Orlando Regional Medical Center responds to Pulse nightclub shooting
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Efforts to execute the payment policies outlined in the Medicare Access and CHIP (Children’s Health Insurance Program) Reauthorization Act (MACRA) are in full swing. Specific details regarding how the Centers for Medicare & Medicaid Services (CMS) will implement the Quality Payment Program (QPP) should be clarified when the final regulation for the 2017 Medicare Physician Fee Schedule (MPFS) is released. (At press time, it was scheduled for release in late October or early November.)

Nonetheless, the American College of Surgeons (ACS) has had a fairly good sense of the general direction that CMS was heading because of the provisions outlined in the proposed rule released in April, and our ongoing negotiations with the agency. The ACS Division of Advocacy and Health Policy (DAHP) has been working tirelessly with CMS to ensure that the QPP is implemented in a way that is fair and equitable to all physicians and that keeps the patient at the center of reimbursement decisions.

The ACS staff and leadership also have been developing strategies to ensure that ACS Quality Programs and registries are compliant with the reporting requirements for the QPP and useful to surgeons who want to participate without being subject to complex and onerous administrative burdens. In addition, we have developed a series of educational videos to help surgeons prepare for the QPP.

**How the QPP will work**

The October issue of the *Bulletin* (pages 20–22) included an article, “The new Medicare physician reimbursement system: Building the Quality Payment Program,” by Christian Shalgian, Director, DAHP, and Patrick V. Bailey, MD, FACS, Medical Director, Advocacy, DAHP, which outlined the basics of the QPP. To review, physicians have two pathways to participation in the QPP: through the Merit-based Incentive Payment System (MIPS) or through Advanced Alternative Payment Models (APMs). At present, limited options are available for surgeons to participate in APMs; thus, most surgeons will be in the MIPS program, at least initially.

Payment adjustments under MIPS will be based on a composite performance score (CPS) derived from four components: Quality, Resource Use, Advancing Care Information (ACI), and Clinical Practice Improvement Activities (CPIA).
The first three correspond to certain elements of the present MPFS and can be described as follows:

- The Quality component corresponds to the Physician Quality Reporting System (PQRS) and will determine 50 percent of a physician’s CPS and payment adjustment. One difference that many surgeons will likely welcome is that physicians will be required to report only six quality measures rather than the nine they are expected to report using PQRS.

- The ACI replaces the Electronic Health Record (EHR) Incentive Program. This component will account for 25 percent of a physician’s payment adjustment and will be derived from a base score (50 percent) and a performance score (up to another 50 percent, depending on whether the base score is achieved).

- The Resource Use component replaces the Value-Based Modifier (VBM) and will account for 10 percent of a physician’s CPS. Surgeons will not need to comply with any reporting mandates for the Resource Use component. Medicare will complete the calculations based on claims data.

The fourth component of MIPS—the CPIA component—is new and has no analogous previous program requirement. According to the proposed rule, in the first year of MIPS (2017), CPIA reporting will be by attestation. Physicians will choose from a list of 94 activities, each with an assigned value. To receive full credit for the CPIA component, providers will need 60 points, although it will be possible to receive partial credit.

Be prepared: The College can help
The College urges all Fellows to prepare for the transition to MIPS and is offering a range of resources and services to help them to succeed in 2017 and beyond.

First, surgeons who have been participating in the PQRS program already have an edge in terms of meeting the Quality component requirements because, although measure options and reporting thresholds may change in 2017, PQRS will continue to serve as the foundation of this component. It is important to understand which measures are most applicable to an individual’s practice and to learn how to incorporate data collection into the workflow. This information can be obtained through a review of PQRS feedback reports. Understanding one’s PQRS measure reporting and past performance rates will be useful in determining the best strategy for MIPS reporting.

Surgeons who are not yet participating in the PQRS still have time to start, and the ACS has two registries that can be used for PQRS reporting in 2016—the Surgeon Specific Registry (SSR) and the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) database. Both databases are PQRS-Qualified Clinical Data Registries.

To fulfill the ACI component, the ACS recommends that surgeons confirm that their EHR is certified by the Office of the National Coordinator for Health Information Technology (ONC). (To determine whether an EHR system is certified, go to chpl.healthit.gov/#/search.) The College also urges Fellows to review the list of measures and objectives for the current EHR Incentive Program. Although reporting thresholds will likely change, most of the current objectives and measures of EHR meaningful use will form the basis of the ACI score. Surgeons who do not have an ONC-certified EHR or who have not participated in the EHR Incentive Program should review the ACS Basic EHR Starter Guide at facs.org/advocacy/regulatory/ehr/basic-ehr-starter-guide.

To take full advantage of the Resource Use component, the ACS suggests that surgeons review their
Surgeons will be relieved to know that, according to CMS Acting Administrator Andy Slavitt, physicians will be allowed to pick their pace for transitioning to MIPS. The ACS and other stakeholders have advocated for incremental implementation and are pleased that CMS has agreed to take steps to ensure a smooth transition.

Quality and Resource Use Reports (QRURs) from CMS. This information is useful in benchmarking one’s performance on quality and cost measures against those of other Medicare providers and in determining how practice patterns might affect one’s score. At press time, our understanding was that CMS intends to use much of the same cost data it currently collects under the VBM to calculate the MIPS Resource Use component score.

To comply with CPIA, the College recommends that surgeons review the list of suggested CPIA activities at the end of the proposed rule (s3.amazonaws.com/public-inspection.federalregister.gov/2016-10032.pdf) and identify six activities aimed at advancing clinical practice that they are likely to perform. An example would be engaging in a patient safety and practice assessment activity, such as using the ACS National Surgical Quality Improvement Program (ACS NSQIP®) Risk Calculator.

Moving forward
Surgeons will be relieved to know that, according to CMS Acting Administrator Andy Slavitt, physicians will be allowed to pick their pace for transitioning to MIPS. The ACS and other stakeholders have advocated for incremental implementation and are pleased that CMS has agreed to take steps to ensure a smooth transition.

Physicians will have four reporting options in 2017: test the QPP, participate for part of the calendar year, participate for the full year, or participate in an Advanced APM. Physicians who choose to test the QPP may submit some data to the QPP after January 1 and will avoid a negative payment adjustment under the QPP. Surgeons who participate for a portion of 2017 may submit QPP information for a reduced number of days and qualify for a nominal positive payment adjustment. Health care professionals who opt to participate for the entirety of 2017 would need to submit all relevant information regarding quality measures, how their practice uses technology, and the activities their practices are conducting to improve patient care. These participants may qualify for a modest positive payment adjustment.

Finally, physicians may participate in an Advanced APM. This option, however, is the least viable for surgeons at present because only two bundles are applicable to surgery—cardiac care and joint replacement. Nonetheless, the College anticipates that physicians eventually will face greater pressures to move into Advanced APMs. Therefore, we are engaged in ongoing efforts with Brandeis University, Waltham, MA, and Bringham and Women’s Hospital, Boston, to develop surgery-specific APMs.

For more information about the QPP and what you can do to prepare for success under this new payment system, check out the series of four educational videos the ACS has created on the QPP—Navigating the Quality Payment Program; What Is MIPS?; What Can You Do Now to Prepare for MIPS?; and CMS Allows You to Pick Your Pace. These videos were unveiled at Clinical Congress 2016 and are now available on the ACS website at facs.org/QPP, along with other resources.

I truly believe that surgeons will do well under MIPS as it moves payment incentives away from volume and toward a focus on value. The ACS has led the charge toward patient-centered, evidence-based care for more than 100 years. Our members are as ready as anyone to meet this latest challenge.

If you have comments or suggestions about this or other issues, please send them to Dr. Hoyt at lookingforward@facs.org.
Orlando Regional Medical Center responds to Pulse nightclub shooting

by Michael L. Cheatham, MD, FACS; Chadwick P. Smith, MD, FACS; Joseph A. Ibrahim, MD, FACS; William S. Havron, MD, FACS; Matthew W. Lube, MD, FACS; Marc S. Levy, MD, FACS; and Susan K. Ono, BSN, RN
At 1:57 am on Sunday, June 12, the deadliest mass shooting in U.S. history erupted at the Pulse nightclub in Orlando, FL. It was a Latin night-themed dance party, and more than 300 people packed the club, most dancing in a large room. A lone gunman, armed with a .233 caliber Sig Sauer AR-15-style military assault rifle and a 9 mm semiautomatic Glock 17 pistol, entered the club and began firing into the crowd.* During a five-minute period, the gunman moved from room to room, repeatedly shooting victims, reloading his weapons, and ultimately firing more than 250 rounds of ammunition.

At 2:07 am, police officers entered the club and engaged the gunman, forcing him to retreat to restrooms at the rear of the club. This allowed law enforcement to evacuate victims to emergency medical services (EMS) personnel waiting outside. The incident quickly turned into a hostage situation with the gunman barricaded in the restroom area and threatening to attach bombs to the remaining hostages. As law enforcement continued to negotiate with the gunman over the ensuing two-and-a-half hours, additional victims were evacuated from the facility. After negotiation efforts broke down, SWAT teams made the decision to rescue the hostages and stormed the club at 5:02 am. They exchanged gunfire with the shooter, who died on the scene.

Orlando Regional Medical Center
The victims were taken to Orlando Regional Medical Center (ORMC)—the only Level I trauma center in central Florida. “It was the best day of my career; it was the worst day of my career,” is how one surgeon who was on call at ORMC describes that morning. As trauma surgeons, we drill and prepare to handle the worst that humanity or Mother Nature can produce, yet hope that such events will never happen. When they do, the lives of all involved—patients, family members, physicians, nurses, and other allied health care workers—are changed forever.

ORMC is an 808-bed tertiary hospital located three blocks north of the Pulse nightclub. Arnold Palmer Hospital (APH), the regional pediatric hospital and part of the Level I trauma center,

and Winnie Palmer Hospital for Women and Babies (WPH) are located on the same campus. Together, ORMC and APH admit approximately 5,000 trauma patients annually. ORMC is staffed around the clock by an in-house attending trauma surgeon/surgical intensivist, as well as four general surgery residents. ORMC and APH each have one operating room (OR) open throughout the night. A busy academic teaching hospital, ORMC supports a variety of training and fellowship programs, including general surgery, orthopaedic surgery, emergency medicine, internal medicine, pediatrics, obstetrics and gynecology, surgical critical care, medical critical care, colon and rectal surgery, and acute care surgery.

For the last 20 years, ORMC has continuously developed and refined its mass casualty intake plan largely due to central Florida’s propensity for hurricanes and tornadoes, as well as the city’s status as an international tourist destination. ORMC holds monthly “trauma alert” training drills with local EMS agencies, and three months before the Pulse mass shooting, the facility participated in a tri-county active shooter scenario mass casualty intake drill. Most of the trauma patients to whom ORMC health care professionals provide care have been involved in motor vehicle crashes or falls, although it is not uncommon for the ORMC trauma team to admit anywhere from four to six gunshot victims per night. Data from our American College of Surgeons Trauma Quality Improvement Program (ACS TQIP®) registry demonstrates a penetrating trauma rate of 10 percent to 15 percent.

**ORMC’s response**

At approximately 2:00 am, the Orlando Fire Department notified the ORMC operator that an active shooter situation was occurring in the vicinity of the hospital. An estimated 10 minutes later, the first victim arrived in the ORMC emergency department (ED) with a gunshot wound to the abdomen, followed by three patients with gunshot wounds to the chest. Chadwick P. Smith, MD, FACS, a coauthor of this article, was the attending trauma surgeon on call. Dr. Smith rushed to the trauma bay, arriving as the second victim was rolled into the room. Dr. Smith was assisted by four on-call general surgery residents: Joshua Corsa, MD; Aura Fuentes, MD; Nicholas Sakis, MD; and Shalini Golla, MD. EMS officials notified the hospital that a mass casualty incident with up to 20 victims had occurred. The ORMC ED was immediately placed on lockdown due to the active shooter situation a few blocks away.

At around 2:20 am, while directing the ongoing resuscitation of multiple victims, Dr. Smith started to become aware of the magnitude of the mass casualty intake event, and he summoned additional trauma surgeons, Joseph A. Ibrahim, MD, FACS, and Michael L. Cheatham, MD, FACS (co-authors of this article), to the trauma bay. Patients began arriving at ORMC at a rate of approximately one per minute, initially brought in by foot, private vehicle, police car or van, and subsequently by ambulance. As the number of victims steadily increased, Dr. Smith called trauma surgeons Matthew W. Lube, MD, FACS, and William S. Havron III, MD, FACS (co-authors of this article), to
the hospital and requested the assistance of additional general surgery residents. Having received the initial mass casualty intake page, article coauthor Marc S. Levy, MD, FACS, the APH pediatric trauma surgeon on call, offered his assistance. All five surgeons rapidly drove to the trauma center, although their arrival at ORMC was hampered by the police blockade of surrounding streets given the proximity of and ongoing gunfire at the nightclub.

Many of the initial victims arrived in extremis with limited or absent vital signs. Three of the initial six patients required immediate resuscitative thoracotomies to treat their traumatic injuries and hemorrhagic shock. These thoracotomies immediately revealed the devastating impact of the high-velocity rounds. Ongoing resuscitation was unsuccessful and these patients rapidly succumbed to their injuries. Four more patients arrived with absent vital signs. Patients who died from their injuries were moved to the hallway outside the trauma resuscitation room to allow additional victims to receive care. A total of nine patients succumbed to their injuries soon after arrival at the trauma center. The first wave of patients consisted of 38 victims in 42 minutes.

Patients were triaged based on their acuity and injuries. Resuscitation was implemented in accordance with Advanced Trauma Life Support® (ATLS®) principles. Physical examination, plain radiographs, and bedside ultrasound were used to assess patient injuries. Computed tomography scans were rarely used in the initial patient evaluations given the large number of victims.

As additional trauma surgeons arrived around 2:40 am, critically injured patients were taken immediately to the OR. Sandeep Mukerjee, MD, the anesthesiologist on call, rapidly expanded OR capacity by summoning the on-call team, as well as bringing APH and WPH OR staff to ORMC. As a result, four ORs were open within 60 minutes and six rooms within 120 minutes of the first patient’s arrival. The operating trauma surgeons remained in their ORs as new patients were brought in from the ED. Orthopaedic and vascular surgeons, including Joshua Langford, MD, FACS, and Shonak Patel, MD, FACS, participated in the initial operative response as necessary, based on the patients’ injuries.

The hospital’s mass casualty intake page resulted in a rapid influx of additional physicians, nurses, and allied health care personnel to help care for the large number of victims. The hospital worked with law enforcement to arrange clear avenues of entry to the campus from the north, avoiding the ongoing active shooter situation to the south.

After assisting in the initial surgical response, Dr. Cheatham joined hospital administrators to activate the hospital’s incident command system. This command post was responsible for fulfilling all logistical needs related to the mass casualty intake, as well as working to facilitate normal hospital operations. Arriving staff were staged in the hospital and deployed to the appropriate areas as the need arose. The incident command center remained continuously staffed for the first 36 hours following the mass casualty intake event.
At around 3:25 am, as victims were actively evaluated and resuscitated, a report was issued indicating that gunfire had been heard in the ED lobby. The hospital’s “code silver” active shooter plan was implemented. Heavily armed police officers and sheriff’s deputies immediately began clearing the ED of any possible threats. Staff closed doors and remained in place while continuing to provide patient care. Portable X-ray machines were used to barricade the trauma resuscitation room doors and prevent entry. Initial reports were that one of the victims had been a second shooter at the club. This allegation was subsequently determined to be false. After 45 minutes, the code silver alert was lifted. Of note, many of the physicians and nurses continued to move from room to room of the ED during this time, caring for patients despite the risk of personal injury.

As additional surgical residents and fellows arrived, patients requiring hospitalization were transferred from the various intensive care units (ICUs) and step-down units to inpatient units as appropriate to increase critical care bed capacity. To accommodate arriving victims, patients requiring nonoperative intervention were rapidly moved from the ED to the ICUs and hospital floors where their evaluation and resuscitation continued. Two attending medical intensivists, Charles Hunley, MD, and Jeffrey Sadowsky, MD, and a surgical critical care fellow, Anthony Gielow, DO, supervised the ongoing management of patients in the ICUs while the trauma surgeons/surgical intensivists were in the OR.

All victims not held hostage in the nightclub had been evacuated to the trauma center by 4:00 am. The frenetic activity of the preceding 1.5 hours gave way to a period of relative calm. After the rapid influx of 38 victims, this lull allowed the ORMC trauma team to evaluate the initial wave of victims and systematically review their injuries and disposition. Patients were reevaluated and triaged to determine who would go to the OR next. This break in activity also allowed the hospital staff to restock the ED with supplies from prepared disaster supply carts, as the large number of chest gunshot wounds had exhausted the ED’s supply of chest tubes and water seal chambers.

At approximately 5:02 am as SWAT teams breached the wall of the nightclub to rescue the remaining hostages. Soon after, a second wave of 10 victims arrived, including a SWAT team member who had been shot in the head. His Kevlar helmet was fractured on impact, but he

Aerial view demonstrating the location of the Pulse night club (lower left) in relation to the Orlando Health campus (upper right). The proximity of the club facilitated rapid transport of victims to the Level I trauma center at ORMC.
sustained no intracranial injuries. Triage, evaluation, and resuscitation of the second wave of patients began. Police officers warned that numerous victims were still in the nightclub and that we should expect a third wave of victims. These remaining 40 victims, one-third with gunshot wounds to the head and some with up to 10 injuries, were subsequently found to have succumbed to their injuries, and the “third wave” never materialized.†

At 7:30 am the trauma surgeons who were not still operating met with the general surgery residents in the ED. Using a master list of victims that Dr. Smith had maintained throughout the morning, each patient’s injuries, laboratory data, and radiologic studies were carefully reviewed and a tertiary survey performed to ensure that all injuries had been noted and addressed.

The large number of victims brought to area hospitals and the number of deceased victims still within the club resulted in an unprecedented influx of concerned families. A family assistance area was established and staffed by hospital personnel. Regular updates were provided to families whenever possible. Families were provided with an e-mail address to send photographs and other details to assist in the identification of the victims. More than 300 e-mails were received from family and friends attempting to locate their loved ones. All but one of the victims who received care at ORMC was identified by that afternoon.

**Evaluating the response**

Of the 107 victims of this mass shooting, 49 were killed and 58 were wounded. ORMC received 49 victims plus the SWAT team member; nine succumbed to their injuries soon after arrival. Another 17 victims, some of whom initially fled the scene of the attack, presented to other local hospitals by EMS or private vehicle. A total of 40 victims died in the club.

The proximity of the nightclub to ORMC was certainly of benefit to the victims. While the first law enforcement officers on the scene were engaging the shooter, others extricated victims from the club to a casualty collection point across the street. Law enforcement vehicles and the initially responding ambulances began immediately transporting victims the short distance to ORMC, frequently carrying more than one patient per trip, and immediately returning to the scene after offloading. One-third of the victims were quickly transported to the trauma center by law enforcement using pickup trucks and patrol cars. This rapid transfer

A significant part of the challenge posed by this mass casualty intake event was timing. The event occurred in the early morning on Sunday when staffing and capacity were at lower levels. By rapidly combining the resources of ORMC, APH, and WPH, we were able to effectively meet the needs of the victims. Of patients to a Level I trauma center only three blocks away greatly facilitated early cessation of hemorrhage and rapid resuscitation. With the exception of the nine victims who arrived with either absent or limited vital signs, none of the remaining 40 victims succumbed to their injuries. Some of these victims would undoubtedly have died had it not been for their rapid transport to the trauma center.

A significant part of the challenge posed by this mass casualty intake event was timing. The event occurred in the early morning on Sunday when staffing and capacity were at lower levels. By rapidly combining the resources of ORMC, APH, and WPH, we were able to effectively meet the needs of the victims. We briefly considered distributing patients among the three facilities but were concerned that this option would divide our manpower and resources, weakening our response.

Instead, we chose to bring the care providers and supplies to the patients, preserving their “golden hour.” Transferring patients to other hospitals 15 to 30 minutes away also was an option, but the victims were already in a Level I trauma center that had the capacity to meet their health care needs. It is notable that through effective triaging of existing inpatients, we still had available critical care beds and operative capacity had the “third wave” of victims materialized. Given the multiple gunshot wounds and traumatic brain injuries they sustained, however, these potential 40 patients would most certainly have been of very high acuity. By 9:30 am, the ORMC Level I trauma center reopened.

Within the first 24 hours following the Pulse tragedy, our surgeons and OR team performed 29 operations on the victims. On the day after the event, two ORs were made available solely to facilitate the ongoing exploration and repair of these patients’ injuries. By the end of the first week subsequent to the event, 54 surgical procedures had been performed.

Because of the large number of gunshot wounds and the nature of the event, many victims reported being exposed to the blood of other victims. After consultation with the Centers for Disease Control and Prevention and the Orange County Health Department, all patients were offered baseline testing for hepatitis B, hepatitis C, and the human immunodeficiency virus (HIV). Patients without a history of previous vaccination to hepatitis B were started on a vaccination program. Post-exposure prophylaxis against hepatitis C and HIV was not recommended. Local television and newspapers publicized these same recommendations to ensure that all individuals who had been inside the club during the mass casualty intake were aware of how to take care of themselves.

Disaster plan enhancements
It has long been recognized that adversity can bring out the best in people. Many of the 33 surgical residents and fellows in our program immediately responded to this tragic situation and worked tirelessly over the subsequent 36 hours to care for the victims. Our team members commonly provided care on patient units and in ORs with which they were unfamiliar, frequently crossing job descriptions in doing so. Further, we were inundated with offers of assistance from surgeons from our own facility, as well as other area hospitals and even other states. By the time these offers had been

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received, however, the immediate surgical needs of most victims had been addressed.

Through this mass casualty intake event, we identified two shortcomings in our disaster plan, which had been honed through years of drills as well as our response to three major hurricanes. First, our plan for family communication and support was designed to meet the needs of our own patient families. We had not planned to be the primary source of support and communication for the families of all victims in the community. Because the identities of the deceased victims were not made public for more than 24 hours, family members were frequently referred to ORMC for support and information. As a result, we had to expand our family assistance plan in real time to accommodate the hundreds of family and friends who came to ORMC and provide them with additional staff, food, water, chaplains, counselors, cellphone chargers, and conference rooms.

Second, our disaster plan did not anticipate the post-event counseling needs of hospital staff in the aftermath of an event of this magnitude. The sheer volume of victims, the catastrophic nature of their injuries, and the belief that an active shooter situation was occurring within the hospital perimeter all placed a significant psychological burden on our team members. We began both individual and group counseling sessions within hours of the event. More than 1,500 of our team members participated in these sessions over the first 10 days following the Pulse tragedy. We continue to see the impact of this event on our team members and greatly appreciate the tremendous outpouring of support that we have received from trauma centers and hospitals around the world.

It has been said that one can never fully anticipate the impact of a mass casualty intake such as the Pulse nightclub shooting. We strongly suspect that the outcome of this event would have been significantly different were it not for the countless hours of training and frequent disaster drills that our hospital has completed over the past two decades. Each of those drills helped to prepare our institution for the events of June 12. Ultimately, however, it was the dedication and hard work of each team member that allowed 40 victims to return home to their families. ♦
You are the surgeon on call and receive a request for consult from the emergency department (ED). A 93-year-old woman with Alzheimer’s dementia is presenting from a nursing home with two days of progressively worsening left lower quadrant pain, now diffusely peritonitic on exam. Her past medical history includes congestive heart failure with an ejection fraction of 20 percent following a myocardial infarction three months ago, as well as chronic obstructive pulmonary disease treated with at-home oxygen. A computed tomography scan reveals grossly perforated sigmoid diverticulitis with free intra-peritoneal air. The patient’s granddaughter, who is her health care proxy, arrives in the ED just as you do.

How do you approach the conversation with the granddaughter? Do you offer her a choice between an attempted sigmoid resection and comfort care, or do you simply express your condolences, discuss the value of palliative care, and admit the patient for pain control and comfort measures? Many surgeons likely would feel pressure to offer the option of surgery despite the patient’s grave prognosis.

Patient-centered care
The National Academies of Sciences, Engineering, and Medicine (previously the Institute of Medicine) defines patient-centered care as “providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions.” Arguably unreasonable treatment plans are now often enacted when requested by the patient.
Part of the “human condition” can be considered the natural inclination to survive. On an instinctual level, death is never the right answer, and humans want to play the odds, even when unfavorable.

in the name of “patient-centered care.” In fact, these kinds of decisions and plans can be considered “patient-driven care.” They infringe upon the autonomy of physicians who must actively participate in medical decision making, functioning as clinical and moral agents—not simply “hired hands.” Thus, a sophisticated notion of patient-centered care should reflect the importance of a patient’s wishes and respect his or her agency, while simultaneously remaining rooted in scientific evidence and supported by the physician’s experience and expertise.

A 2014 article by Martin and colleagues illustrates the reliance on patient-driven care despite the knowledge that it often leads to an inadvisable course of action. In a survey of 375 members of the Eastern Association for the Surgery of Trauma, 92 percent of whom were physicians, 65.5 percent of the respondents reported relying on the wishes of family members most or all of the time in making end-of-life decisions; however, 79.9 percent reported a belief that families are rarely or only sometimes in an appropriate state to aid with these decisions. These results suggest discordance between medical opinion and patient or surrogate preferences. How do we close this gap?

The human condition

Patients and their families require expert guidance in high-stakes surgical decision making due to a lack of medical knowledge and because the human condition can obscure rational thinking. Part of the “human condition” can be considered the natural inclination to survive. On an instinctual level, death is never the answer, and humans want to play the odds, even when unfavorable. This basic innate response often inhibits families from making logical end-of-life decisions; even when faced with certain mortality, survival with significant pain and suffering is often still considered better than death. This decision-making process is amplified when a proxy decision maker is involved, in part because, in many cases, that proxy has nothing to lose in choosing aggressive care.

The fallacious belief that one can “beat the odds” has been described through the “prospect theory” of psychologist and Nobel Prize-winner Daniel Kahneman, PhD. Originally applied to economics, prospect theory can be applied to difficult choices in surgery. Although humans tend to be risk-averse when presented with a situation that involves sure gains (that is, most would rather take a sure $900 than a 90 percent chance of $1,000), they tend to be risk-seeking when presented with a situation that involves sure loss (that is, most would rather take a 90 percent chance of losing $1,000 than a sure loss of $900). A related principle, the principle of diminishing sensitivity, further explains human nature. In this theory, the same incremental loss is viewed as smaller when the overall scale is larger (that is, the difference between $900 and $1,000 seems smaller than the difference between $100 and $200).

Both of these principles may be applied to surgical decision making. The human tendency to be risk-seeking is illustrated by the choice to pursue surgery with a 95 percent chance of painful death instead of selecting comfort care with a 100 percent chance of a comfortable death. The principle of diminishing sensitivity further reinforces the bias; when both outcomes involve death, it is difficult to appreciate the true value of added pain.

Another factor that influences patients and surrogates is a common societal perception that one must do everything, up to and including the most aggressive treatments, to save a patient even when the steps are of questionable benefit. Unfortunately, this expectation has become a cultural norm that colors many Americans’ interpretation of what it means to do the right thing. However, when a patient approaches the point at which aggressive treatments cause more suffering than benefit, they may no longer be in the interest of every patient.

A 2015 study regarding patient perspectives of surgical decision making addressed the issue of surgery versus palliative care. Elderly patients were convened in focus groups, presented with a case of surgical futility (a tender thoracoabdominal aneurysm in a 79-year-old woman with multiple comorbidities), and asked
to discuss their own hypothetical decision-making process. The group choosing surgery expressed a perceived imperative to choose life. They cited reasons including leaving their fate up to God and the guilt they would feel toward their families if they were to choose death. They felt the need to choose surgery to demonstrate a will to live.

An erroneous belief in the omnipotence of medicine is another potential hazard in patient decision making. In the 2015 study, some members of a panel of 37 elderly patients “struggled to believe that medical technology had nothing else to offer.” Furthermore, they believed that if they were to die, they would die in the operating room, which they thought would be a quick and painless death, despite being told that a scenario involving a prolonged intensive care unit death was more likely. An understanding of basic human tendencies should motivate physicians to carefully reflect before offering patients potentially futile options. A surgeon may feel that, for the sake of transparency, the patient or family should be informed of less advisable options; however, desperate families and patients rarely appreciate nuance and caveats. The therapeutic misconception permeates both clinical and research contexts. How can a treatment be futile if a physician is offering it? Being realistic and understanding the human condition, a surgeon cannot blame patients for choosing such options. Rather than depending on the patient and family to make difficult decisions, surgeons should accept more responsibility for defining futility and be more conservative in offering high-risk/low-benefit procedures.

**Defining surgical futility**

Two criteria should be used to define futility: first, the clinician must define a successful outcome; second, he or she must determine the level of certainty that the outcome will occur. A successful outcome is one that provides a clinical benefit and must align with the patient’s self-defined goals of care. It cannot be stressed enough that the goals of care are determined largely by the patient. Some medical ethicists have proposed a physiologic definition of futility, such as an inability to keep a heart beating or maintain blood pressure. However, such reductionist approaches ignore the broader goal of medicine. Procedures that ultimately will not improve the patient’s well-being—as defined by the patients and their families—are futile. Treatments should only be considered non-futile if they have the potential to either improve quality of life or prolong life.

The more difficult part of defining futility is determining how certain a clinician should be that a treatment will achieve one of these goals. It is impossible to make such estimations an exact science, but we propose that clinicians start with a reasonable threshold in mind and adjust it according to the situation. For example, if a treatment is estimated to be successful less than 5 percent of the time, perhaps it should be considered futile. This threshold is admittedly arbitrary but can serve as a starting point. Because every case is different, surgeons should consider the impact of the particular circumstances. For example, it may be more reasonable to provide an operation with only a 2 percent to 3 percent success rate to a 17-year-old healthy male than to provide an operation with a 10 percent success rate to an 86-year-old male with a cardiac history and a previous stroke. Health care professionals should use realistic criteria to make rational decisions, keeping in mind that such statistics are likely to elicit inappropriate optimism in patients and families.

Surgical diseases have an additional consequence—namely that operations have a significant risk of additional pain, disability, and suffering for the patient. Thus, an important factor to consider in determining futility should be the possibility of doing harm. A high probability of inflicting significant pain and suffering with a poor chance of a successful outcome should render a procedure futile.

**Recommendations**

Physicians must assess futility from the medical standpoint before engaging patients. Part of this assessment requires patient insight and input—specifically, the
It should be noted, though, that physicians are subject to a “condition” of their own. Surgeons, in particular, are apt to focus primarily on a “cure” from the technical standpoint, rather than taking a step back and looking at the big picture. patient’s definition of a successful outcome. However, assessing potential harm and interpreting the likelihood of a successful outcome should be performed by the skilled physician and not the untrained patient or proxy. A definition of mutual decision making should be just that—mutual. Patients often appreciate appropriate guidance from the physician.

It should be noted, however, that physicians are subject to a “condition” of their own. Surgeons, in particular, are apt to focus primarily on a “cure” from the technical standpoint, rather than taking a step back and looking at the big picture. As such, a shift in training and practice for many surgeons is necessary. More specifically, surgeons should be educated about the goals and ideals of palliative care medicine and encouraged to use these services more often.

Physician and surgeon incentives, financial and otherwise, also must change. In a case such as the one described at the beginning of this article—a 93-year-old woman with Alzheimer’s dementia and a medical history that includes congestive heart failure—the surgeon is less apt to provide nonoperative treatment. Although he or she will spend the same amount of time on the operation as it would to take to meet and discuss care planning with the family, the latter activity would only pay a fraction of the potential procedural fee.

Nonoperative planning also requires skilled communication with a humanistic approach. Many surgeons lack adequate training in how to discuss this form of patient care. Thus, surgeons will need to develop a new skill set so that discomfort does not prevent them from participating in appropriate palliative care conversations. These conversations should be patient-centered but not patient-driven. They should be time-sensitive, but not rushed—particularly since research suggests increased communication leads to greater patient satisfaction and a decrease in futile treatments.10,11

In the words of Hippocrates, the physician is sometimes mandated to “refuse to treat those who are overmastered by their disease, realizing that in such cases medicine is powerless.”12 In these cases, we hope that surgeons will resist offering futile options and focus more on compassionately guiding patients and their families through the difficult process of end-of-life care. ♦

REFERENCES


Boston Marathon survivors find treatment, care, and solidarity among veterans

by Jeannie Glickson

Above: Mr. Downes and Ms. Kensky (pictured with their service dog, Rescue) threw out the first pitch at a Boston Red Sox game last summer
Captain Butler and Jessica arranged to talk via Skype. To her surprise, they spoke openly for three hours. She learned not only that they shared many of the same anxieties, but also that someone who lost both legs was able to lead a full, purposeful life.
eventually gained access to the military health care system. On their initial visit to Walter Reed, they were awestruck by the America Building, which houses the Military Advanced Training Center (MATC)—a state-of-the-art facility with a team of physical and occupational therapists who follow service members from their initial evaluations through their discharge. MATC technicians fit and adjust prosthetic devices on site. Cameras and interactive screens are available with special treadmills.

American College of Surgeons (ACS) Executive Director David B. Hoyt, MD, FACS, wrote about MATC in his “Looking forward” column in the March 2014 issue of the Bulletin.* The facility impressed him as the most “patient-centered, accessible, high-quality care available within the military health system.” The MATC’s goal is to help patients move from injury or illness to functional, independent recovery and reintegration through rehabilitation. The on-site prosthetic service, he pointed out, uses three-dimensional printers to produce titanium prosthetic and orthotic components. Once fitted with the device, occupational therapists work to ensure that the patient is able to use the apparatus properly and independently.

For the last two years, Mr. Downes and Ms. Kensky have resided at the Naval Support Activity Bethesda naval base, where they continue to receive comprehensive care from clinicians with experience in treating complex blast-related injuries. At the Navy base, the two patients have access to an integrated system of comprehensive care from specialists of several disciplines, including surgery, rehabilitation, therapy, pain management, prosthetics, and behavioral health. They have benefited not only from the support of the most astute surgical minds focused on blast injuries, but also from the camaraderie with other patients who have injuries similar to their own.

“The kinship we feel with active duty patients as a result of our experience here is eternal,” Mr. Downes said. “Before this happened to us, we had an appreciation for those who served our country, but we tended to have those thoughts as clichés. Now it’s very real for us. We’ve formed such important bonds of friendship here with members of several not-for-profit organizations.”

Their common experiences have forged a lasting friendship between Captain Butler and his wife Laura and Ms. Kensky and Mr. Downes. “I always joke that in another life, we would not have crossed paths, and now we talk to each other every week,” Captain Butler said. All four of them continue to work in support of several not-for-profit groups that serve military veterans and disabled citizens, including Achilles International, which enables people with all types of disabilities to participate in mainstream running events; the Semper Fi Fund, which provides financial assistance to wounded Marines and their families during recovery; and the Vail Veterans Program, which sponsors outdoor recreational programs for individuals injured in the military and their families.

**Day of the bombing**

Mr. Downes’ and Ms. Kensky’s lives were, indeed, very different before April 15, 2013. There was no hint of impending tragedy that spring day of the famed Boston Marathon. The young couple, who had been married a little more than seven months, walked hand-in-hand enjoying the sunny Patriots’ Day celebration, a state holiday and a rite of spring in Boston. The couple was planning a move to San Francisco, CA, where Mr. Downes would begin a doctoral internship in clinical psychology. Although

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both were runners, they were enjoying this event as spectators. They stopped at the finish line to cheer on the runners completing the 26.2 mile course.

Two bombs, which contained BB-like pellets and nails that exploded 12 seconds apart near the finish line on Boylston Street, abruptly changed their lives. According to the U.S. Federal Bureau of Investigation, the bombs exploded from pressure cookers hidden inside backpacks. The blasts killed three spectators and left an estimated 264 injured, with 17 people, including Ms. Kensky and Mr. Downes, requiring traumatic amputations.

Mr. Downes has no recollection of the blasts. “I was in and out of consciousness. I have snapshots of what happened that day, but everything I know is from Jess retelling it,” he said. Mr. Downes and his wife, an oncology nurse at Massachusetts General Hospital, Boston, each sustained grievous injuries that, in both cases, resulted in the amputation of their left leg below the knee. They suffered a number of other serious but less visible injuries, including ruptured eardrums, shrapnel wounds, impaired vision, depression, anxiety, mild traumatic brain injury, and post-traumatic stress disorder.

In the chaos that followed the blasts, the two were transported to different hospitals. An ambulance carried Mr. Downes to Beth Israel Deaconess Medical Center. Ms. Kensky went to Boston Medical Center for her injuries, and for one day, neither patient knew the condition of the other. “Jess and I first saw each other two weeks after the bombing,” he said. “Her team transported her to see me at Beth Israel.”

Recovery
Mr. Downes’ injuries were less extensive than his wife’s, and he has recovered more quickly. He is able to move around with a prosthetic leg. Ms. Kensky’s right leg, however, sustained considerable damage. “Her Achilles heel was blown off, and her foot was missing so many essential pieces,” her husband explained. Walking was excruciating. Her right ankle was so out of alignment that with each step, she splintered cartilage and bone. In addition, a painful knot of bone at the end of her amputated left leg—a heterotopic ossification—made wearing the prosthetic almost unbearable. This excess bone growth in soft tissue is common among Iraq and Afghanistan war amputees. Two years after the bombing, Ms. Kensky, who her husband said has endured “so many operations we’ve lost count,” had her right leg amputated below the knee.

Both Mr. Downes and Ms. Kensky wish they had a timetable that would allow them to map out their recovery, but they have been forced to be patient. “We wish we knew that it will take X number of days, and then we can move to the next step, but the body has its own time frame,” Mr. Downes said.

The couple will always feel profoundly grateful to the Boston first responders and the medical personnel who took care of them immediately after the bombing. “Boston is the mecca of medicine,” Mr. Downes said. “The doctors and nurses were incredibly helpful. They took care of us. They took care of our families. They ran errands for our families. We remain very close to the Boston clinicians.”

The young couple has stayed in close contact with other Boston bombing victims who underwent amputations. “The feeling that we all have, I think, can only be understood by those who have experienced it,” Mr. Downes said. “We get to see them whenever we go home to Boston. We will forever share a bond with them.”

Likewise, they will always be grateful to the clinicians and veterans who continue to provide their support at Walter Reed. “We feel so blessed that here at Walter Reed, we are accepted and understood,” Mr. Downes said.
Running the marathon

In the spring of 2015, Mr. Downes put on his running shoes again and began to train. In April 2016, wearing a running blade, he ran the Boston marathon alongside friends and family members. As he passed through the neighborhoods of his hometown, he ran with the initials on his chest of the three bystanders killed in the 2013 blast and the Massachusetts Institute of Technology police officer murdered by the bombers a few days later. As the runner passed Boston College (BC), his alma mater, he heard cheers and saw BC supporters holding up signs of the team’s mascot, the Eagles. He ran on behalf of a generous scholarship endowment, Boston College Strong, created by the Class of 2005, to honor the young couple. The perpetual fund will provide scholarships to disabled students.

Mr. Downes and Ms. Kensky continue to advocate for a strengthened national trauma system that would merge care in the military and civilian populations and ultimately result in “zero preventable deaths.” This type of military-civilian collaboration is exactly what is being advocated in the newly released report from the National Academies of Sciences, Engineering and Medicine (NASEM), and sponsored in part by the ACS. The NASEM report, *A National Trauma Care System: Integrating Military-Civilian Trauma Systems to Achieve Zero Preventable Deaths after Injury*, seeks to enhance the care of civilian trauma patients while preserving the military trauma system during interwar periods. (For details, see the October 2016 *Bulletin*, pages 23–28.) Merging of the two systems also facilitates adoption of the advances made in Iraq and Afghanistan into civilian trauma care and serves to enhance research endeavors. The ACS Committee on Trauma and the ACS partnership with the Military Health System initiated in 2014 support these efforts."
ACS WiSC addresses ongoing challenges for women in surgery

by Christina Grassi, MD; Vikisha Fripp, MD, FACS; and Susan Pories, MD, FACS
Women have practiced medicine in the U.S. for more than 160 years. Nonetheless, they remain an underrepresented part of the surgical community. A recent call for medical student applicants to fill seats on the American College of Surgeons (ACS) Women in Surgery Committee (WiSC) has shed some light on why this situation persists. This article examines the ongoing challenges women in surgery face, reports the results of the WiSC medical student call for applicants, and offers insights into how to make surgery a more welcoming profession for women surgeons.

**Historical perspective**

Elizabeth Blackwell, MD, is recognized as the first woman physician in the U.S. She graduated with honors from Geneva Medical College in Upstate New York in 1849. It is not widely known that Dr. Blackwell’s ultimate goal was to become a surgeon. Unfortunately, Dr. Blackwell lost her left eye to infection, ending her dream of performing surgery. Nonetheless, she had a long and illustrious career.

Since Dr. Blackwell’s day, women have made considerable progress in realizing their aspirations in the medical professions. By 1934, 72 percent of U.S. medical schools opened their doors to women. By 1944, only 9 percent of medical schools continued to exclude women. Jefferson Medical College, Philadelphia, PA, was the last school to admit women, starting in 1960. Since then, the number of women in medicine has grown exponentially. In fact, the number of women in medical school now is equivalent to men. According to data from the Association of American Medical Colleges, 21 percent of full professors are women, 15 percent of department chairs are women, and 16 percent of deans are women.

Mary Edwards Walker, MD, is credited as being the first woman surgeon in the U.S, graduating from Syracuse Medical College, NY, in 1855 (see related story, page 60). Overall, surgery has been less welcoming to women than other specialties. As recently as 1980, only 2 percent of women medical students chose surgery as a specialty. Although these numbers have improved and increasing numbers of surgery residents are now women, the number of women in surgical leadership positions continues to lag far behind men. Only 21.3 percent of all surgeons in the U.S. are women, less than 10 percent of full professors of surgery are women, and 5.7 percent of surgical chairs are women.

**WiSC call for applicants**

The mission of the ACS WiSC is to enable women surgeons of all ages, specialities, and practice types to develop their individual potential as professionals; promote an environment that fosters inclusion, respect, and success; develop, encourage, and advance women surgeons as leaders; and provide a forum and networking opportunities to enhance women’s surgical career satisfaction. WiSC includes members from a variety of specialties, medical students, and representatives from the ACS Board of Governors, the Resident and Associate Society of the ACS, and the Association of Women Surgeons (AWS).

Traditionally, one or two medical students a year were invited to join the committee, based on recommendations of committee members. However,
in 2015, the WiSC Structure and Mission Subcommittee recommended a new and more transparent method of recruitment for all committee members, including medical students. As such, a call was sent out via the ACS and AWS e-newsletters inviting interested medical students to apply for the one open seat. A total of 55 medical students applied for this single vacancy.

Each interested student wrote a short essay describing her interest in the committee’s mission and activities. Notably, many of the essays commented on the fact that women medical students are still discouraged from pursuing a surgical career. Perspectives expressed by these student applicants described the ongoing challenges a woman faces when demonstrating interest in the surgical specialties. The applicants were from the U.S., including 29 states and the District of Columbia, and Canada.

The experiences described in the medical student essays were telling. One student wrote that at a specialty panel organized by her medical school, “The male surgeons were asked for the secrets of creating financially successful practices, while the female surgeons were asked only how long they chose to put off childbearing.” Another student commented, “On my surgery rotations, I could not help but notice the gender imbalance. This disparity was not only in numbers, but also in whose contributions were respected, valued, and seen as authoritative.... There is still a barrier to women in surgery, ultimately resulting in talent being lost to other specialties.... This barrier is entrenched in multiple ways—in traditions and biases.”

Another wrote, “Having completed two general surgery and two subspecialty rotations thus far, I have seen firsthand the disproportionate underrepresentation of women in this field.... I have witnessed many talented young women choose not to follow their passion for surgery.”

Several other applicants expressed discouragement, noting a continuous thread of “naysayers who doubted, warned against, and questioned my ability to succeed in the field of surgery as a woman.” Almost all students were told how difficult it would be to be a surgeon, as well as a wife and mother. One wrote, “Since declaring my interest in surgery as a female medical student, people began warning me about how hard life would be, how difficult it would be to have a family. I can assure you that my male colleagues have not been subject to the same warnings, at least not with the same ardor.” Another applicant noted that she was told she could not have a successful surgical career given that she was a single mother.

Some applicants reported blunt skepticism, with comments ranging from, “You can’t do surgery—you are too nice,” to “You want a family. You want to be there for your kids. Do you really think you can do that when you are in the operating room all day?” One student wrote that she received plenty of unsolicited feedback about why she should reconsider her choice. She described one attending who spent nearly an hour trying to convince her to pursue another specialty because the female surgeons he knew were “miserable.” Another student noted that as a third-year medical student she didn’t have a single female preceptor during her surgery rotation. She noted that many residents and medical students lack female role models who can serve as mentors. Another wrote that throughout her core clinical year, the fact that she was a female was always brought up in some way when she would address her aspiration of pursuing surgery.

Another student noted that the reply when she said she wanted to be a surgeon was often, “Are you sure? You know that you are not going to have a life.” This applicant revealed that her brother, also an aspiring surgeon, was never asked these questions. “As my seriousness to pursue surgery became apparent the replies changed from questions to...statements such as: ‘You won’t be able to raise children. You won’t be happy,’” she wrote. Another student recounted an experience attending a surgery interest group meeting, which consisted of an all-male panel. She felt that every surgeon on the panel was intimidating and trying to scare off anyone with the slightest doubt about entering the field of surgery.
Barbara L. Bass, MD, FACS, chair, department of surgery, Houston Methodist Hospital, TX; ACS President-Elect; Past-Chair, ACS Board of Governors; and Past-Member, ACS Board of Regents, commented, “There was a time when there was serious doubt within the surgical community that women were capable of becoming surgeons—from technical concerns raised by one outspoken opponent to women in the surgical workforce, to simple common assumptions that women were not tough enough or committed enough to train in surgery or to engage in successful surgical careers. Surely the demands of ‘womanhood’—being a wife and mother—would undermine even the most committed person, not to mention weathering the bias of many surgeons who truly believed that being a surgeon was a privilege that should be reserved for men, who could be counted on to give it their all. These days, I think that…[those] who dissuade women from pursuing a surgical career are doing so based on a different set of assumptions and likely misconceptions. I do believe the vast majority of this [behavior] these days falls into the unconscious bias category.” (Personal communication with the authors, February 22, 2016.)

The power of mentorship
Some applicants offered positive comments about the power of mentorship from women role models. One student commented that one of her attendings, a surgical oncologist, led by example in the caring way she interacted with her patients and through her expertise in the operating room. “She spent time teaching me to tie knots late on a Friday night, while inviting discussion about the pros and cons of a career in surgery.” She also was appreciative of resident teaching. “One of my chief residents was a wife, mother of two daughters, and future transplant surgeon. She pushed me to make my presentations more concise, precise, and accurate. She taught me to suture...[and] I hope one day to emulate her as both a surgeon and a teacher,” she wrote. “There have been many more [mentors], including wonderful junior residents and fellows. Combined, the effect of these women as role models, mentors, and teachers is powerful.”

Another student wrote that while she learned something from every surgeon with whom she interacted, working with women surgeons—watching them scrub into cases she would one day lead—was empowering. One student highlighted the encouragement she received from women surgical residents. Another commented how much she valued working alongside exceedingly skilled, compassionate, confident women surgeons and that she hoped to emulate them professionally, as well as personally. As one student put it, “Mentoring and encouragement helped me feel great about choosing surgery as my career and be proud to be a female as well as a mother.”

Women are gradually achieving leadership roles in the surgical profession. However, there is clearly a long way to go, as the number of chairs, academic professors, and senior partners in private practices remains relatively small. The ACS has had two women Presidents in its more than 100-year history, and 10 women members of the Board of Regents.

Recommendations for further advancement
Female medical students comprise approximately 40 percent of the ACS student membership. Some surgical disciplines are particularly challenged, such as neurosurgery, orthopaedics, and plastics, with respect to women leaders. “Taking on these jobs does require a great deal of ambition and the support of one’s personal infrastructure—partner, family, spouse, and parents. And this is personal infrastructure—not infrastructure that one can count on as built into our professional environments,” Dr. Bass said. “Our society and culture still prioritizes the role of women in most responsibilities of home, and women embrace these roles, of course; it’s how we were raised and what we do—we want these roles as well as our lives as surgeons.”

With respect to starting a family and life outside of work, numerous advances have been made in the surgical profession. Many student applications
Another student wrote that while she learned something from every surgeon with whom she interacted, working with women surgeons—watching them scrub into cases she could lead one day—was empowering.

echoed that through mentorship, they have learned how many women surgeons have found individual solutions to accommodate irregular hours, on-call duties, and so on with pregnancy and child care. Those women surgeons with strong mentors have learned how to focus on making the most of their time away from work. “Personal health, entertainment, hobbies can all be accommodated into a busy career, and we are fortunate that our financial positions are quite healthy compared to many others. Do we need to defer some activities at times? Of course, but on balance I think I have seen more and more surgeons place appropriate and substantial effort into their activities outside of work—a very positive trend for women and men in the next generation of surgeons,” Dr. Bass noted.

Successfully encouraging women medical students to choose surgical careers may be achieved by the following:

• Continuing to foster an atmosphere in surgical training programs that is more accepting of the competing demands that trainees and attendings face with respect to balancing work and personal obligations regardless of gender

• Acknowledging that women face unique challenges but that creating a fulfilling harmony between work and personal life is a universal issue that is not gender-specific

• Fostering strong mentorship programs for women interested in surgery

As one student noted, “Without mentorship, I likely would not have had the inclination or desire to pursue a career in a surgical subspecialty.” To combat this feeling, Dr. Bass urges women to “hear the full story from multiple perspectives.”

Despite initial discouragement, all applicants shared a remarkable motivation and dedication to a surgical career as a calling. Our current task is to guarantee that women have equity in both opportunity and guidance as they shape their career choices.

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REFERENCES
RAS-ACS Symposium essays: Residents debate the boundaries of surgeon disclosure

by William H. Ward, MD

Each year, the Advocacy and Issues Committee of the Resident and Associate Society of the American College of Surgeons (RAS-ACS) hosts a symposium at the Clinical Congress that features a debate on timely and controversial issues relevant to surgical training and practice. Based on input from RAS-ACS members across the nation, this year’s topic was Exploring the Limits of Surgeon Disclosure: Where Are the Boundaries?

Over the last several decades, health care has undergone a seismic shift toward increasing transparency, disclosure, and an overall focus on patient-centered care. With this change in the physician-patient relationship and the clear rejection of surgical paternalism by society, patients, and physicians alike, the traditional boundaries between surgeon and patient have changed. Some patient advocates and physicians demand full disclosure of these formerly “personal” aspects of a surgeon’s practice, whereas others defer such disclosure to the individual surgeon’s judgment, guided by the principles of professionalism. Given the interest in this topic among patients, legislators, and the media, it is clear that if surgeons do not lead the discussion, third parties will ultimately decide the outcome of this debate.

Resident members of the RAS-ACS participated in this discussion by submitting essays about the challenges and opportunities associated with surgeon disclosure, and the winners of the essay competition were given the opportunity to participate in a live debate at the ACS Clinical Congress 2016 in Washington, DC. Following are the winning essays on this topic. ♦
Exploring the limits of surgeon disclosure: Where are the boundaries?

First-place essay—Pro

by Christopher F. McNicoll, MD, MPH, MS

A 68-year-old woman has just arrived in the preoperative area for her elective sigmoidectomy. Recently diagnosed with adenocarcinoma of the sigmoid colon, she is eager to complete her surgical resection and adjuvant chemotherapy and return to her daily activities of gardening and reading without worry. She has been anxious for weeks about her surgery, given that it will be her first major operation. Although you are a surgeon, you share her apprehension equally because this particular patient is your mother.

Because you are a well-respected surgeon, your mother asked you to review her records, attend her clinic visits, and accompany her to the hospital on the day of her surgery. When you picked her up from your childhood home early this morning, she was understandably nervous. You reassured her that she is in the capable hands of your esteemed surgical colleagues. The nurse and anesthesiologist complete their preoperative duties and checklists, and the operating room is staffed and prepared for the 7:30 am start. The surgical resident introduces himself, and mentions to you that the case will be delayed for 30 minutes. You inquire as to why, since everything seems to be ready. The resident informs you that the attending surgeon was on call overnight and is wrapping up the second emergent case of the evening. As you thank the resident for his assistance in your mother’s care, you privately wonder just how tired your surgical colleague is given the previous evening’s caseload.

Effects of sleep deprivation

Sleep deprivation is one of many variables that may limit a surgeon’s ability to provide optimal care. The profession has historically encouraged each surgeon to make their own determination about their capacity to operate, as advocated for in a 2010 letter to the editor written by College leaders and published in the New England Journal of Medicine. Whether the surgeon is incapable of performing the indicated surgery due to ill health, intoxication, unfamiliarity with the surgical technique, or any other reason, the patient should be informed. Respect for the patient’s autonomy, the edict primum non nocere, and the desire to improve the patient’s health implore the surgeon to disclose these personal limitations. The authors of the 2010 letter to the editor noted “…the root of the problem…is a lack of awareness about our human limitations,” though they did not believe mandatory disclosure to be the solution. However, without mandatory disclosure, the admirable professional traits of optimism, confidence, and determination...
will overwhelm the aspiration to fully complete the consent process via voluntary disclosure.

Yet, how easily can a surgeon deal with the repercussions of this disclosure? What options are available for the sleep-deprived surgeon scheduled to perform your mother’s sigmoidectomy? There is no standard, institutionalized process to deal with mandatory or voluntary disclosure of sleep deprivation. To improve outcomes, the surgical profession must recognize that sleep deprivation harms patient care, is an issue that affects informed consent, and requires systemic changes to accommodate the effects of mandatory disclosure.

Sleep deprivation affects surgeon performance as it affects all people—by impairing motor performance and cognitive performance.2 Drivers who slept less than six hours the previous night were 10 times more likely to be involved in a vehicle crash.3 The performance of fighter pilots, who are trained extensively to execute tasks reflexively, suffers from sleep deprivation.4 Though difficult to admit for some, surgeons also are human and suffer from performance deficits secondary to sleep deprivation. Sleep loss leads to a reduction in resident physician performance, and an increase in perioperative complications.5,6 Conflicting evidence from large retrospective reviews show that the science is not settled, and randomized trials are needed.7,8 Nevertheless, in light of recent evidence that medical errors are the third-leading cause of death in the U.S., surgeons can improve quality by reducing errors due to sleep deprivation.9 The stakes are too high to wait until further research confirms these preliminary findings. Recognizing that sleep deprivation affects performance and could affect patient outcomes, even slightly, is the first step.

Informing the patient
After acknowledging that surgeon sleep deprivation could endanger patients, our duty is then to inform patients of this risk factor. The informed consent procedure is a hallowed process, more intricate than a simple contract. It is one aspect of a fluid discussion where the surgeon describes the patient’s disease or injury, the medical and surgical treatments considered, and the potential risks and benefits for that particular patient.

Yet, are we truly informing the patient of all the risks of surgery? Are all the ramifications that affect this sacred opportunity to operate on another person being discussed? A simple categorization of the variables affecting postoperative outcomes could be divided into “patient factors” and “health care factors.” As part of the informed discussion, the patient learns about the risks associated with their comorbidities and the steps taken to reduce those risks. Health care factors are varied and difficult to alter, and they are more challenging to explain as part of an informed consent. Even the definition of sleep deprivation is ethereal and differs from surgeon to surgeon or patient to patient. However, the number of hours that a surgeon has slept in a 24-hour period or the number of sleep interruptions during the night are quantifiable. If it can be calculated, and its effect on patient care can be placed into the proper context, then it must be disclosed.

The precise definitions, mechanisms, and recommendations of disclosure will not be delineated here. Rather, the surgical community needs to conduct an honest and thoughtful critical analysis of how to achieve the goal of informed consent as it pertains to the provision of health care by surgeons. The debate should not center on whether the surgeon should inform the patient, but instead on how to integrate the disclosure into the surgeon’s schedule. Surgical societies have a duty to draft consensus statements supporting and outlining the details of mandatory disclosure. If we don’t create the process, then the terms will be foisted upon us by a well-meaning but inexperienced populace supported by nonsurgical groups.10
The deliberation over the specific mechanisms surrounding mandatory disclosure of sleep deprivation does not nullify the requirement to disclose this information. Adherence to the principles of beneficence, non-maleficence, and autonomy should not be contingent upon the creation of policies and plans to deal with the consequences of the disclosure.

As your mother waits to speak with the surgeon and sign the consent form, you think about the amount of sleep deprivation your colleague has sustained. Will this fatigue cause even minor complications? You begin to wonder what systemic changes could make this situation more tenable for you, your surgical colleagues, and your patients.

REFERENCES


Surgical societies have a duty to draft consensus statements supporting and outlining the details of mandatory disclosure. If we don’t create the process, then the terms will be foisted upon us by a well-meaning but inexperienced populace supported by nonsurgical groups.
Exploring the limits of surgeon disclosure: Where are the boundaries?

First-place essay—Con

by Reema Mallick, MD

The Boston Globe’s 2015 coverage of the case of Tony Meng, a young man who unfortunately suffered paralysis following complex spinal surgery in the course of overlapping procedures by his surgeon, has reinvigorated the debate regarding the extent of necessary physician disclosure. Although it is unclear if simultaneous surgeries and potentially autonomous trainee involvement affected Mr. Meng’s outcome, occurrences such as these and the concerns they elicit erode the integrity of the physician-patient relationship. Furthermore, they result in public distrust of current practice paradigms, which are guided by medical professionalism. The question then arises of whether certain aspects of a surgeon’s practice—including the extent of trainee participation in patient care or surgeon fatigue—should be divulged in a mandatory fashion to patients as a part of the informed consent process to maintain patient autonomy and, ostensibly, facilitate greater patient safety.

Inconclusive evidence

There are multiple pitfalls, however, regarding the enhancement of the informed consent process, which will limit its utility in producing its desired outcomes. The first is lack of conclusive evidence that these factors—though they may seem distressing to a patient in the particularly vulnerable and anxiety-provoking moments prior to an operation—have a measurable impact on a patient’s postoperative outcomes. For instance, there is conflicting evidence regarding the actual effect of sleep deprivation on the ability of a seasoned surgeon to complete the technical elements of an operation, as well as whether there is an impact on outcomes. Extrapolating from the sleep-deprivation challenges discerned in other skilled practitioners, including those in locomotion or aviation, it stands to reason that sleep-deprived surgeons will be less mindful than well-rested ones. In fact, acute sleep deprivation has been linked to diminished cognitive performance, reaction time, and visual-perceptual ability, among other deficits.

A substantial body of literature investigates physician skills in simulated settings or examining retrospective patient outcomes. Results vary, but several of these studies fail to demonstrate a deleterious effect on patient outcomes or diminished performance. For instance, Tomasko and colleagues observed in one study of sleep-deprived and control students that although there was greater “cognitive workload” in the sleep-limited students, they were able to complete technical tasks and demonstrate learned proficiency in new ones. Similar results have been seen at more advanced levels of the profession, including among
staff surgeons, and experimentation with skills at the resident level.6,7 These results, however, are inconsistent with other studies, which indicate reduced performance, specifically in laparoscopic skills in sleep-limited residents as demonstrated by Eastridge and colleagues. This study contrasts with a similar study showing non-inferiority in laparoscopic ability.8,9 When examining patient outcomes, the results are, again, mixed. Although Rothschild and colleagues noted an increase in complications in elective cases following call (3.4 percent versus 6.2 percent), on examination of the data from all types of procedures and all surgeons, there was no significant difference in outcomes with or without a prior night of call.10 Several investigations of cardiac procedures have not detected an increase in morbidity of patients of post-call surgeons.11-13 One item which may be suggested by the variations in the data is that there are disparities in the operations that are affected by sleep deprivation, whereas others exist where necessary technical abilities are well-preserved despite operator fatigue; this may also vary depending on the surgeon. These considerations still need to be elucidated. Therefore, any attempt to standardize mandatory disclosures seems somewhat heavy-handed.

Some of the inconsistencies are affected by confounding factors, and comparisons between studies are limited by differing definitions of sleep-deprived. A surgeon may be classified as such if limited sleep opportunities between call and elective cases are available, or simply if he or she takes a call shift the preceding evening. However, countless other factors play into the surgeon’s performance, even if post-call status disclosure is mandated. An off-duty surgeon may not have slept well the previous night in his or her own bed; the corollary is that a post-call surgeon may have not been disturbed once during their shift. Additionally, other pressures, personal or professional, arguably may have an equivalent impact on performance.14 Further, given the group dynamics of a successful operation, would the state of all members of the operative team be expected to be disclosed in the informed consent? Mandating disclosure of one aspect of a provider's mental state opens the gate to further unwarranted personal investigation. And without conclusive evidence to confirm consistently different outcomes, these actions pander to public fear, rather than improve patient safety.15

REFERENCES

Informed consent is, at its core, based on patient autonomy and empowerment of patients to make voluntary and educated health care decisions.

**Resident involvement in operations**

Another major point of contention is disclosure of the trainee’s role in invasive procedures. One study of 30 surgeons at an academic center determined that 83 percent did not discuss the role of residents during the informed consent process. However, it’s notable that these surgeons still espoused an educational propensity, with 77 percent permitting independent operating prior to their presence within the operating room. This practice is in conflict with a recent study of patients surveyed at a large military teaching hospital where only 18.2 percent agreed that they would consent to such an unsupervised scenario. In fact, in their survey, a realistic description of trainee involvement reduced patient assent to greater than 50 percent in most cases. These concerns are not well founded, though. Myriad investigations of outcomes in the American College of Surgeons National Surgical Quality Improvement Program suggest that resident involvement is safe and results in similar morbidity.

Informed consent is, at its core, based on patient autonomy and empowerment of patients to make voluntary and educated health care decisions. Legally, we are compelled to disclose those factors that would pose material risk to the patient although, at present, no consistent evidence exists that obligatory disclosure of trainee responsibilities or previous call will result in improved outcomes or that avoidance of these factors mitigates risk. Ethically, it remains our duty as physicians to act professionally and provide quality care, which may require postponing an operation if we are unfit to provide appropriate supervision to surgical trainees. The responsibility to make an informed decision together with the patient cannot be aided or supplanted by mandates from governing bodies. Instead, the burden should remain on the physician to ensure excellent care with recognition of the finite nature of resources and the need for optimal education of trainees. However, surgeons should be supported in this process by health care systems, specifically by the development of policies that strive to reduce surgeon fatigue and provide a safe working environment.

**REFERENCES (CONTINUED)**

The American College of Surgeons (ACS) Chapter Lobby Day Grant Program, now in its sixth year, provides financial support for chapters’ state capital lobby days. In 2016, the program awarded 17 grants to eligible chapters.

Chapters often work with their state medical society or other specialty groups to organize an event, some organize their own lobby days, and others host dinners or other advocacy-related events. The goals range from introducing chapter members to the state legislature to pushing for, or opposing, a specific legislative proposal. These events are critical not only for grassroots advocacy, but also for establishing the ACS chapters as the voice of surgery in their state and building long-term relationships with legislators.

Following is a summary of the 17 participating chapters’ events and their accomplishments.

**Alabama**
The Alabama Chapter of the ACS held its annual Day at the Capitol April 6. Representing the chapter at the event were Charles B. Rodning, MD, PhD, FACS, Past-President of the Chapter and professor of surgery, University of South Alabama College of Medicine, Mobile; D. Lynn Dyess, MD, FACS, professor of surgery, University of South Alabama College of Medicine; and Lisa Beard, Executive Director, Alabama Chapter of the ACS. During the weekly meeting of the Senate Health and Human Services Committee, chapter representatives engaged in a presentation on funding for the Alabama Statewide Trauma System and for the Alabama Medicaid program. The group also attended a press conference convened by Gov. Robert J. Bentley, MD (R), and Medicaid Commissioner Stephanie McGee Azar to discuss the potential impact of proposed cuts to the agency.

**Alaska**
The Alaska Chapter’s first Advocacy Day was held in late January. Organized by Chapter President Danny Robinette, MD, FACS, Fellows gathered in Juneau to participate in meetings
with 11 legislators and several agency officials, largely to advocate for increased state trauma funding. Specifically, the Alaska Chapter asked the legislature to approve Medicaid funding to cover trauma activation fees because the state was facing a $3.5 billion budget deficit, and there were concerns that the current trauma funding would not be appropriated.

California
The three California ACS chapters joined together April 13 to participate in the California Medical Association (CMA) Annual Legislative Advocacy Day in Sacramento. Leadership from the chapters included John Maa, MD, FACS, Past-President, and Pascal Fuchshuber, MD, FACS, President-Elect, Northern California Chapter; Shirin Towfigh, MD, FACS, Immediate Past-President, Southern California Chapter; and Jon Greif, DO, FACS, San Diego Chapter. Other surgeons included James Hinsdale, MD, FACS (former CMA president); Luther Cobb, MD, FACS (former CMA president); Christina Maser, MD, FACS (Secretary-Treasurer of the Northern California Chapter); and Peter Richman, MD, FACS (President of the Los Angeles County Medical Association).

The chapters focused their advocacy on A.B. 1763, a bill that would require health care coverage without copayment for colorectal cancer screening. Surgeons met with the bill sponsor’s legislative staff, as well as members of the Assembly Health Committee, to discuss the legislation and to deliver a statement of support. This bill was passed out of the legislature but vetoed by Gov. Jerry Brown (D) in September.

Florida
The Florida Chapter of the ACS held its annual Advocacy Day February 4. Surgeons representing multiple surgical specialties, including urology, otolaryngology, vascular surgery, and obstetrics/gynecology, met with lawmakers to discuss bills addressing telemedicine and balanced billing for out-of-network and emergency care. ACS staff, representatives of the Florida Department of Health, and other advocates briefed lawmakers on health care issues in the state.

Georgia
The Georgia Society of the ACS held its lobby day in conjunction with the Medical Association of Georgia (MAG) January 27. Of the more than 60 physicians in attendance, approximately 15 were surgeons affiliated with the society. The Uniform Emergency Volunteer Health Practitioners Act model legislation was the major focus of the society when working the rope line and in conversations with legislators at the society-sponsored lunch. The bill was signed into law by Gov. Nathan Deal (R) in April. MAG president John Harvey, MD, FACS, an active society member, recognized the Georgia Society and the ACS for their sponsorship of the lunch through the generosity of the grant program.

Indiana
The Indiana Chapter of the ACS hosted the Annual Day at the Capitol in Indianapolis February 9. State Rep. Cindy Kirchhofer (R), Chair of the House Public Health Committee, spoke on the importance of physician-legislator interaction. In addition, Michael Brady, Director of INSPECT, the Indiana Board of Pharmacy Prescription Monitoring Program, spoke about upcoming changes to the system. John J. Wernert, MD, Secretary of the state’s Department of Family and Social Services, gave an update on Healthy Indiana Plan 2.0, the state’s Medicaid expansion program. Attendees then had the opportunity to meet with their elected officials to discuss legislation addressing opioid overdose interventions, step therapy protocols for prescription medications, and hospital employee immunizations.
Kansas
The Kansas Chapter of the ACS, in conjunction with the Kansas Medical Society, hosted a state lobby day in Topeka in January. The well-attended event included in-depth presentations on state and federal advocacy, the current state of the Kansas legislative environment, and medical liability reform. In addition to the briefings, several legislators addressed the current state of affairs in Kansas. After the briefings, members met with their state legislators to discuss legislation regarding advanced practice registered nurse scope-of-practice expansion, an indoor tanning ban for minors, and whether Kansas would expand Medicaid. The indoor tanning ban for minors was signed into law in June. The day ended with a reception for attendees and legislators.

Massachusetts
The Massachusetts Chapter of the ACS hosted its lobby day at the State Capitol in Boston on September 20. The main topic of the event was the surgical response to firearm violence. Middlesex County Sheriff Peter Koutoujian moderated a discussion with Boston Police Commissioner William Evans; David King, MD, FACS, trauma surgeon at Massachusetts General Hospital; Michael Hirsh, MD, FACS, division chief of pediatric surgery and trauma, University of Massachusetts Memorial Children’s Medical Center; and Eric Goralnick, MD, medical director, Emergency Preparedness at Brigham and Women’s Hospital. Attendees then met with their legislators to discuss the issue further.

Metro Chicago Chapter
The Metro Chicago Chapter of the ACS sent a small group to Springfield, IL, April 13 to advocate on opioid abuse issues. One attendee, Richard A. Jorgensen MD, FACS, the DuPage County Coroner, described his experience dealing with the devastating impact of the opioid abuse epidemic. Dr. Jorgensen pointed to a bill in the state legislature that would allow health care workers to remove opiate medication from the home of hospice patients after they die, in an effort to decrease unintended access to these drugs.

New York
The New York and Brooklyn/Long Island Chapters cosponsored a lobby day with the New York Coalition of Specialty Care Physicians May 17 in Albany. More than 100 physicians participated in the event. The day began with presentations from various physicians and government affairs staff. Attendees received a legislative briefing, advocacy training, and a presentation on legislative talking points pertinent to issues before the legislature. Lobby day participants then met with their legislators to advocate on several pieces of pending legislation, including scope-of-practice expansion, opioid prescribing limits, and health care billing transparency. A bill limiting initial prescriptions of opioids to seven days was signed into law by Gov. Andrew Cuomo (D) in June.

Ohio
The Ohio Chapter of the ACS hosted its annual state legislative dinner April 19. A number of state legislators, including Senate President Keith Faber (R), and Rep. Anne Gonzales (R), Chair of the House Health and Aging Committee, discussed issues of importance to Ohio physicians. The chapter is advocating on a number of bills this session, including H.B. 261, legislation that would reform the state’s trauma system, and S.B. 129, which would improve prior authorization requirements set by health plans by establishing uniform response deadlines, requiring health plans to honor prior authorizations for a specified time frame, and allowing providers to submit requests electronically. Other issues discussed with the legislators included the state’s ongoing opiate and prescription drug abuse crisis and pending medical marijuana legalization.

Oregon
The Oregon Chapter of the ACS held its annual Day at the Capitol March 6–7 in Salem. The event began with a speech by Republican gubernatorial candidate Bud Pierce, MD, an oncologist from Salem, who expressed his views on health care in the state, including his thoughts on how the implementation
of the Affordable Care Act could be improved. The following day, participants met with James Rickards, MD, chief medical officer at the Oregon Health Authority, who discussed Medicaid and coordinated care organizations, as well as rural access issues. Oregon Medical Association staff briefed participants on the health care issues that were being considered this year in the legislature, which included continued focus on health care reform and the opioid abuse epidemic. ACS staff led an in-depth discussion about the current status of opioid abuse prevention and treatment-related legislation across the country.

**Tennessee**
The Tennessee Chapter of the ACS joined with the Tennessee Medical Association March 1 to host the 2016 Day on the Hill in Nashville. More than 250 physicians of all specialties visited with their state legislators, attended committee hearings on legislation important to the medical community, and ate lunch with state legislators and staff. Surgeons had opportunities to discuss opioid-prescribing legislation exemptions, the Tennessee Surgical Quality Collaborative, and motorcycle helmet legislation.

**Texas**
The North and South Texas Chapters of the ACS hosted their first joint Lobby Day event in Austin September 13–14. The event started with a dinner, during which attendees heard from Stacey Silverman, PhD, Deputy Assistant Commissioner for Academic Quality in the Division of Academic Quality and Workforce of the Texas Higher Education Coordinating Board; Rep. Trent Ashby (R); and Sen. Charles Schwertner, MD (R), an orthopaedic surgeon and Chair of the Senate Committee on Health and Human Services. The main topic of discussion was how Texas is working to increase access to graduate medical education (GME) for medical school graduates. Texas Medical Association staff briefed participants on current issues in the state legislature and provided best practices for meetings with legislators. ACS staff then discussed issues facing state legislatures around the country. Attendees concluded the event by meeting with legislative staff to advocate for continued funding for GME.

**Virginia**
The Virginia Chapter of the ACS, in conjunction with several other surgical societies, hosted a lobby day in Richmond February 25. The day began with a briefing and an Advocacy presentation from the Virginia Medical Society on a variety of legislative and political issues, including the prospects for Medicaid expansion. After the briefing, Fellows headed to the State Capitol for meetings with their individual state legislators. These meetings were productive, and Fellows were able to advocate for prescription prior authorization reform legislation and for workers’ compensation reform.

**Wisconsin**
The Wisconsin Surgical Society participated in the state’s annual Doctor Day program February 10 in Madison. More than 300 physicians from more than 20 medical specialties gathered for the event. This is the first year the surgical society has participated in Doctor Day with support from the ACS Chapter Lobby Day Grant Program. During the program, Lt. Gov. Rebecca Kleefisch (R) described her experience with colon cancer, and attendees were updated on the H.O.P.E. (Heroin, Opioid Prevention and Education) Agenda, which was moving through the state legislature. The surgeons then went to the Wisconsin State Capitol to meet with their legislators.

These events provided Fellows across the country with firsthand experience in advocating for their patients and profession, and exposed them to current issues being discussed in the state legislatures—issues that have the potential to significantly affect the medical profession. If your state is hosting an event in 2017, we strongly encourage you to attend. If you have any questions about the Lobby Day Grant Program or ACS State Affairs, contact Tara Leystra Ackerman at tleystra@facs.org or 202-672-1522.
Over the last three decades, there has been a significant shift in cancer care from the generalist to the specialist setting. This shift is especially true in surgical oncology, where surgeons specializing in the care of breast cancer, esophageal cancer, and pancreatic cancer have become the norm for many facilities treating cancer patients in the U.S. Much of this shift in care delivery has been evidence-based and has identified issues such as case volume for both provider and facility as a strong predictor of improved cancer-specific outcomes.

However, despite a move to rectal specialists for rectal cancer care in Europe, this is not yet the norm in U.S. surgical oncology. In many European countries, the outcomes for patients with rectal cancer are better compared with the outcomes for patients with colon cancer as a consequence of these changes in care pathways. Unfortunately, the management of patients with rectal cancer in the U.S. and their care process had not been altered until recently.

Given this shift from the generalist to specialist setting around the world and recognizing the significant variability in the quality of rectal cancer care in the U.S., the OSTRiCh (Optimizing the Surgical Treatment of Rectal Cancer) Consortium was founded in 2011 with the goal of improving rectal cancer outcomes through advocacy, education, and research. Over the past five years, OSTRiCh has expanded considerably from the founding group of 14 institutions and now includes more than 250 centers representing all facets of the U.S. health care delivery system—both large and small private clinics, university-affiliated hospitals, large health care systems, and smaller community hospitals.

While OSTRiCh was initially developed by fellows of the American Society of Colon and Rectal Surgeons (ASCRS), it was decided from the outset that the collaborative should be inclusive and not specialty based. Consequently, members of the following organizations are involved in the consortium, reflecting the modern, multidisciplinary approach to rectal cancer: the American College of Surgeons (ACS), the College of American Pathologists, the American College of Radiology, the American Society of Clinical Oncology, the American Society of Radiation Oncology, the Society of Surgical Oncology, the Society of American Gastrointestinal and Endoscopic Surgeons, and the Society for Surgery of the Alimentary Tract.

The OSTRiCh Consortium has worked to raise awareness of the disparities that currently exist in U.S. rectal cancer care. Manuscripts have been published in peer-reviewed journals using data from the National Cancer Database (NCDB) illustrating suboptimal adherence to published guidelines for the use of neoadjuvant and adjuvant therapies in locally advanced rectal cancer and excessive rates of involved circumferential resection margins after rectal cancer resections.1,2

The consortium also maintains a website (www. ostrichconsortium.org) that facilitates communication between member institutions, disseminates information related to rectal cancer care,
OSTRiCh members are working directly with ACS and CoC leadership to write the NAPRC standards manual and to design the various components of the program.

and provides a Web page where interested parties can join the consortium.

**Developing the NAPRC**

A primary goal of the consortium was achieved in June 2014 when the ACS Commission on Cancer (CoC) accepted an OSTRiCh proposal to create the National Accreditation Program for Rectal Cancer (NAPRC). The NAPRC is structured around evidence-based processes of rectal cancer care and employs the multidisciplinary team approach that has improved outcomes in several European countries over the past decades. OSTRiCh members are working directly with ACS and CoC leadership to write the NAPRC standards manual and to design the various components of the program. Six pilot site surveys were completed by the CoC in early 2016 in an effort to document current processes and to hone the standards and accreditation process with the goal of accepting applications to the program from interested CoC-accredited hospitals in early 2017.

In addition to developing the NAPRC, OSTRiCh has launched two major rectal cancer quality improvement initiatives in the last several months. The Transanal Total Mesorectal Excision (TaTME) Registry is tracking outcomes of a new technique in the U.S. for the surgical treatment of rectal cancer. This project is a cooperative effort with the English Low Rectal Cancer Development Programme (LOREC), which created a similar registry in 2013. The TaTME database will be identical to the LOREC registry and will allow data sharing and amalgamation in due time. The TaTME Registry has been funded by a grant from the ASCRS. The OSTRiCh Rectal Cancer Registry is a broader initiative that is open to all 250-plus OSTRiCh Consortium members, which allows users to enter their rectal cancer cases, track a number of quality indicators, and compare their own outcomes against national means. At present, 250 patient records from more than 30 registered centers have been completed within this database.

OSTRiCh continues to welcome new members. Interested centers can register for consortium membership and participation in either of these quality initiatives at the OSTRiCh Consortium website.

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**REFERENCES**


On August 8, 1934, President Franklin Delano Roosevelt traveled by train to Rochester, MN, to pay tribute to William J. Mayo, MD, FACS, and his brother Charles H. Mayo, MD, FACS, both for their many contributions to the science of medicine and for their service to their country in the military. This visit—which brought a world leader to the comparatively small city of Rochester—highlighted the importance of the Mayo brothers’ work and gave global attention to the Mayo Clinic and its founders. President Roosevelt spent the day visiting the clinic, followed by lunch at Charles Mayo’s Mayowood estate and a broadcast speech at Soldiers Field Veterans Memorial. He then had a short ride down the Mississippi River on William Mayo’s yacht, the North Star, before his return train trip to Washington, DC.

Military heritage at the Mayo Clinic

Both Charles and William Mayo joined the U.S. Army Reserve 10 years before the start of World War I.* During the war, they both served at the rank of colonel. Each Mayo brother had military leadership roles in developing a military hospital with the University of Minnesota, Minneapolis; neither physician served overseas. They worked closely with American College of Surgeons (ACS) founder Franklin H. Martin, MD, FACS, in establishing the College and in the war effort by serving on the Advisory Commission to the Council for National Defense.† Both Charles and William Mayo were promoted to rank of brigadier general in the U.S. Army Reserve following World War I.

At the time of their subsequent retirement from military duty, they both received the U.S. Army’s Distinguished Service Medal for their wartime service to the country.

**Dr. Beahrs and the Mayo Clinic military heritage**
Oliver H. Beahrs, MD, FACS, served as President of the ACS from 1988 to 1989. Dr. Beahrs also served in World War II and remained in the U.S. Naval Reserve until his retirement from military duty. In one of his lectures at the Uniformed Services University of the Health Sciences (USUHS), Bethesda, MD, he said “I will always consider myself a military surgeon.” For many years, he contributed to academic activities at USUHS and was always proud to promote the long history of support for military surgery from Charles and William Mayo, as well as the work of the Mayo Clinic in general in the 20th century.³ When Dr. Beahrs passed away in 2006, the American flag was flown at half-mast at USUHS. The flag was later presented to his widow at the memorial services in Rochester.

Like Dr. Beahrs, both Dr. William Mayo (1917–1920) and Dr. Charles Mayo (1924–1925) served as President of the ACS. Each of them had 30 years of military service including the Reserve.

The American College of Surgeons (ACS) Foundation is proud to feature three Fellows who have received an ACS Faculty Research Fellowship or Resident Research Scholarship, supported by the generous contributions from members of the ACS Foundation’s Mayne Heritage Society (MHS). The MHS recognizes Fellows who have provided a bequest or other planned gift to the College through their estate plan.

Many Fellows who have made planned gifts to the College have done so with no restrictions on the use of the donations. Therefore, these gifts are directed to the ACS Foundation’s Greatest Needs Fund. Each year, this fund supports ACS fellowships and scholarships, which makes it possible for young surgeons to perform potentially lifesaving surgical research.

Finding treatment for adolescent liver cancer
Kimberly Riehle, MD, FACS, is a skilled surgeon at Seattle Children’s Hospital, Washington and an amateur artist using a unique medium—bandages. She cuts shapes, like flowers and stars, out of gauze to place on the incision site, much to the delight of her young patients during recovery.¹

Another facet of Dr. Riehle’s dedication to pediatric care is her work as a surgical investigator. Her current research is focused on liver cancer in children and determining why otherwise healthy children and young adults develop a deadly form of the disease.²

Dr. Riehle is quick to credit the ACS Foundation with helping to make her research possible. In a letter to the ACS, she expressed her appreciation for two ACS scholarships that helped set her on a successful research career path, saying, “The ACS Foundation Faculty Fellowship gave me the time and freedom to transition my laboratory’s focus from basic investigations on liver regeneration to a subject more relevant to my clinical practice as a pediatric surgeon: fibrolamellar hepatocellular carcinoma (FL-HCC). FL-HCC is a subtype of liver cancer that occurs in otherwise healthy children, but for which there are currently no effective nonsurgical therapies. My lab now focuses on understanding the molecular biology of this deadly pediatric cancer, with the goal of developing curative therapies for these patients.” (Personal communication with the author, August 30, 2016.)

Dr. Riehle also recently was named a recipient of National Institutes of Health funding for her research project titled Neurotensin in Fibrolamellar Hepatocellular Carcinoma.

Providing expertise in craniofacial disorders
As a surgical expert in craniofacial disorders, Chad Perlyn, MD, FACS, is one of the most sought-after pediatric plastic surgeons in Florida. He is an attending plastic surgeon, division of plastic and reconstructive surgery, Nicklaus Children’s Hospital, and assistant professor and chief, division of plastic surgery, Florida International University’s Herbert Wertheim College of Medicine, Miami. As the recipient of an ACS fellowship, he was accepted at the University of Oxford in England and completed a doctorate degree in craniofacial molecular biology in three years. While at Oxford, Dr. Perlyn studied why children are born with particular facial...
birth defects; as a result of his efforts, he received several national and international research awards, including the Cassio M. Raposo do Amaral Award, which is presented for the best resident presentation by the International Society of Craniofacial Surgery at its annual meeting. As a surgical resident interested in research, it was very important to me to obtain formal scientific training,” Dr. Perlyn noted in his fellowship outcomes report. “When the opportunity for me to do a PhD in craniofacial development at Oxford arose, I was honored and delighted, but was also concerned that I may not be able to attend the program due to funding issues. However, the ACS scholarship allowed me to pursue this training and begin a surgical career in rare and complicated craniofacial disorders. One of Dr. Perlyn’s most remarkable cases was a child born with a tongue the size of a full-grown adult’s because of a rare genetic condition called Beckwith-Wiedemann syndrome. He struggled constantly to eat and breathe, but many surgeons were unwilling to operate due to his age. However, with Dr. Perlyn’s specialized training in craniofacial development, he felt confident performing the operation, which was a success. The child was then able to breathe, eat, and speak normally.

### Improving outcomes in emergency general surgery

Kathleen B. To, MD, FACS, assistant professor of surgery, division of acute care surgery (trauma, burns, critical care and emergency surgery), University of Michigan Hospital and Health System, Ann Arbor, was the inaugural recipient of the Thomas R. Russell, MD, FACS, Faculty Research Fellowship, in 2015. Dr. To’s clinical practice and research interests are in emergency general surgery, trauma, critical care, wound care, patient outcomes, and quality improvement. She has been a principal investigator or co-investigator for a number of research studies in these areas. Through her ACS fellowship award, Dr. To is focused on improving surgical outcomes for trauma patients. Her project title is Emergency General Surgery—Catalyst for Change: Outcomes, Models of Care, and Performance Improvement. Her research will focus on identifying key factors and correlation of the variations with patient outcomes, and using this data to determine best practices in emergency surgical care. In her presentation at the ACS Foundation’s Donor Recognition Luncheon at Clinical Congress 2015, Dr. To explained that emergency general surgery patients are a unique cohort. “They only make up 10 percent of surgical cases but have a 32 percent mortality rate and make up 40 percent of complications, costs, and resource utilization.”

### Preparing surgical leaders

Drs. Riehle, Perlyn, and To are just three examples of surgeons who have benefited from the ACS fellowship and scholarship funding and are on the path to becoming surgeon leaders like other ACS awardees, including the following:

- ACS Regent Henri R. Ford, MD, MHA, FACS, vice-president and surgeon-in-chief, Children's
Hospital of Los Angeles; and vice-chair and vice-dean for medical education, Keck School of Medicine, University of Southern California; Los Angeles

• Barbara L. Bass, MD, FACS, ACS President-Elect; Past-Member, ACS Board of Regents; and recipient of the 2013 Distinguished Service Award, the John F. and Carolyn Bookout Distinguished and Endowed Chair of Surgery, Houston Methodist Hospital Research Institute, TX; and professor of surgery at Weill Cornell Medical College, New York, NY

• N. Scott Adzick, MD, MMM, FACS, FAAP, surgeon-in-chief, The Children’s Hospital of Philadelphia, PA, and the founder and director of the Center for Fetal Diagnosis and Treatment

ACS fellowship award recipients, bolstered by the generosity of others, have affected the lives of countless patients and shared their research and knowledge within the surgical field. Each MHS member is ensuring that support for the profession and optimal patient care will continue beyond his or her lifetime. A planned gift is a powerful legacy and can mean so much to the careers of the next generation of surgical researchers and leaders.

If you are interested in learning how you can join MHS members in planning for a future gift to the ACS, contact Shane Hollett, Executive Director, ACS Foundation, at 312-202-5506.

REFERENCES

The Ernest Amory Codman Award was presented earlier this year to Najmedin (Najm) Meshkati, PhD, whose work focuses on leadership areas applied to health care that supports The Joint Commission’s mission of continuously improving the safety and quality of care. In conjunction with receiving the award, Dr. Meshkati delivered a lecture at the Physician Leader Forum hosted by The Joint Commission in Oak Brook, IL.* The presentation, titled Lessons from the Nuclear Industry, touched on the culture of safety and its importance.

**The Codman legacy**

The Ernest Amory Codman Award, established in 1996, recognizes achievement in performance measurement and honors the legacy of Dr. Codman, a Fellow of the American College of Surgeons (ACS), who originated what is today known as outcomes reporting and transparency. It was Dr. Codman’s lifelong mission to establish an end results system to track the outcomes of every patient treated for a given condition in order to identify clinical mistakes and develop solutions to improve patient safety and the quality of patient care. He believed that all of these data should be made public, so that patients would have the information they need to objectively guide their selection of physicians and hospitals.

Dr. Codman was a surgeon at Massachusetts General Hospital, Boston, and one of the founders of the ACS and its Hospital Standardization Program, which eventually became The Joint Commission.

In his Presidential Address at Clinical Congress 2014 in San Francisco, CA, Andrew L. Warshaw, MD, FACS, FRCSEd(Hon), delivered an address that touched on the life of Dr. Codman and the relevance of his legacy to surgeons today.

Dr. Warshaw recounted that Dr. Codman, as a medical student in 1895, and a classmate, Harvey Cushing, MD,

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Dr. Meshkati was chosen to receive the award earlier this year because he embodies Dr. Codman’s legacy.

Dr. Codman

FACS, witnessed a fatal outcome from the administration of ether anesthesia. “To provide data to ensure the safety of their patients, they began to record pulse, respiratory rate, and blood pressure when this anesthesia was used,” Dr. Warshaw said. “These ether charts, now residing in the Harvard Medical School Countway Library of Medicine, were the first anesthesia records and have contributed to saving many thousands of lives.”

According to Dr. Warshaw, however, Dr. Codman’s biggest contribution to surgery was the “end result idea.” “This concept centered on the common-sense notion that every hospital and every surgeon should follow every patient long enough to determine whether the treatment was successful, and to inquire, ‘If not, why not?’” Dr. Warshaw said.

The purpose of this assessment was to prevent similar failures in the future and to improve the efficiency of care. At the time, Dr. Codman’s end results idea—and his opinion that outcomes should be the basis for determining surgeons’ promotions—was not well received. “With a century’s hindsight, we see the strength of his pioneering ideas on quality based on a record of scientific truth, as he put it—on evidence, not eminence,” Warshaw said. “He asked if it was possible to standardize the treatment of disease or the work of individual members of hospital staffs. He answered, ‘Such standards can be established. The object of standards is to raise them.’ Good enough is not good enough.”

Dr. Meshkati’s distinguished commitment to safety

Dr. Meshkati was chosen to receive the award earlier this year because he embodies Dr. Codman’s legacy. Dr. Meshkati is a professor of civil/environmental engineering, industrial and systems engineering, and international relations at the Viterbi School of Engineering at the University of Southern California, Los Angeles. He was a Jefferson Science Fellow and a senior science and engineering advisor, as well as an Office of Science and Technology advisor to the Secretary of State, U.S. State Department. He also is a member of the advisory council of CRDF Global.

Dr. Meshkati has been a trailblazer and innovator in his field and has been dedicated to solving high-risk problems, such as risk reduction and reliability enhancement for complex technological systems, including nuclear power plants. He was part of a national panel that investigated the Deepwater Horizon explosion and oil leak near the Gulf Coast. He also has been the principal investigator or co-investigator on several projects of the U.S. Nuclear Regulatory Commission, and his knowledge of human factors and how humans interact with technology—in particular, the automation of systems, how they function, and how human intervention can save the day when automation fails—has direct relevance to patient safety and quality of care.

In an interview after receiving the Codman Award, Dr. Meshkati said, “It was one of the most pleasant surprises of my life.” To see the interview, visit vimeo.com/163573153.

Disclaimer

The thoughts and opinions expressed in this column are solely those of Dr. Pellegrini and do not necessarily represent those of The Joint Commission or the American College of Surgeons.
Idealized for relaxation and leisure, reaching the golden years of life has been a romanticized goal after a lifetime of hard work. With the latest census data revealing that people age 65 years and older comprise the fastest-growing sector of the U.S. population, it appears more Americans are entering this stage of life.* In fact, the Centers for Disease Control and Prevention estimate that by 2030, 19 percent of the population will be older than 65 years of age.† While the carefree lifestyle of retirement may be an aim for many, others find themselves facing unanticipated challenges related to these years. As the size of this population continues to grow, so too will its presence in the trauma setting. Geriatric trauma has long been recognized as a unique challenge, largely because management of injuries is often confounded by the presence of pre-existing comorbidities related to the natural aging process. These factors can lead to longer hospitalization and a more challenging recovery.

**Increasing injury rate in the elderly**

While firearm-related injury is more common among the younger population, mortality rates for these injuries are increased in the elderly. In reviewing the National Trauma Data Bank® (NTDB®) datasets from admission years 2007 to 2014, along with the steady increase in firearm-related injuries in patients less than 65 years of age, the data reveal a consistent rise in these injuries among elderly patients (see Figures 1 and 2, this page). Notably, mortality after self-inflicted firearm injury is highest among the elderly.‡

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To examine the occurrence of patients injured by firearm in the NTDB research dataset admission years 2007–2014, medical records were searched for “injured by firearm” designation and were then divided into two groups: younger than age 65 (32,884) and older than or equal to 65 (1,149). Of the combined total of 34,033 records, 24,797 records contained a discharge status. In comparing the older group with the younger group, respectively, 355 and 19,095 patients were discharged to home; 150 and 2,214 to acute care/rehab; and 62 and 404 were sent to skilled nursing facilities. Almost 30 percent of the older group (237) died, while just under 10 percent (2,280) of the younger patients died, representing a more than three-fold increase in mortality in the older group (see Figures 3 and 4, this page).

It is not surprising that elderly patients do not recover as well after a major injury when compared with their younger counterparts. Physiologic changes that come with aging place additional strain on the body as it attempts to heal, often causing a protracted course for recovery.

On its current trajectory, the U.S. elderly population, as well as those injured in a firearm-related incident, will continue to increase—resulting in, among other deleterious effects, an increased strain on the trauma system. Post-injury care of elderly patients, particularly those with firearm-related injuries, requires careful consideration. Awareness, planning, and early action is likely key to the overall recovery of this sector of the population, and will help them return to their leisurely golden years.

Throughout the year, we will be highlighting these data in brief reports that will be found monthly in the Bulletin. The National Trauma Data Bank Annual Report 2015 is available as a PDF file at facs.org/quality-programs/trauma/ntdb. In addition, information is available on our website about how to obtain NTDB data for more detailed study. If you are interested in submitting your trauma center’s data, contact Melanie L. Neal, Manager, NTDB, at mneal@facs.org.

Acknowledgment
Statistical support for this article was provided by Chrystal Caden-Price, Data Analyst, NTDB.
In light of production costs, American College of Surgeons (ACS) Regents and the leadership of the Board of Governors, Young Fellows Association, and Resident and Associate Society have determined that the College would be best served by transitioning readers of the Bulletin to an online publication, effective with the January 2017 issue. The Bulletin will continue to offer the same array of features, news stories, and columns online, with the added benefit of providing more timely access to the Bulletin.

Members for whom we have an e-mail address will be notified each month when the new issue of the Bulletin becomes available. The e-mail notification will include a link that takes you directly to the Bulletin home page. (If your e-mail address is not on file or you need to update it, do so now via “My Profile” on the ACS website.)

From the Bulletin home page, bulletin.facs.org, you have three options: (1) start reading the current issue right there; (2) click the link on the right-hand side of the page, which will take you to a digital version that looks exactly like the print edition; or (3) download the Bulletin app, which will notify you each month when a new issue is available.

Note that for a limited time, dues-paying members who do not have access to the Internet or who have a strong preference for print media may opt in to continue receiving print copies of the Bulletin. Members who transition to non-dues-paying status will no longer receive the print edition. Dues-paying members (active Fellows, Associate Fellows, and Residents) should have received a notification from the College offering them the print option. If you do not recall receiving this notification e-mail or letter, you may request continuation of your print subscription via e-mail at ms@facs.org or by calling 800-621-4111. All requests should be made by December 9, 2016.
Courtney M. Townsend, Jr., MD, FACS, installed as 97th President of the ACS

Courtney M. Townsend, Jr., MD, FACS, a general surgeon from Galveston, TX, was installed as the 97th President of the American College of Surgeons (ACS) during the Convocation on October 16 at the Walter E. Washington Convention Center, Washington, DC.

Dr. Townsend is the Robertson-Poth Distinguished Chair in General Surgery, department of surgery, University of Texas Medical Branch (UTMB), Galveston; professor of surgery, department of surgery; professor of physician assistant studies, School of Allied Health Sciences; and graduate faculty in the cell biology program, UTMB.

Dr. Townsend is a distinguished surgical investigator whose research in gastrointestinal endocrinology and cancer has been supported through grants from the National Institutes of Health (NIH) and the American Cancer Society. He has authored or coauthored 416 articles in peer-reviewed publications, 123 articles in other publications, and 364 abstracts. He became an ACS Fellow in 1981.

Dr. Townsend earned his bachelor's degree in history and English from the University of Texas, Austin. He then earned his medical degree and completed his internship and general surgery training at UTMB. Dr. Townsend completed a surgical oncology fellowship at the University of California, Los Angeles (UCLA), and was a McLaughlin Fellow twice, a Jeane B. Kempner Fellow, an American Cancer Society clinical fellow, and an NIH postdoctoral fellow.

Dr. Townsend’s first teaching position was as an adjunct assistant professor of surgery, division of oncology, department of surgery, at UCLA (1974–1976). He then served in the U.S. Navy from 1976 to 1978 as a staff surgeon and surgical director in the intensive care unit at the National Naval Medical Center, Bethesda, MD.

In 1978, Dr. Townsend returned to UTMB as an associate professor in the department of surgery. In 1981, he was promoted to Robertson-Poth Associate Professor of Surgery, and the next year he became director of the surgical research laboratory at UTMB. From 1983 to 1995, Dr. Townsend was the Robertson-Poth Professor of Surgery, and from 1987 to 1995 he served as interim director of the UTMB Cancer Center. He assumed his current roles as professor of physician assistant studies in 1989, as graduate faculty in the cell biology program in 2001, and as Robertson-Poth Distinguished Chair in General Surgery in 2009.

Dr. Townsend also served as John Woods Harris Distinguished Chairman from 1995 to 2013.

Dr. Townsend has served in many leadership roles at the College, including ACS Secretary (2006–2015). He held prominent positions on the Board of Governors (B/G), including Chair (2004–2005), B/G Executive Committee Member (1999–2003); and ACS Governor from the Society for Surgery of the Alimentary Tract (1986–1992). He has also served in various capacities on the Commission on Cancer (CoC) and on other ACS committees. Dr. Townsend served on the CoC Committee on Approvals (1989–1994), the CoC National Cancer Data Committee and the National Cancer Data Base Governing Board (1989–1995), the ACS Committee for the Forum on Fundamental Surgical Problems and the Committee on Special Issues (both 1991–1994), the Committee on Papers (2000–2003), the Member Services Liaison Committee (2003–2004), and the Nominating Committee of the Fellows (2000–2002).

Most recently, Dr. Townsend served on the ACS Surgical Research and Education Committee.
Committee, which he chaired for two years (1998–2000). At the local level, he has served on the Southern Texas District #1 Committee on Applicants (1996–1999) and as President of the ACS South Texas Chapter (1988–1989).

Dr. Townsend has assumed leadership roles in several other medical organizations as well. He is past-director and chair of the American Board of Surgery (2000–2007); served on the Accreditation Council for Graduate Medical Education Residency Review Committee for Surgery (1994–1999); American Pancreatic Association president (1992–1993); American Surgical Association president (2007–2008); Southern Surgical Association president (2004); and Texas Surgical Society council member (1997–1999). He is an honorary member of the Society of Black Academic Surgeons and the Association of Women Surgeons (AWS) and is a recipient of UTMB’s John P. McGovern Lifetime Achievement Award in Oslerian Medicine.

Dr. Townsend has been editor-in-chief of the *Sabiston Textbook for Surgery: The Biological Basis of Modern Surgical Practice* since 2000 and was the editor of *Surgical Oncology* (1992–1999). He has served on the editorial board of the *Journal of the American College of Surgeons (JACS)*, *Surgery*, and *The American Journal of Surgery*.

**Vice-Presidents**

In addition, during the Convocation, Hilary Sanfey, MB, BCh, MHPE, FACS, FRCSI, FRCS, was installed as ACS First Vice-President, and Mary C. McCarthy, MD, FACS, was installed as ACS Second Vice-President.

Dr. Sanfey is professor of surgery and vice-chair for educational affairs, department of surgery, and associate director, Academy for Scholarship and Education, Southern Illinois University (SIU) School of Medicine, Springfield. Dr. Sanfey, who hails from Ireland, graduated from Trinity College Dublin School of Medicine in 1976. She trained at the Royal College of Surgeons in Ireland (RCSI), spent three years as a research fellow at Johns Hopkins University, Baltimore, MD, and worked as a consultant transplant surgeon at the Royal Infirmary of Edinburgh for four years before moving to the University of Virginia, Charlottesville, in 1996. She remained on the clinical faculty at the University of Virginia, starting as an assistant professor of hepatobiliary surgery in 1991 and leaving in 2008 for SIU as a tenured professor of surgery. In 2009 she received a master’s degree in health professions education from the University of Illinois, Chicago.

Dr. Sanfey is the immediate past-president of the International Society of Surgery, U.S. chapter, and a member of the American Surgical Association. Dr. Sanfey serves as faculty for the ACS Residents as Teachers and Leaders Program and has served as a specialist advisor in postgraduate surgical training and education in the department of surgical affairs, RCSI.

An ACS Fellow since 2001, Dr. Sanfey served as the ACS Liaison to the American Medical Association (AMA) Women Physicians Congress (2006–2009) and an ACS Governor (2006–2012). As a Governor, she chaired the B/G Committee on Chapters Subcommittee on Diversity (2009–2011) and the Nominating Committee (2010–2012). In addition, she served on the Executive Committee of the Committee on Medical Student Education (2005–2011) and as a liaison to the Program Committee. She presently serves on the Executive Committee of the Scholarship Committee.

She has been active on the Women in Surgery...
Committee since 2005. She has held high-ranking positions in other prestigious surgical organizations as well, including the AWS (president, 2005–2006) and the U.S. chapter of the International Surgical Society (president, 2013–2015). In addition, she has served on key committees of the Association of Program Directors in Surgery, the Association for Surgical Education, and the American Society of Transplant Surgeons.

Dr. Sanfey is on the editorial boards of the Association for Surgical Education, Journal of the Royal Colleges of Edinburgh and Ireland, and JACS. She is an accomplished surgical investigator and has contributed to more than 100 peer-reviewed papers and 24 book chapters, and has been a frequent guest lecturer and visiting professor at international symposia and workshops.

She is the recipient of many awards in surgical education. The AWS in 2010 renamed its Outstanding Woman Resident Award as the Hilary Sanfey Outstanding Resident Award, and in 2013 and 2014, respectively, Dr. Sanfey was honored with the AWS Olga Jonasson Distinguished Member Award and Nina Starr Braunwald Award.

An ACS Fellow since 1986, Dr. McCarthy has served in a number of leadership positions within the organization, including as an ACS Governor (1995–2001). As a Specialty Society Governor for the AWS, she served on the Nominating Committee (member, 1996–1997, and Vice-Chair, 1997–1998); the Governors Committee on Chapter Activities (1995–2001), chairing the committee’s Subcommittee on Chapter Membership Recruitment, Retention, and Diversification (1998–2001); and Advisor to the Governors Committee on Chapter Activities Executive Committee (1995).

Dr. McCarthy also served on the ACS Advisory Council for General Surgery and is a current member of the Committee on Trauma. She has served on the Surgical Education and Self-Assessment Program (SESAP®) Committee, including as Co-Chair for SESAP XII, 1999; the Committee on Continuing Education (Member, 1994–1999, and Vice-Chair, 1995–1997); the Committee on Applicants for District 6 (present); and the Clinical Congress Abstract Selection Committee (2007–2009). While at IU, she was active in the Indiana Chapter, and she remains active in the Ohio Chapter, having served on the Executive Committee (1995–2001) and the Ohio Committee on Trauma (1991–present).

She is a past-president of the AWS (1990–1992) and has served in prominent positions in the Association for Surgical Education, Eastern Association for the Surgery of Trauma, Halsted Surgical Society, Midwest Surgical Association, Parkland Surgical Society, and Society of Critical Care Medicine.

She is the recipient of numerous professional awards, including the American Hospital Association Nova Award, and AWS Distinguished Member, Olga Jonasson Award, and Nina Starr Braunwald Awards. She is a prolific author of peer-reviewed publications, book chapters, and abstracts on trauma and critical care.
Inaugural Mary Edwards Walker Award presented to Dr. Maniscalco-Theberge

Mary E. Maniscalco-Theberge, MD, FACS, Interim Medical Inspector, Veterans Health Administration, Washington, DC, and clinical professor of surgery, Uniformed Services University of the Health Sciences, Bethesda, MD, received the inaugural Mary Edwards Walker Inspiring Women in Surgery Award October 16 at the American College of Surgeons (ACS) Convocation Ceremony at Clinical Congress 2016, in Washington, DC.

The award, established by the ACS Women in Surgery Committee (WiSC), is a tribute to Mary Edwards Walker, MD (1832–1919), the first woman surgeon to serve in the U.S. Army and the only woman to receive the Congressional Medal of Honor, the highest U.S. armed forces decoration for valor.

Dr. Maniscalco-Theberge has long championed the advancement of women surgeons. She served as a U.S. Army Colonel and chief, department of surgery; general surgery residency program intern coordinator/advisor; and as program director, surgical critical care fellowship, Walter Reed Army Medical Center, then located in Washington, DC. The U.S. armed forces have honored Dr. Maniscalco-Theberge with several awards, including the Legion of Merit, Order of Military Merit, and the “A” Proficiency Designator, in recognition of the highest level of professional achievement.

Work for change
A Fellow of the College since 1989, Dr. Maniscalco-Theberge has held many leadership positions within the ACS, including President of the Metropolitan Washington, DC, Chapter of the ACS (2003–2004), and the District of Columbia chapter of the Association of Women Surgeons (AWS). In addition, she is a Past-Vice-Chair, ACS Committee on Resident Education (2004–2006), was a member of the ACS Committee on Patient Safety and Quality Improvement (2006–2009), and served on the DC Chapter Credentials Committee (1996–2000, 2002–2014).

A graduate of Eastern Virginia Medical School, Norfolk, she completed her general surgery residency at the Dwight D. Eisenhower Army Medical Center, Augusta, GA (1981–1986), a trauma/critical care fellowship at the
The award, established by the ACS Women in Surgery Committee (WiSC), is a tribute to Mary Edwards Walker, MD, (1832–1919), the first woman surgeon to serve in the U.S. Army and the only woman to receive the Congressional Medal of Honor, the highest U.S. Armed Forces decoration for valor.

Dr. Walker, for whom the award is named, graduated with honors from Syracuse Medical School in 1855, the only woman in her class. Dr. Walker volunteered to serve with the Union Army at the outbreak of the American Civil War. She was a prisoner of war for four months in 1864 after being captured while crossing enemy lines to treat wounded civilians.

Following her service in the Civil War, Dr. Walker worked for women’s suffrage in the U.S. She died one year before the passage of the 19th Amendment to the U.S. Constitution, which guarantees women the right to vote. Dr. Walker, who displayed an unwavering commitment to surgery, continues to serve as a role model for women surgeons.

The ACS will present the Mary Edwards Walker Inspiring Women in Surgery Award annually at the Clinical Congress in recognition of one individual’s contributions to the advancement of women in the field of surgery. ♦
The Continuum of Trauma Care

The Trauma Systems Consultation (TSC) Program evaluates state and regional trauma systems and provides consultative guidance on the organization and optimization of a variety of resources necessary to ensure patients are treated at the right facility in the right amount of time.

The program also supports and assesses future trauma system development in the specified area.

The TSC process and final report can assist the region to leverage change or provide assistance in securing additional resources.

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facs.org/quality-programs/trauma/tscp
Five outstanding surgeons conferred Honorary Fellowship in the ACS

Honorary Fellowship in the American College of Surgeons (ACS) was awarded to five prominent surgeons from Colombia, France, Pakistan, Japan, and Australia at the October 16 Convocation that preceded the official opening of Clinical Congress 2016 in Washington, DC. The granting of Honorary Fellowships is one of the highlights of the Clinical Congress. This year’s recipients were as follows.

Hernando Abaúnza Orjuela, MD, FACS, MACC(Hon), Bogotá, Colombia, is the founder, past-president, and current executive director of the Colombian Association of Surgery. He also is past-president of the Latin American Federation of Surgery (FELAC), which promotes research, teaching, and the practice of surgery among surgeons in Latin America. He became a Fellow of the ACS in 1970 and served on the ACS Board of Governors (1993–1999) and as President of the ACS Colombia Chapter (1990–1991). Dr. Abaúnza has written several articles on breast cancer and complex abdominal surgery problem, as well as more than 120 scientific papers and book chapters on gastric cancer, laparoscopy, and other clinical topics. Dr. Abaúnza became professor of general surgery and chief, department of surgery, San Pedro Claver Hospital, and professor, National University of Colombia, Bogota.

Dr. Abaúnza is a member of the International Society of Surgery and past-president of the Colombian Association of Gastroenterology.

Jacques Belghiti, MD, PhD, Paris, France, has made significant contributions to the fields of hepatocellular carcinoma and liver transplantation and has conducted vital studies in liver resection and hepatobiliary surgical oncology. His technical innovations include preservation of portal and caval flows during liver transplantation, the hanging maneuver to facilitate liver resection, and the use of peritoneal patch to provide an immediate and safe vascular graft. Dr. Belghiti was chief, department of hepatobiliarypancreatic surgery and liver transplantation, Beaujon Hospital, University of Paris, for 20 years. In 2014, the department was classified as the first French surgical digestive center. French President François Hollande invited Dr. Belghiti to serve on the board of the National Health Authority in 2014; he now chairs the board’s medical devices and health technology committee for reimbursement. Dr. Belghiti is associate editor, liver surgery and biliary section, World Journal of Surgery.

S. Adibul Hasan Rizvi, MB, BS, FRCSEng, FRCSEd, Karachi, Pakistan, is the founder of the Sindh Institute of Urology and Transplantation (SIUT) and a leader of transplantation in Pakistan. He started SIUT in 1972, which has become one of the fastest-growing urological and transplant centers in the region. SIUT offers procedures such as dialysis, lithotripsy, surgery, and transplantation. Pakistan’s first successful liver transplant was performed there in 2003, eight years after Dr. Rizvi and his team performed the first deceased renal transplant in the country. SIUT’s Dewan Farooque Medical Complex trains nurses, technical staff, and postgraduate physicians. All patient care is provided free of charge. The SIUT’s Hanifa Sulaiman Dawood Oncology Center now treats patients with post-transplant cancers and other malignancies. SIUT opened its first satellite unit in 2000, and three other
dialysis centers that are part of the institute offer free dialysis to medically indigent patients in Karachi. Dr. Rizvi is a member of the World Health Organization advisory panel on organ transplantation and the Global Alliance for Transplantation.

Sachiyo Suita, MD, PhD, Fukuoka, Japan, was the first woman professor to head a surgery department at a Japanese national university. Dr. Suita realized she wanted to become a surgeon during the Vietnam War, when she interned at the American Air Force Hospital, Tachikawa, Japan. A mentor at Kyushu University, Fukuoka, encouraged her interest in pediatric surgery. Dr. Suita became surgeon-in-chief at Fukuoka Children’s Hospital in 1983 and professor of pediatric surgery at Kyushu University in 1989. Her promotion to professor marked the first time a woman had been on the faculty of medicine at the university. Dr. Suita’s areas of interest include fetal surgery, neonatal surgery, pediatric oncology, clinical nutrition, liver and small bowel transplantation, and grief care. In 2004, Dr. Suita became the first woman director of Kyushu University Hospital.

John Francis Thompson, AO, MD, FACS, FRACS, FAHMS, Sydney, Australia, has provided distinguished service in the field of oncology research, particularly melanoma, in international and national professional organizations, and in medical education. Dr. Thompson has written more than 700 peer-reviewed scientific articles, which led to his appointment as an Officer of the Order of Australia in 2014. His research interests are in lymphatic mapping and regional node management of patients with melanoma and other malignancies, and local and regional therapies for recurrent and advanced limb tumors. He is executive director and research director, Melanoma Institute Australia, and professor, melanoma and surgical oncology, University of Sydney. Dr. Thompson is a member of the Melanoma Staging Committee of the American Joint Committee on Cancer and chairs the workgroup to update Australia’s clinical practice guidelines for management of cutaneous melanoma in Australia.

Presenting on behalf of the College, respectively, were Marco Patti, MD, FACS, Chicago, IL; Leslie H. Blumgart, MD, FACS, FRCS, New York, NY; Prof. Mehmet A. Haberal, MD, FACS(Hon), FICS (Hon), FASA(Hon), Ankara, Turkey; Arnold G. Coran, MD, FACS, Ann Arbor, MI; and Jeffrey E. Gershenwald, MD, FACS, Houston, TX.

Sir Rickman Godlee, president of the Royal College of Surgeons of England, was awarded the first Honorary Fellowship in the ACS during the College’s first Convocation in 1913. Since then, 458 internationally prominent surgeons, including the five chosen this year, have been named Honorary Fellows of the ACS. Following are the citations presented at the Convocation.

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President Richardson, it is my distinct privilege to present you and this assembly Prof. Hernando Abaúnza Orjuela of Bogota, Colombia, a renaissance surgeon and one of the principal thought leaders in South American surgery, for Honorary Fellowship in the American College of Surgeons.

Professor Abaúnza completed medical school and a residency in general surgery at the National University of Colombia, Bogota. After a few years, he became professor of general surgery and chief, department of surgery at the San Pedro Clever Hospital, a leading medical center in Colombia.

Over the years, he has contributed to the surgical literature with more than 120 scientific papers on breast cancer and complex abdominal surgery.

Professor Abaúnza was the founder, and then president, of the Colombian Association of Surgery.

In 1970, he became a Fellow of the American College of Surgeons, and from 1993 to 1999 he was the ACS Governor for Colombia. He is an honorary member of the majority of the surgical associations in Latin America. Notably, he was President of FELAC, the Latin American Federation of Surgery, and is currently the executive director of the Colombian Association of Surgery.

President Richardson and colleagues, I have summarized for you in a few words the professional life of Professor Abaúnza. Let me tell you now about the man. During the many times I have interacted with him, I have seen a charismatic, gentle, and humble man who leads by example with grace. He personifies the essence of the phrase, “It is nice to be important, but it is more important to be nice.”

President Richardson, Professor Abaúnza is a remarkable individual who has dedicated his professional life to the development of surgery in South America. I am honored to present him for Honorary Fellowship in the American College of Surgeons.

Professor Abaúnza
President Richardson, it is my privilege to present to you and this assembly a renowned surgeon and clinical scientist, Prof. Jacques Belghiti, from Paris, France, for Honorary Fellowship in the American College of Surgeons.

Professor Belghiti was born in Casablanca, Morocco, and graduated in medicine from the University of Paris in 1979. He was appointed professor of surgery in 1988, and in 1994 was appointed chief of hepatobiliary and pancreatic surgery and liver transplantation at Beaujon Hospital in Paris.

Professor Belghiti embodies everything that is excellent in an academic surgeon. He is a first-class technical surgeon and considered one of the most innovative and productive surgeons in the world. He has trained many young surgeons in the field of hepatobiliary and pancreatic disease and his program is recognized both nationally and internationally. He is widely published in peer-reviewed journals and has contributed to many books and served as co-editor of the major reference textbooks on hepatobiliary and pancreatic disease. The results of his controlled clinical studies and his innovative techniques are used worldwide.

Dr. Belghiti has received many honors. He is a member of many important societies around the world and has been president of the European HepatoPancreatobiliary Association and of the International Liver Transplantation Society. His achievements have been recognized by his appointment as a member of the American Surgical Association, as well as being named an honorary member of academic surgical societies in Japan, Argentina, Brazil, India, and Spain. In France, his achievements have been recognized by the award of the Chevalier de la Légion d’Honneur in 2003 and Officier de l’Ordre National du Mérite in 2008. He is the former president of the French Hepatopancreatobiliary Association and the National French Congress of Surgery, and he is a member of the French Academy of Medicine.

President Richardson, Professor Belghiti is a surgeon of distinction, and it is my honor to present him to you and to this association for Honorary Fellowship in the American College of Surgeons. ♦

Citation for Prof. Jacques Belghiti, MD, PhD

by Leslie H. Blumgart, MD, FACS, FRCS
President Richardson, it is my distinct privilege to present to you and this assembly Prof. S. Adibul Hasan Rizvi, founder of the Sindh Institute of Urology and Transplantation (Sindh Institute), for Honorary Fellowship in the American College of Surgeons.

After graduating from Dow Medical College, Karachi, Pakistan, in 1961, Professor Rizvi traveled the U.K., where, by 1967, he had completed his fellowship in surgery in London and Edinburgh. His intention had always been to return to Pakistan, where medical care was in greater need of specialists; as such, Professor Rizvi returned to Karachi in 1971. His dream of providing high-quality medical expertise free of charge first became a reality when he set up the Sindh Institute—an eight-bed unit in the burn ward of Civil Hospital, Karachi. Humble beginnings they may have been, but the Sindh Institute has since grown to be Pakistan’s leading and largest urology and transplantation facility.

I have had the honor of knowing Professor Rizvi on a professional and personal level for several decades, and in my opinion, he has provided more humanitarian aid for his people and his patients than any other single individual that I know. His outstanding accomplishments in medicine and the provision of free health care to his patients in Pakistan—one of the most poverty-stricken areas in the world—is nothing short of a miracle and worthy of great praise and recognition.

During the many years that I have known Professor Rizvi, I have never witnessed anything other than the most honest and humble desire to bring relief to the people of Pakistan and the world. I have enormous respect for him and for the work of Sindh Institute. Everyone who has had the privilege of meeting this man is acutely aware of his great knowledge and skill, and of his determination to help humanity in its struggle against disease.

It has been a privilege to know Professor Rizvi, whose passion and energy are unparalleled. His lifelong mission of providing “free health care with dignity” is an example to all of us.

President Richardson, Professor Rizvi is a brilliant and dedicated scientist and humanitarian. I am proud to call him my friend, and honored to present him for Honorary Fellowship in the American College of Surgeons.
President Richardson, it is my distinct privilege to present to you and this assembly Prof. Sachiyo Suita of Japan for Honorary Fellowship in the American College of Surgeons.

Professor Suita received her medical degree in 1966 and her PhD degree in 1973 from Kyushu University in Fukuoka, Japan. She completed postgraduate training at the same university in pediatric surgery. She spent 1968–1970 as a senior house officer in the department of pediatric surgery at the Alder Hey Children’s Hospital, Liverpool, U.K.

Following her training in pediatric surgery, she joined the faculty of pediatric surgery at Kyushu University, where she moved up the academic ladder and eventually became a professor of pediatric surgery and was chairman of the department from 1989 to 2010. She is the first woman in Japan to attain the position of department chair of pediatric surgery, and she presently serves on the board of directors at Kyushu University. She has held several important positions over the last several decades, including president of the Japanese Society of Pediatric Surgeons, president of the Asian Association of Pediatric Surgeons, a board member of the Pacific Association of Pediatric Surgeons, a council member of the British Association of Pediatric Surgeons, and an executive member of the World Federation of Associations of Pediatric Surgeons. Professor Suita is on the editorial board of the Journal of Pediatric Surgery and Pediatric Surgery International, the two major journals in our specialty. She is a fellow of the American Academy of Pediatrics.

Professor Suita’s main academic interests are in neonatal metabolism and parenteral nutrition. Professor Suita has been an active clinical pediatric surgeon for 35 years, in addition to all of her research and administrative responsibilities.

President Richardson, Professor Suita is a highly respected academic pediatric surgeon, recognized internationally. Having had the honor of receiving honorary membership in the Japanese Society of Pediatric Surgeons from Professor Suita at the time of her presidency of that association in 1997, I am honored to present her for Honorary Fellowship in the American College of Surgeons.
President Richardson, it is my distinct privilege to present to you and this assembly Prof. John F. Thompson of the University of Sydney and the Melanoma Institute Australia for honorary fellowship in the American College of Surgeons.

Born in England, Professor Thompson moved as a child to Norfolk Island, a tiny Australian island more than 900 miles off the northeastern coast. He later completed his undergraduate studies in Perth and medical studies in Western Australia and at the University of Sydney. He pursued postgraduate general surgical training in Sydney and Papua New Guinea and fellowship training in transplantation at the University of Oxford, U.K. This was followed by surgical oncology training at the Royal Prince Alfred Hospital, Sydney.

As executive director of the Melanoma Institute Australia, Professor Thompson leads one of the world’s largest melanoma treatment and research centers. During his long-standing tenure as a consummate academic surgical oncologist, he pioneered the minimally invasive surgical technique of isolated limb infusion. He has been among the most prolific international collaborators, including surgical clinical trials, research, and education, spanning nearly four decades. He led the first Australia-New Zealand Melanoma Guidelines Revision Working Group and was chairman of the Australia-New Zealand Melanoma Trials Group.

He is a Fellow of both the Royal Australasian College of Surgeons and the American College of Surgeons, was made an honorary fellow of the American Surgical Association, and was elected as an inaugural fellow of the Australian Academy of Health and Medical Sciences. In 2014, he became an officer of the Order of Australia, the nation’s highest recognition for distinguished service to medicine in the field of oncology research, particularly melanoma.

President Richardson, Professor Thompson is a consummate clinical and academic surgeon, mentor, and researcher who leads by example and demonstrates the highest moral character. I am honored that he has been a collaborator, friend, and role model, and am particularly delighted to present him for Honorary Fellowship in the American College of Surgeons.
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The December issue of the Bulletin will feature an in-depth exploration of past, present, and future American College of Surgeons (ACS) efforts to improve the quality of surgical care for older adults. The following is a brief summary of these initiatives.

Decades of progress
Over the years, the College has been a leader in responding to the growing need for the aging American population to have access to high-quality surgical care. People older than 65 years of age represent a rapidly growing segment of the U.S. population and a disproportionate share of individuals who undergo surgical procedures. Older adults have unique physiology, which often puts them at risk for complications after surgery. At a time when the quality and value of health care are under increasing scrutiny, the need for high-quality standards to improve surgical care delivery for this vulnerable population is on the rise.

The ACS has invested in improving surgical care for older adults over several decades. The ACS has partnered with the American Geriatrics Society (AGS) and The John A. Hartford Foundation since 1995 and has had a standing Geriatric Surgery Task Force since 2004. In an interdisciplinary effort, the ACS, the AGS, and The John A. Hartford Foundation issued a set of guidelines for preoperative care of geriatric patients in 2012, with a follow-up set of guidelines for perioperative and postoperative care in 2016.

Through the College’s National Surgical Quality Improvement Program (ACS NSQIP®), members of the Geriatric Surgery Task Force began collecting 14 patient-centered, geriatric-specific variables to better appreciate the unique risk factors and outcomes of older adults.

Coalition for Quality in Geriatric Surgery
Most recently, the ACS, with support from The John A. Hartford Foundation, convened a group of more than 50 stakeholders as the Coalition for Quality in Geriatric Surgery. This interdisciplinary, patient- and family-centered coalition aims to systematically improve surgical care for older adults. These improvements are intended for all geriatric surgical care programs, regardless of hospital size, location, or academic status. After an extensive standards evaluation process, the interdisciplinary panel is preparing to release the first iteration of high-quality geriatric surgery standards.

The project has garnered 74 mentions in the media as of press time, in addition to interviews on SiriusXM Doctor Radio, featuring Julia Berian, MD, ACS Clinical Scholar in Residence; Clifford Y. Ko, MD, MS, MSHS, FACS, FASCRS, Principal Investigator, and Director, ACS Division of Research and Optimal Patient Care; and Ronnie Rosenthal, MD, MS, FACS, Chair, ACS Geriatric Surgery Task Force and Co-Principal Investigator, Standards Subcommittee Co-Chair. Media outlets that have reported on the project include FOX News, Reuters, Medscape, and Surgical Products.

♦
New history of ACS Bulletin reflects history of the College

To celebrate the centennial of the *Bulletin of the American College of Surgeons* (ACS), David L. Nahrwold, MD, FACS, has written a history of the ACS member magazine, titled *A Mirror Reflecting Surgery, Surgeons, and their College: The Bulletin of the American College of Surgeons*.

“After studying the history of the College and the content of 100 years of *Bulletins,*” writes Dr. Nahrwold in the book’s foreword, “I soon realized that the *Bulletin* has conveyed the remarkable story of how the College and its members laid the foundation for our healthcare system.”

The *Bulletin* began in 1916 as a series of single-subject bulletins to the Fellowship from the College’s founders. The first issue described the mission of the College, listed the requirements for admission to Fellowship, and included a packet of blank case history forms for candidates to fill out and submit with their application. Subsequent issues established hospital standards, summarized external and internal meetings and conferences, and reported on credentialing, record keeping, education, specialization, ACS finances and structure, public health issues, scientific advances, international relations, and military surgery, among other subjects.

The book covers the history of the magazine through the end of World War II, and illuminates the background, concerns, and personalities of the College’s founders and leaders as they explained and defended their actions to the members and determined what role the ACS would play in the practice of surgery.

“Given the unpredictable fates of periodicals,” Dr. Nahrwold writes, “it is remarkable—indeed astonishing—that this mirror, the *Bulletin*, has not only existed, but has thrived, for one hundred years. Its fortunes, of course, have been tied to those of the College, but its editors and staff have continuously adjusted the mirror to make it informative, pertinent, and interesting, and its readers have found deep within the mirror a reservoir of truthfulness, accuracy, and good taste.”

Dr. Nahrwold is Emeritus Professor of Surgery at Northwestern University Feinberg School of Medicine, Chicago, IL, where he was the Loyal and Edith Davis Professor and Chairman, department of surgery, and surgeon-in-chief, Northwestern Memorial Hospital. He served as a Regent, Chairman of the Board of Governors, First Vice-President, and Interim Director of the ACS, and in 2001 he received its highest honor—the Distinguished Service Award. He represented the College at The Joint Commission, where he was chairman of the Board of Commissioners.

He was a director and chairman of the American Board of Surgery and president of the American Board of Medical Specialties.

Dr. Nahrwold is co-author, with Peter J. Kernahan, MD, PhD, FACS, of *A Century of Surgeons and Surgery: The American College of Surgeons 1913–2012*.

*A Mirror Reflecting Surgery, Surgeons, and their College* is available for purchase for $15.95 at amazon.com. ♦
Health Services Research Methods Course registration now open

The Health Services Research Methods Course (previously the Outcomes Research Course) will take place December 8–10 at the American College of Surgeons (ACS) headquarters in Chicago, IL. Course Chair Arden M. Morris, MD, MPH, FACS, vice-chair, clinical research, and professor of surgery, Stanford University School of Medicine, CA; and Vice-Chair Caprice C. Greenberg, MD, MPH, FACS, director, Wisconsin Surgical Outcomes Research, University of Wisconsin Hospital and Clinics, Madison, will lead the three-day course, which has been redesigned for clinical and health services researchers with varying degrees of experience.

Attendees will participate in didactic lectures and skills-based labs. In addition, participants will select modules appropriate to their skill levels and interests, with a focus on quantitative, qualitative, mixed methods, and implementation science. Each course attendee will schedule a consultation with a leading expert, who will offer a critique and advice on a specific research idea or project. Breakout sessions will review writing R-award and K-award proposals, as well as securing a first-faculty position. Leaders in the field will expose participants to the scientific and practical aspects of ongoing surgical health services research.

Registration is limited to 70 participants, with ACS members receiving preference. This course is offered only every other year. View the course website (facs.org/quality-programs/about/cqi/education/outcomes-research-course) for the schedule, registration, and additional course details.

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Health Services Research Methods Course registration now open
ACS now accepting 2017 Jacobson Promising Investigator Award applications

The American College of Surgeons Surgical Research Committee is accepting applications until February 24, 2017, for the 2017 Joan L. and Julius H. Jacobson II Promising Investigator Award. This award recognizes outstanding surgeons engaged in research, advancing the art and science of surgery, and demonstrating early promise of significant contributions to the practice of surgery and the safety of surgical patients.

This award is intended for surgeons who are at the “tipping point” of their research careers with a track record indicative of early promise and potential. Well-established surgeon-scientists are ineligible for the award.

For details on award criteria and nomination procedures, visit the Jacobson Promising Investigator Award website at facs.org/quality-programs/about/cqi/Jacobson.

20 cancer care facilities receive biannual CoC Outstanding Achievement Award

The Commission on Cancer (CoC) of the American College of Surgeons (ACS) has granted its mid-year 2016 Outstanding Achievement Award (OAA) to a select group of 20 accredited cancer programs throughout the U.S.

Award criteria were based on qualitative and quantitative surveys conducted January 1 through June 30, 2016. The biannual award was established in 2004 to recognize cancer programs that strive for excellence in demonstrating compliance with the CoC standards and are committed to ensuring high-quality cancer care.

A CoC-accredited cancer program is eligible to earn the OAA after completing the accreditation survey and receiving a performance report that indicates an accreditation award of “Three-Year with Commendation.” Specifically, the program must receive commendation ratings for the seven commendation level standards and no deficiencies for the remaining 27 standards.

View the list of this year’s first group of OAA recipients on the ACS website at facs.org/quality-programs/cancer/coc/info/outstanding/2016-part-1.

Coming in December in JACS, and online now

Operative Site Drainage after Hepatectomy: A Propensity Score Matched Analysis Using the American College of Surgeons NSQIP Targeted Hepatectomy Database

David G. Brauer, MD, MPHS; Timothy M. Nywening, MD, MS, MPHS; David P. Jaques, MD, FACS; and colleagues use the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP®) targeted hepatectomy database to analyze operative site drainage after elective hepatectomy. In a propensity score matched population, operative site drainage is not associated with a diagnosis of post-hepatectomy bile leaks requiring intervention, but is associated with a greater number of drainage procedures, and contributes to greater length of stay and increased unplanned 30-day readmissions.

This article and all other JACS content is available at www.journalacs.org.
Being selected to serve as the American College of Surgeons (ACS) Traveling Fellow to Australia and New Zealand (ANZ) was truly a dream come true. As someone who has traveled considerably and has visited most continents, I had always wanted to travel to Australia and New Zealand, but they always seemed too far away. So, I was excited to represent the ACS on this trip and to share this experience with my 21-year-old son, Nima.

**An adventurous start**

We arrived in Auckland, New Zealand, at approximately 6:00 am on ANZAC Day, which is the equivalent of Veterans Day in the U.S. The esteem that New Zealanders of all ages have for their veterans was palpable. We had breakfast at a café on the nearby island of Devonport, where a memorial parade was under way.

From there we took a tour of Auckland with the President and Governor of the ANZ Chapter of the ACS, Ian Civil, MB, BCh, FACS. Dr. Civil took us to the highest point in Auckland, one of many volcanic craters in the area.

The next day we traveled south to visit the famous Waitomo caves. Perhaps because I consider myself a moderately adventurous surgeon, the name of the tour, The Abyss, somehow did not register as beyond my ability. The start of the tour involved “abailing,” which is rappelling nine stories down into a cave with an ice-cold river running through it. I had not calculated how we would be coming out of the cave in the dark at 8:30 at night. It involved climbing back up nine stories of sheer rock. I made it out alive, but it was the scariest thing I have ever done. Once we were back on firm ground, the view of the starry sky was amazing.

At dinner that night I learned from my host, Win Meyer Rochow, MB, BCh, PhD, FRACS, an endocrine laparoscopic and general surgeon at Waikato Hospital, one contributing factor to the national obsession with adventure and the general lack of worry about injuries: all New Zealanders and visitors to the country have no-fault personal injury insurance coverage through the Accident Compensation Corporation. This insurance provides compensation for virtually all physical and mental injuries and applies to all aspects of care, treatment, and rehabilitation. It is provided in place of the ability to sue for personal injury.
According to the surgeons I met, this system, which has been in place for more than 10 years, has eliminated lawsuits against surgeons while ensuring that all patients receive appropriate care for any surgical complications resulting in injury. The surgeons assured me that this system has allowed them to be honest with their patients and to candidly admit any complications so that they can be addressed in a straightforward fashion.

Waikato and North Shore Hospitals
My trip to Australia and New Zealand coincided with the week when senior registrars, or residents, prepare for their oral board exams. Preparations were intense, and I was asked to help prepare these residents with a variety of endocrine and head and neck cases. Richard M. Harman, MD, FACS, gave me a tour of North Shore Hospital in Auckland, including the operating rooms. I learned that in the ANZ training system, the first year or two is spent as a registrar in a hospital, followed by training as a surgical registrar. Not all registrar spots are for training, and some registrars continue to function for many years almost as moonlighting residents do here in the U.S., tasked with the daily functions of the hospital and patient duties. The training registrars in general surgery go on to train in all aspects of surgical care, but in contrast to the U.S. system, in which residents match to a particular program, the registrars in New Zealand and Australia are free to move from hospital to hospital every few months. Many residents thus seek the best training for a particular area of general surgery—such as a three- to six-month rotation at hospitals with expertise in surgical oncology or endocrine surgery. Resident training occurs in both the public and private hospital setting, as most attending surgeons practice at both sites. The private hospitals are often adjacent to or near the public hospitals, and the residents get the benefit of a bit of increased independence at the public hospitals.

The trainees were surprised by the U.S. work-hour restrictions and the results of the Flexibility In duty hour Requirements for Surgical Trainees (FIRST) Trial, which I described to them. In their system, the registrars work far fewer hours and get paid overtime if they have to stay beyond their regular work hours. I asked exam questions similar to those we ask U.S. residents during mock oral boards at three different hospitals—Waikato Hospital, Auckland’s Northshore Hospital, and Sydney’s Northshore Hospital. There was great diversity among the residents, and they had a solid knowledge base and practical know-how. The senior residents are given a lot of independence at night to provide care for routine general
surgery cases, and attendings are available nearby if needed.

**Multidisciplinary research at the Kolling Research Institute**

My next stop was Sydney, Australia, where I spent one day visiting the Opera House and nearby gardens. We could see the Opera House from all angles as we traveled to Manley Beach via the ferry. Biking the nearly vertical, winding roads to the bluffs above Manley beach was an exhausting effort, but the views were expansive and exhilarating.

I had the pleasure of meeting the endocrine surgeons and endocrinologist at the Royal North Shore Hospital and the Kolling Research Institute in Sydney. My lecture, Aggressive Thyroid Cancers—Lessons from Surgical Labs, was well received. I met with researchers and surgical colleagues and rounded with Mark Sywak, MB, BS, MMed Sci, FRACS, associate professor of surgery. We discussed opportunities for collaboration, and in the upcoming year we will be partnering with our endocrinology colleagues in a multicenter international clinical trial of immunotherapeutics for radioiodine-resistant thyroid cancer. Dr. Sywak and his team presented their annual endocrine surgery census, which is culled from their extensive database. It was interesting to see that in Australia, as in the U.S., there is a drive to extensively capture data about surgical patients, but no one wants to directly pay for the resources required to accomplish this. In Sydney, much like at U.S. hospitals, there is a yearly scramble to gather funds from various sources to pay for the database manager.

**Operating with respect**

The final leg of the trip was in Brisbane—the host city for the 85th Annual Scientific Congress of the Royal Australasian College.
of Surgeons (RACS). My host, Jenny Gough, MB, BCh, FRACS, an endocrine surgeon at Melbourne, arranged the entire endocrine surgery program at the RACS, which was superb. I gave a number of lectures in my three days there—one on vocal cord ultrasound, another involving thyroid nodules, and a third on difficult parathyroid surgical cases. I learned a lot from abstracts and talks presented at this meeting.

The theme of this RACS program was Operate with Respect. It was resoundingly clear that this surgical organization, like the ACS, believes that being inclusive and respectful of all members of the operating team, including the patient, will yield dividends in the future for patients and surgeons alike.

I was impressed with the equanimity of RACS president David Watters, MCh, FRCSEd, FRACS. His interest in promoting diversity was especially evident when he attended the Women in Surgery Breakfast where he individually interacted with the 80 attendees and answered questions about the RACS’ efforts to promote gender equity. He introduced the keynote speaker, Clare L. Marx, CBE, DL, MB, BS, the first woman President of the Royal College of Surgeons of England.

The Women in Surgery group of the RACS, under the leadership of Ruth Bollard, MD, BCh, FRACS, has started a mentorship program, and I put her in touch with the ACS Women in Surgery Committee, which also manages a successful mentorship program.

During the dinner at the RACS, we enjoyed three stunning operatic performances by the Melbourne Opera.

I was recognized for my contributions to the RACS, but it was my pleasure to have been there and to have met these wonderful colleagues with whom I hope to be in contact for years to come.

While I got to see only a sliver of Australia and New Zealand, I learned about the warmth of the people of these two countries, and now I understand why the RACS and ACS established this wonderful fellowship. The trip included so many high points, but it finally ended with two fantastic, fun days, which included a visit to Lone Pine Koala Sanctuary in Brisbane, the oldest Koala Sanctuary in the world, where I got to hug a koala; as well as three once-in-a-lifetime dives at the Great Barrier Reef. I cannot wait to go back and see all these lovely friends again soon. ♦
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**2016 Webcast Package**
Access all 122 webcast sessions from Clinical Congress 2016.

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<th>For Residents</th>
<th>Other</th>
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**Pick 25 of 2016**
Select 25 of the 122 webcast sessions from Clinical Congress 2016.

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*Practicing Surgeons are eligible for CME Credit and Self-Assessment Credit.

Visit [facs.org/clincon2016/about/resources/webcasts](http://facs.org/clincon2016/about/resources/webcasts) or contact Olivier Petiaux by phone at 866-475-4696 or by e-mail at elearning@facs.org.
Calendar of events

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

NOVEMBER

Argentina Chapter
November 14–17
Buenos Aires, Argentina
Contact: Raul Ferreres, albertoferrerest@gmail.com, www.facs.org.ar

Patient-Reported Outcomes in Surgery Conference
November 17
Washington, DC
Contact: Katie Sommers, k.sommers@plasticsurgery.org, bit.ly/2bkEFJ

Keystone Chapter
November 18
Danville, PA
Contact: Lauren Newsmaster, l.newmaster@pamedsoc.org, www.keystonesurgeons.org

Arizona Chapter
November 19–20
Tucson, AZ
Contact: Joni Bowers, jonib@azmed.org, www.azacs.org

New Jersey Chapter
December 3
Iselin, NJ
Contact: Andrea Donelan, njsurgeons@aol.com, www.nj-acs.org/

Philippines Chapter
December 6
Manila, Philippines
Contact: Vicky Pamintuan, Tel. 011-63-632-7432119

Brooklyn-Long Island Chapter
Annual Clinic Day
December 7
Uniondale, NY
Contact: Teresa Barzyk, acsteresa@aol.com, www.blia.org

DECEMBER

Massachusetts Chapter
December 3
Boston, MA
Contact: Amy Nolfi, anolfi@prri.com, www.mcacs.org/

New Jersey Chapter
December 3
Iselin, NJ
Contact: Andrea Donelan, njsurgeons@aol.com, www.nj-acs.org/

Philippines Chapter
December 6
Manila, Philippines
Contact: Vicky Pamintuan, Tel. 011-63-632-7432119

Brooklyn-Long Island Chapter
Annual Clinic Day
December 7
Uniondale, NY
Contact: Teresa Barzyk, acsteresa@aol.com, www.blia.org

Puerto Rico Chapter
February 18–20
San Juan, PR
Contact: Aixa Velez-Silva, acspuertoricochapter@gmail.com, www.acspuertoricochapter.org/

North & South Texas Chapters
February 23–25
Austin, TX
Janna Pecquet, janna@southtexasacs.org, www.ntexas.org/ and www.southtexasacs.org/

JANUARY 2017

Southern California Chapter
January 20–22
Santa Barbara, CA
Contact: James Dowden, jdowden@prodigy.net, www.socalsurgeons.org/

Montana-Wyoming Chapter and Idaho Chapter
January 27–29
Teton, WY
Contact: Cyan Sportsman, csportsman21@outlook.com, squ.re/2dK13CI

FEBRUARY

Puerto Rico Chapter
February 18–20
San Juan, PR
Contact: Aixa Velez-Silva, acspuertoricochapter@gmail.com, www.acspuertoricochapter.org/

North & South Texas Chapters
February 23–25
Austin, TX
Janna Pecquet, janna@southtexasacs.org, www.ntexas.org/ and www.southtexasacs.org/

FUTURE CLINICAL CONGRESSES

2017
October 22–26
San Diego, CA

2018
October 21–25
Boston, MA

2019
October 27–31
San Francisco, CA