advocacy Workgroup
Chad A. Rubin, MD, FACS, Chair
Scot B. Glasberg, MD, FACS, FACS, Vice-Chair

The Advocacy and Health Policy Pillar discusses advocacy philosophies, as well as specific strategies and tactics. Its discussions have culminated in the development of a grassroots advocacy program—the District Office Contact by Surgeons program—piloted by the Massachusetts and Tennessee ACS Chapters.* This program is supported by the College’s SurgeonsVoice website, which provides educational infrastructure for home district visits with legislators. It is believed that this model can support the structure of advocacy for both the College and its coalition partners and will continue to enhance the program and disseminate it among all chapters.

Communication Pillar
Joseph J. Tepas, MD, FACS, Pillar Lead

The Communication Pillar worked on the following initiatives in 2014–2015:

• Enhanced reporting of Governor activities in a manner that informs Fellows and solicits feedback

• Sought the Young Fellows Association’s input for publications and other relevant issues

The Governors’ representative to the ACS website is Tyler G. Hughes, MD, FACS. The B/G representatives to the Bulletin and NewsScope

are G. Thomas Shires, MD, FACS, and Peter A. Andreone, MD, FACS, respectively.

The Board of Governors was one of the first groups to have a presence in the new ACS Communities site. A special presentation conducted by Dr. Hughes, Community Site Editor, was given during the 2014 Board of Governors Annual Meeting.

Newsletter Workgroup
Michael D. Sarap, MD, FACS, Chair
Russell J. Nauta, MD, FACS, Vice-Chair

• Now publishes a quarterly newsletter, renamed The Cutting Edge: News and Notes from the Board of Governors, which includes human interest stories, pillar updates, and other timely topics

• Columns published in the newsletter include:

  – International Café, which focuses on international Governors/Fellows

  – Fascinating Facts, which provides details on little-known facts about the ACS

  – On the Shoulders of Giants, which highlights the achievements of surgical pioneers

• Actively recruits young surgeon input for the newsletter

Survey Workgroup
Mark W. Puls, MD, FACS, Chair
David J. Welsh, MD, FACS, Vice-Chair

• Conducted the annual Governors survey; concerns raised in the study are addressed by the College’s leadership

• Compared common issues and themes from the recent College-wide membership survey

Education Pillar
Karen J. Brasel, MD, FACS, Pillar Lead

Initiatives that the Education Pillar led in 2014–2015 included:

• Worked closely with the ACS Division of Education to further align College programs and products.

• Called upon Governor representatives to the ACS Program Committee to educate Governors and B/G workgroup leadership on the Clinical Congress submission process. Governors (all MD, FACS) served on the following ACS Education committees:

  – Committee on Resident Education, Antonio M. Pavia

  – Committee on Medical Student Education, Deborah S. Loeff

  – Committee on Patient Education, Dennis H. Kraus

  – Committee on Continuous Professional Development, Charles R. Bridges

  – Clinical Congress Program Committee, Diana L. Farmer and David Spain

  – Committee on Ethics, Karen J. Brasel

  – Committee on Emerging Surgical Technology and Education, Joann M. Lohr

Continuing Education Workgroup
Mark J. Watson, MD, FACS, Chair
Daniel L. Dent, MD, FACS, Vice-Chair

• Worked to improve the functionality of the MyCME (continuing medical education) page to better meet Maintenance of Certification requirements

• Developed a plan for a MyCME dashboard, which will populate from the College’s database and contain events such as chapter meetings

Patient Education Workgroup
Terry Sarantou, MD, FACS, Chair
Dennis Kraus, MD, FACS, Vice-Chair

• Sought to further align this workgroup with the ACS Committee on Patient Education
• Reviewed ACS patient education materials to ensure information is up-to-date

Surgical Training Workgroup
Fred A. Luchette, MD, FACS, Chair
Carol Scott-Conner, MD, FACS, Vice-Chair

• Finalized and disseminated a standardized letter of recommendation for medical students

• Developed several teaching tools

Member Services Pillar
Kevin E. Behrns, MD, FACS, Pillar Lead

The Member Services Pillar led the following initiatives in 2014–2015:

• Continued to strengthen chapters and create useful tools for chapter leadership

• Focused on creating opportunities and additional communication vehicles for the international Governors and chapters

• Enhanced the visibility of the Surgical Volunteerism and Humanitarian Awards Program through more widespread publicity and by streamlining the application process

• Appointed Governors to serve on the ACS Member Services committees, including (all MD, FACS):
  - ACS Committee on Diversity Issues—David Jacobs
  - ACS Women in Surgery Committee—Annesley W. Copeland
  - Young Fellows Association—Shoaib I. Sheikh
  - Resident and Associate Society—Glen A. Franklin

Chapter Activities
Domestic Workgroup
S. Rob Todd, MD, FACS, FCCM, Chair
Frank T. Padberg, Jr., MD, FACS, Vice-Chair

• Worked to expand and promote the Chapter Partner Program

• Offered suggestions to Chapter Services and made enhancements and updates to the Chapter Guidebook

• Worked with staff to create a Chapter Event Tool Kit, which will offer best practices for ACS-related meetings

• Suggested topics for Chapter Webinars, which are designed for chapter administrators and officers but open to viewing by all ACS members

• Recommended topics for a possible Chapter Officer Training Program

Chapter Activities
International Workgroup
Miguel A. Cainzos, MD, FACS, Chair
Jamal J. Hoballah, MD, FACS, Vice-Chair

• Assisted in the development of charters for new international chapters

• At Clinical Congress, promoted the sharing of best practices for international chapters via a special networking event co-hosted with the Domestic Workgroup

• Continued the development of the International Regional Subcommittees Program to promote the growth of needed ACS programs and the creation of annual regional meetings

• Coordinated communication with international chapters and members through the creation of new ACS international Web communities

Surgical Volunteerism and Humanitarian Awards Workgroup

• Streamlined the application and review process by continually enhancing the information technology interface, review of applications, and scoring

• Increased awareness of the awards through multiple media venues, particularly the ACS Communities
• Aligned activities with Operation Giving Back leadership to enhance efforts in global surgery

Quality, Research, and Optimal Patient Care Pillar
Diana L. Farmer, MD, FACS, Pillar Lead

The Quality, Research, and Optimal Patient Care Pillar led the following initiatives:

• Worked closely with the ACS Division of Research and Optimal Patient Care

• Continued to research and discuss issues, such as the aging surgeon and burnout

• Reviewed and revised surgical guidelines to ensure that the College remains current and relevant

• Governors (all MD, FACS) serve on the following ACS quality-related committees:
  – Committee on Perioperative Care—Mika Sinanan
  – Committee on Cancer—Helen Pass
  – Committee on Trauma—Michael Coburn

Best Practices Workgroup
Joseph P. Minei, MD, FACS, Chair
Brian G. Harbrecht, MD, FACS, Vice-Chair

• Completed the Post-Op Ileus Guideline; efforts are under way to publish the guideline in various venues, such as the Bulletin

• Reviewed Evidence-Based Decisions in Surgery guidelines

Physician Competency and Health Workgroup
Roger R. Perry, MD, FACS, Chair
Christian de Virgilio, MD, FACS, Vice-Chair
Michael P. Vezeridis, MD, FACS, Vice-Chair

• Finalized white paper on the aging surgeon

• Evaluated new topics for the next white paper to be written by this group

Surgical Care Delivery Workgroup
Steven De Jong, MD, FACS, Chair
Christopher McHenry, MD, FACS, Vice-Chair

• Four subcommittees carry out the workgroup’s projects:
  – The Surgeon Workforce Subcommittee has been developing a checklist for new surgeons to use in any environment
  – The Patient Access to Surgical Care Subcommittee has been reviewing and summarizing recent surveys published on the topic. The subcommittee also has been working on a panel session for a future Clinical Congress
  – The Electronic Health Record (EHR) Subcommittee has been in preliminary discussions with vendors regarding an EHR solution, a top concern among U.S. Fellows. Issues include meaningful use, disruption of physician workflow, and the ability to extract relevant quality data. Workgroup members believe the College should aggressively pursue the possibility of incorporating data from the ACS National Surgical Quality Improvement Program into EHR systems such as Epic and Cerner. Workgroup members also strongly urge that the ACS Program Committee reevaluate the EHR proposal submitted for presentation at Clinical Congress 2015.

– The Ambulatory Surgery Subcommittee created a document on ambulatory surgery guidelines, which is being vetted by College leadership.

Finally, the Committee to Study the Fiscal Affairs of the College is chaired by James Denneny, MD, FACS, who also serves as the B/G Secretary. This committee continues to review and monitor the fiscal health of the College.
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View webcasts on demand. Individualize your education. Receive a certificate of completion.

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Access all 118 webcast sessions from Clinical Congress 2015 and MP3 audio recordings of all Named Lectures and most Panel Sessions. More than 175 CME credits and 175 self-assessment credits are available for practicing surgeons.

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2015 Webcast Package
Access all 118 webcast sessions from Clinical Congress 2015.

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Pick 25 of 2015
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*Practicing surgeons may earn CME credit and claim self-assessment credit.

For more information, visit www.facs.org/education/resources/elearning/webcasts or contact Olivier Petinaux at 866-475-4696 or elearning@facs.org.
**North California Chapter meeting features many resident activities**

The Portola Hotel, Monterey, CA, was the site of the Annual Scientific Meeting of the Northern California Chapter of the American College of Surgeons (NCACS), May 15−16. Approximately 60 ACS Fellows, residents, and guests attended the meeting, which began on Friday evening with a President’s Dinner and continued on Saturday with a program rich in educational activities, many aimed at Resident Members. Examples included a Research Paper Competition, Surgical Jeopardy, and a Laparoscopic Bowl that pitted resident teams from area training programs against one another in a skills competition.

Speakers at the NCACS annual business meeting included Chapter President Shelley A. Marks, MD, FACS, who provided an update on chapter activities. The chapter presented a ceremonial plaque to Dr. Marks in recognition of her service during the past year. John Maa, MD, FACS, also was recognized for his service as Past-President of the NCACS.

The keynote speaker was Ronald V. Maier, MD, FACS, FRCSEd(Hon), First Vice-President-Elect of the ACS. Dr. Maier offered an update on College activities and described the opportunities available to ACS members to become involved in College programs. Also representing the College was Clifford Y. Ko, MD, MS, MSHS, FACS, FACRS, Director, ACS Division of Research and Optimal Patient Care, and Director, ACS National Surgical Quality Improvement Program (ACS NSQIP®). Dr. Ko presented his thoughts on Achieving Surgical Quality—Observations from the Field. NCACS member Mary H. McGrath, MD, MPH, FACS, spoke about the ACS Foundation’s 1913 Legacy Campaign, including its history and goals. Donna Tieberg, Chapter Services Manager and author of this article, was in attendance.

**Southwestern Pennsylvania Chapter local residents offer Most Interesting Cases**

Members of the ACS Southwestern Pennsylvania Chapter (SWPA) met May 11 at the Pittsburgh Rivers Casino. Sheri Mancini, MD, FACS, SWPA Chapter President, welcomed
attendees and introduced Richard Daly, MD, FACS, who offered a presentation on the ACS Foundation’s goals and scholarships. The SWPA contributes to the Foundation each year, earmarking its contribution to the Thomas R. Russell, MD, FACS, Scholarship Fund.

The chapter also hosted residents from local surgery programs for a Most Interesting Cases presentation. Residents from various training programs submitted a total of 17 abstracts, which the Chapter Council reviewed. From those abstracts, six residents were selected to give oral presentations and were introduced by Dr. Mancini at the meeting. Following the resident presentations, three were awarded the Most Interesting Cases of 2014. Award winners were as follows: Tad Witek, MD, University of Pittsburgh Medical Center Mercy Hospital, first place for Traumatic Esophageal and Tracheal Disruption; Michael Stellmaker, MD, FACS, Allegheny General Hospital, second place for Acute Trauma in Pregnancy: Perimortem C-Section Results in Survival of the Fetus; and Ravi Ambani, MD, Allegheny General Hospital, third place for The Tuberculous Peritonitis—A Rare Cause of Abdominal Pain and Ascites in a Young Male.

New York Fellows attend fourth New York Coalition of Specialty Care Physicians meeting
Fellows of the ACS Brooklyn-Long Island Chapter and College staff participated in the fourth New York Coalition of Specialty Care Physicians Meeting in Albany on May 12. The meeting was organized by the New York Society of Ophthalmologic Surgeons, and was broken into a morning orientation session focused on current legislation, followed by an afternoon of meetings with state representatives and senators. Liability reform was a focus of the sessions with legislators, and it is anticipated that with new leadership in the House and Senate in place over the next six months, it will be possible to advance liability reform legislation. Several Fellows in attendance were new to advocacy work and appreciated the opportunity to observe the legislative process and to build relationships with legislators at the grassroots level.

Metropolitan Philadelphia Chapter hosts second Young Surgeons Night at the Museum
The Metropolitan Philadelphia Chapter of the College (MPACS) held its second young surgeons’ networking event May 1 at the Philadelphia Museum of Art. More than 40 attendees, including young surgeons, chapter officers, and ACS Governors, received a guided tour of the museum with a focus on exhibits featuring the medical arts. As part of their commitment to engaging young surgeons in the chapter, MPACS offers residents from local medical programs the opportunity to...
participate in networking events and the MPACS Annual Mock Oral Examination, scheduled this year for September 19. Additional photos from the May 1 meeting are posted at http://metrophilasurgeons.org/youngsurgeons.html.

**Minnesota Surgical Society holds annual Spring Meeting and social event in Minneapolis**

The Minnesota Surgical Society (MSS), a chapter of the ACS, held its annual Spring Meeting May 1 at the Lowes Minneapolis Hotel. Highlights of the meeting included presentations by Richard T. Zera, MD, FACS, Hennepin County Medical Center; Todd M. Tuttle, MD, FACS, University of Minnesota Medical Center; and David R. Farley, MD, FACS, Mayo Clinic, Rochester, who shared their expertise in surgical approaches to unexpected abdominal cancers. The audience responded enthusiastically to the case-based presentations.

James G. Schlaefer, MD, FACS, HealthPartners Coon Rapids Clinic, presented his experience of performing more than 1,000 intraoperative cholangiograms, with a focus on determining when a cholangiogram should be considered during a laparoscopic cholecystectomy.

ACS Regent John L. D. Atkinson, MD, FACS, provided an update on College activities and encouraged audience members to participate in advocacy efforts at the national and local levels. Donna Tieberg, ACS Chapter Services Manager, and Chapter Administrator Janna Pecquet participated in a preconference chapter council meeting, which focused on possibly revising the chapter bylaws, revamping the chapter website, and reorganizing the council positions, among other topics.

A total of 39 residents, research trainees, and medical students participated in the MSS Spring Meeting and shared their research on trauma, cancer, and general surgery. Resident Award Winners for Basic Science were Shennen Mao, MD, Mayo Clinic, Rochester, first place; Rohini Khatri, MD, University of Minnesota, Minneapolis, second place; and Johnathon Aho, MD, Mayo Clinic, third place. Winners in the Clinical Research category were as follows: Christopher Shubert, MD, Mayo Clinic, first place; Cornelius Thiels, DO, MBA, Mayo Clinic, second place; and Matthew Hernandez, MD, Mayo Clinic, third place. The winner of the Committee on Cancer paper competition was Christopher J. LaRocca, MD, of the University of Minnesota. The MSS Chapter plans to hold its fall conference October 23–24 in Duluth.

**Dr. Mattox guest speaker at Japan Surgical Society/ Japan Chapter meeting**

ACS Second Vice-President Kenneth L. Mattox, MD, FACS, was the guest speaker at a meeting of the Annual Congress of the Japan Surgical Society (JSS) and the ACS Japan Chapter, April 16–18, in Nagoya. Dr. Mattox’s talk on Symbiosis and Serendipity in the History of the Management of Aortic Trauma included the inspiring message that “there is always a better way.” The Japan Chapter is currently concentrating its efforts on encouraging young surgeons to join the chapter, and members are planning to attend Clinical Congress in Chicago this fall.
**Record attendance for Mexico Tri-Chapter meeting in Monterrey**

There was record attendance of 250 surgeons, 45 of whom are Fellows of the College, at the 37th ACS Mexico Tri-Chapter Meeting, June 11–13, at Doctors Hospital, Monterrey. All of the officers from the three Mexico Chapters—The Mexico Federal, Nor-Ocidental, and Northeast Mexico Chapters—participated in the meeting. ACS Governors from Mexico also participated, as did Jose Octavio Ruiz Speare, MD, FACS(Hon), founder of the Advanced Trauma Life Support® program in Mexico. The chapter honored other senior College members. Jesus Zacarias Villarreal, MD, Health Secretary for Mexico, led the inaugural ceremony of the Tri-Chapter meeting. The deans of all the medical schools in Monterrey participated as well.

More than 50 educational sessions were offered, and special guest Dr. Mattox participated in the opening ceremonies of the conference, speaking on the ACS and Mexico As Partners. Dr. Mattox also spoke on Confounding Variables in Confusing Chest Bullets and Abdominal Vascular Catastrophes. Raffle prizes on the last day of the event included ACS history volumes and electronic tablets donated by medical vendors.

**Dr. Healy addresses combined symposium of Florida and Jacksonville Chapters**

The ACS Jacksonville and Florida Chapters held a combined symposium on March 31 in Jacksonville, FL. This is the first joint meeting of the two chapters; it was facilitated under the leadership of Florida Chapter President John P. Rioux, MD, FACS, and Jacksonville Chapter President Michael S. Nussbaum, MD, FACS. ACS Past-President Gerald B. Healy, MD, FACS, professor of otology and laryngology, Harvard Medical School, Boston, MA, was the keynote speaker. Dr. Healy spoke on Managing Practice in 2015—The Science of Quality Improvement: Transforming Health Care to Achieve the Healthiest Population. Dr. Healy’s address was dedicated to the inauguration of the Florida Surgical Quality Collaborative as the continued extension of the Florida Surgical Care Initiative. The day after the symposium, Dr. Healy officiated at Surgical Grand Rounds at the University of Florida Health Jacksonville Hospital, discussing the importance of personal commitment to quality and professional excellence.

**West Virginia Chapter holds special Q&A session with medical students and surgeons**

The 65th Annual Meeting of the ACS West Virginia (WV) Chapter took place May 7–9 at the 235-year-old landmark Greenbriar Resort in White Sulphur Springs. The chapter has hosted meetings at this location for more than 60 years. Over the years, the landmark resort has hosted U.S. presidents, as well as international celebrities and dignitaries, and features a large bunker that was built in the 1950s during the Cold War. The bunker was intended to serve as a fallout shelter for the U.S. Congress in the event of an attack.

Chapter President Bryan K. Richmond, MD, FACS, welcomed the more than 120 participants of the meeting, including Fellows, residents, medical students, and affiliate members. Dr. Richmond challenged young surgeons to participate in ACS
West Virginia Chapter officers and meeting participants, from left (all MD, FACS, except for Ms. Tieberg and Ms. Bartholomew): Rebecca Wolfer, COT State Chair; ACS Governor Robert Gustafson; President Bryan Richmond; Ms. Tieberg; President-Elect Frederick Martinez; and William Burns, Secretary/Treasurer. Second row: James Carrier, Councilor; Curtis Harrison, First Vice-President; John DeLuca, Councilor; Patrick Stone, Second Vice-President; Hannah Hazard, COC State Chair; Sharon Bartholomew, Chapter Administrator; Roger King, Past-ACS Governor; Thomas McClellan, Councilor; Richard Vaughan, Past-President; and Gene Duremdes, Immediate Past-President.

and other surgical educational opportunities, network via the ACS Communities, and to identify and reach out to mentors. The meeting also included the annual WV State Resident Trauma Competition, the WV ACS Surgery Resident Competition, and a series of Pro/Con debates, one of which included a discussion about whether an 80-hour workweek was beneficial to surgical training. Guest Mark R. Katlic, MD, MMM, FACS, chair, department of surgery, and director, Center for Geriatric Surgery, Sinai Hospital, Baltimore, MD, addressed the subject of the Aging Surgeon.

Guest Dr. Mattox offered a presentation titled Innovations within the House of Surgery: American College of Surgeons in Education, Quality, and International Leadership, which featured the College’s 100 Years, 100 Reasons to Join video. Dr. Mattox gave a second presentation, 10 Operations that Changed My Life, and was able to spend extra time with medical students and residents after the day’s activities.

Ms. Tieberg was present for the educational sessions and chapter social events and attended the chapter council meeting. She also was the guest at a luncheon of the West Virginia Plastic Surgery Society, which included Fellows who were attending the chapter meeting. A luncheon discussion covered topics of creating a Web presence for the society and grassroots advocacy.

A new feature of the WV chapter meeting was a dialogue between medical students, Fellows of the chapter, and guest surgeons. More than 55 medical students from the state’s surgical programs participated in an informative question-and-answer session with 25 general and specialty surgeons who attended the weekend program. Questions posed to the senior surgeons by medical students broached the topics of time management for surgeons, flexibility of practice, the ins and outs of rural surgery, fellowships, and time spent doing research.

San Diego Chapter has record turnout for Resident Surgical Jeopardy Competition

The San Diego Chapter of the ACS held its first Resident Surgical Jeopardy competition at its Spring Meeting on May 19 at the University of California at San Diego (UCSD) Ida and Cecil Green Faculty Club in La Jolla. A record turnout of nearly 80 Fellows, residents, and young surgeons attended a dinner and the competition, cheering on the two teams from the UCSD and the Naval
Medical Center San Diego. UCSD and Navy are the only two general surgery programs in the San Diego Chapter area. The team from UCSD was awarded a trophy for winning on the final Surgical Jeopardy question. Daniel D. Klaristenfeld, MD, FACS, FASCRS, Chapter Councilor, helped to facilitate the competition.

The meeting included a talk by Bryan M. Clary, MD, FACS, chair, department of surgery, UCSD School of Medicine, and surgeon-in-chief, UCSD Health System. Dr. Clary’s presentation was titled The Imperial Valley: Personal Reflections on our Neighbor to the East. The San Diego Chapter received its Resident Surgical Jeopardy Tool Kit via the Education Committee of the Resident and Associate Society of the ACS. The Committee is pilot testing the tool kit through the end of 2015. If your chapter is interested in participating in the pilot phase of the Surgical Jeopardy Tool Kit, e-mail rasnews@facs.org.

Chapter Speed Networking to be special interest session at next Clinical Congress

The ACS Governors of the Chapter Activities Domestic and International Workgroups will offer a Special Interest Session for chapter officers, their staffs, and Governors of the College, to take place on Tuesday, October 6, at the 2015 Clinical Congress in Chicago, IL. Chapter Speed Networking is a new, fun activity that allows attendees to accelerate their Clinical Congress networking experiences through short chapter-related table talks. The table talks portion of the event will last approximately one hour, and participants will spend the final hour socializing with colleagues from around the world. Attendees can expect many invigorating conversations and are encouraged to bring plenty of business cards. For more information, contact Donna Tieberg, Chapter Services Manager, at dtieberg@facs.org or 312-202-5361.

Corrections

The incorrect edition number of the American Joint Committee on Cancer’s Cancer Staging Manual was cited in the “Looking forward” column, page 8, of the June 2015 Bulletin. The manual is in its seventh edition.

The institution where Courtney Townsend, Jr., MD, FACS, practices was incorrectly identified on page 9 of the July 2015 issue. Dr. Townsend is at the University of Texas Medical Branch, Galveston. The editors regret the errors.
Applications for 2017 ACS Traveling Fellowships due November 16

The International Relations Committee of the American College of Surgeons (ACS) has announced the availability of traveling fellowships to Australia and New Zealand (ANZ), Germany, and Japan. The closing date for receipt of completed applications for all three destinations is November 16, 2015.

The traveling fellowships are intended to encourage international exchange of information concerning surgical science, practice, and education and to establish professional and academic collaborations and friendships. These are exchange fellowships; so, for example, a U.S. or Canadian ACS Traveling Fellow will visit Japan for the annual meeting of the Japan Surgical Society, and a Traveling Fellow from Japan will visit the U.S. for the ACS Clinical Congress.

Basic requirements
The traveling fellowships are available to Fellows of the ACS in most of the surgical specialties who meet the following requirements:

• Has a major interest and accomplishment in basic sciences related to surgery
• Holds a current full-time academic appointment in Canada or the U.S.
• Is younger than 45 years of age on the date the application is filed
• Is enthusiastic, personable, and possesses good communication skills

Activities
The Traveling Fellows are required to spend at least two or three weeks in the countries that they visit and engage in the following activities while abroad:

• Attend and participate in the annual scientific meeting of the host country:
  – Royal Australasian College of Surgeons, Adelaide, Australia (May 2–5, 2017)
  – Germany Society of Surgery, Munich (March 21–24, 2017)
• Participate in the formal convocation ceremony of that annual meeting
• Attend and address the local ACS chapter meeting
• Visit at least two medical centers in the country before or after the annual meeting to lecture and to share clinical and scientific expertise with the local surgeons

The academic and geographic aspects of the itinerary will be finalized in consultation and mutual agreement between the Fellow and the president or designated representative of the local chapter of the ACS. The surgical centers to be visited depend to some extent on the special interests and expertise of the Fellow and his or her previously established professional contacts with surgeons in the selected country.

The Traveling Fellow’s spouse is welcome to accompany the successful applicant. There will be many opportunities for social interaction in addition to professional activities.

Financial support
The College will provide $10,000 to each successful applicant. The awardees must meet all travel and living expenses, as appropriate to the country visited. Senior chapter representatives will consult with the Fellows about the centers to be visited, the
The traveling fellowships are intended to encourage international exchange of information concerning surgical science, practice, and education and to establish professional and academic collaborations and friendships.

Local arrangements for each center, advice, and travel schedules. The Fellows are advised to make their own travel arrangements in North America to take advantage of reduced fares and travel packages for travel overseas.

The ACS International Relations Committee will select the three Traveling Fellows after review and evaluation of applications. A personal interview may be requested before the final selection. The successful applicants and alternates will be selected and notified by March 2016. Full requirements and links to the application forms are located at www.facs.org/member-services/scholarships/traveling. Send the application form plus the additional required documents in the form of a single PDF to kearly@facs.org or via post to: International Liaison Section, American College of Surgeons, 633 N. Saint Clair Street, Chicago, IL 60611-3211.

The traveling fellowships are intended to encourage international exchange of information concerning surgical science, practice, and education and to establish professional and academic collaborations and friendships.

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  - #S4 Solid 14K Gold $1150
- Key (shown actual size of 3/4")
  - #S5 Gold-Filled $85
  - #S6 Solid 14K Gold $700
- Miniature Key (Not Shown)
  - #S7 Gold-Filled $70
  - #S8 Solid 14K Gold $450
- Charm (Not Shown)
  - #S9 Gold-Filled $85
  - #S10 Solid 14K Gold $550
- Miniature Charm
  - #S11 Gold-Filled $60
  - #S12 Solid 14K Gold $350
  - #S13 Sterling Silver w/ 18" Sterling Silver Neckchain $65
  - #S13-1 Sterling Silver Charm $50
- Ring
  - #S14 Solid 14K Gold $2250
  - #S14.1 Solid 10K Gold $1675
  (Indicate finger size)
- Tie Bar
  - #S15 Gold-Filled Emblem $75
- Necktie
  - #S16A Dark Blue $35
  - #S16B Light Blue $35
  - #S17 Maroon $35
  Extra long add $5.00
- Diploma Plaques*
  - #S18 Satin Gold Finish $380
  - #S19 Satin Silver Finish $380
  8-1/2 x 12" metal plaque on 11" x 14-1/2" walnut. Specify name, day, month, year selected.
- Men's Bow Tie (Untied) (Not Shown)
  - #S22 Dark Blue $35
  - #S23 Maroon $35
- Women's Scarf - Silk (Not Shown)
  - #S24 36" x 36" cream w/ dark blue and maroon border $35
- Rollerball Pen - Chrome
  - #S25 Cross Townsend Medalist with 23/K Gold Plated Emblem $135
- Money Clip (Not Shown)
  - #S26 With Gold-Filled emblem $75
- Desk Set (Not Shown)
  - #S27 Solid Walnut with Cross Gold-Filled Pen & Pencil/Gold-Filled emblem; name and year elected a Fellow engraved on gold polished plate $325
- Wallet (Not Shown)
  - #S28 Black cowhide with Gold-Filled emblem $90
- Blazer Buttons (Not Shown)
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- Blazer Patch
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AUG 2015 BULLETIN American College of Surgeons
### MEETINGS CALENDAR

#### AUGUST

**Colombia Chapter**  
**August 11–14**  
Bogota, Colombia  
Contact: Sonia Babativa, soniapatriciab@ascolcirugia.org

**Hawaii Chapter**  
**August 14–15**  
Honolulu, HI  
Contact: Gary Belcher, gbelcher@hawaiiresidency.org, hawaiifacs.org

**Georgia Society of the ACS**  
**August 29–30**  
Atlanta, GA  
Contact: Kathryn Browning, kdb@georgiaacs.org, www.georgiaacs.org

#### SEPTEMBER

**Jacksonville Chapter**  
**September 1**  
Jacksonville, FL  
Contact: Patti Chapman, rotaryexecsec@aol.com

**Kansas Chapter**  
**September 11–12**  
Overland Park, KS  
Contact: Denise Lantz, dlantz@kmsonline.org, www.kansaschapteracs.org

**New Mexico Chapter**  
**September 18–19**  
Albuquerque, NM  
Contact: Gloria Chavez, gchavez@nmms.org

**Connecticut Chapter**  
**November 6**  
Farmington, CT  
Contact: Christopher Tasik, info@ctacs.org, www.ctacs.org

**Keystone Chapter**  
**November 6**  
Scranton, PA  
Contact: Robb-Ann Cook, rcook@pamedsoc.org, www.keystonesurgeons.org

**Wisconsin Surgical Society**  
**November 13–14**  
Kohler, WS  
Contact: Terry Estness, wisurgical@att.net, www.wisurgicalsociety.com

**Arizona Chapter**  
**November 14–15**  
Scottsdale, AZ  
Contact: Ross Goldberg, ross_goldberg@dmgaz.org, www.azacs.org

#### OCTOBER

**Arkansas Chapter**  
**October 17**  
Little Rock, AR  
Contact: Linda Townsend, lindac92@comcast.net

**Israel Chapter**  
**October 20–21**  
Tel Aviv, Israel  
Contact: Mordechai Gutman, motti.gutman@sheba.health.gov.il

**Italy Chapter**  
**October 21–24**  
Milan, Italy  
Contact: Giuseppe Nigri, giuseppe.nigri@uniromal.it, www.facsitaly.org

**Minnesota Surgical Society**  
**October 23–24**  
Duluth, MN  
Contact: Janna Pecquet, janna@mnsurgicalsociety.org, www.mnsurgicalsociety.org

#### NOVEMBER

**Southwestern Pennsylvania Chapter**  
**November 4**  
Pittsburgh, PA  
Contact: James Ireland, jireland@acms.org, www.acms.org/spec/ACS/index.html

**South Korea Chapter**  
**November 5–7**  
Seoul, South Korea  
Contact: Sun-Whe Kim, sunwkim@plaza.snu.ac.kr

### FUTURE CLINICAL CONGRESSES

- **2015**  
  **October 4–8**  
  Chicago, IL

- **2016**  
  **October 16–20**  
  Washington, DC

- **2017**  
  **October 22–26**  
  San Diego, CA

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*Dates and locations subject to change. For more information on College events, visit www.facs.org/events or http://web2.facs.org/ChapterMeetings.cfm*