Ensuring patient safety in the modern OR
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Over the course of the last year, many Fellows, Associate Fellows, and Resident Members of the American College of Surgeons (ACS) have taken to the ACS Communities to voice concern that the hospitals where they practice have imposed restrictive guidelines regarding proper attire in and out of the operating room (OR). As an organization that is dedicated both to serving the professional interests of our members as well as to safeguarding the well-being of the surgical patient, the ACS sought to determine whether the restrictions at these institutions were reasonable and appropriate.

This issue of the Bulletin includes an article on the efforts of the Young Fellows Association of the ACS to gauge young surgeons’ reaction to the protocols and to study the scientific evidence supporting or refuting the need for these restrictions (see page 10). Also in this issue is the College’s “Statement on operating room attire” (see page 47). A task force led by ACS Regent L. Scott Levin, MD, FACS, and comprising members of the ACS Committee on Perioperative Care and the Council on Surgical and Perioperative Safety developed the statement, which is based on the principles of professionalism, common sense, decorum, and the available evidence. The Board of Regents approved the guidelines in July.

Turning the “green tide”
One of the behaviors that led members of the patient safety community to develop OR attire restrictions is the rising “green tide” of hospital personnel who arrive at and leave their work area and institutions at the start or the end of their shifts or breaks in their OR scrubs. It has become commonplace in cities such as New York, NY, and Chicago, IL, to see droves of hospital personnel emerging from medical center campuses and entering restaurants, stores, and subway stations while still in their green scrubs. When patients and their families see health care professionals wearing greens in environments that are anything but sterile, it raises red flags about patient safety and welfare.

To address this problem, the College’s statement recommends that OR scrubs be worn outside of the hospital’s OR area only when worn under a clean lab coat or other appropriate cover up and even then should only be worn only within the hospital perimeter. Furthermore, the ACS encourages surgeons to wear clean professional attire (not scrubs) during all patient encounters outside of the OR. To facilitate enforcement of the guideline on wearing scrubs only within the perimeter of the hospital, the ACS also suggests the adoption of distinctively colored scrub suits for OR personnel.

Head covering
Another concern that led to the development of OR attire guidelines is the debate over proper covering of the head. The College maintains that during invasive procedures, the mouth, nose, and hair on the skull and face should be covered to avoid potential wound contamination, and that the surgical mask should never be allowed to dangle from the face during an operation.

Large sideburns and ponytails should be covered or contained; however, we found no evidence to suggest that leaving ears, a limited amount of hair at the nape of the neck, or modest sideburns uncovered contributes to wound infections. In fact, covering the ears may be detrimental to patient care by making communication more difficult. Therefore, contrary to the guidelines set forth at some institutions, the College maintains that the surgical skullcap provides sufficient coverage of the head when worn with a mask and proper eyewear and in accordance with other patient safety protections. We have found no evidence to suggest that the bouffant head covers mandated under some guidelines provide more effective coverage. Indeed, as the photo on page 9 shows, hair is as likely to creep out of bouffant hats as any other head covering.

Keep it clean
Further debate has centered on how frequently scrubs need to be changed, especially since they are often worn under impermeable OR gowns. The ACS maintains that scrubs and hats worn during dirty or
contaminated cases should be changed as soon as feasible and certainly before speaking with family members after an operation. Furthermore, scrubs and caps worn during dirty or contaminated cases should be changed prior to subsequent cases even if not visibly soiled. All cloth caps should be cleaned and sanitized daily, and paper caps should be disposed of daily.

Nationwide adoption
The professional attire guidelines implemented at some institutions are based largely on protocols that other organizations have developed recently. Now that the College has produced this statement, we look forward to being a constructive contributor to this conversation.

To ensure the widespread implementation of our recommendations, the College also is collaborating with the Centers for Medicare & Medicaid Services and The Joint Commission to ensure that their policies and regulatory oversight activities are aligned with the ACS recommendations. Mark R. Chassin, MD, MPP, MPH, FACP, president and chief executive officer of The Joint Commission, has indicated that he is sympathetic to the College’s perspective and is willing to work with verification programs to adopt policies that are based on the available evidence and common sense. We will be reaching out to other groups to achieve consensus.

The ACS “Statement on operating room attire” reflects our strong commitment to patient safety and to providing an optimal surgical care environment for our patients. These recommendations for a comprehensive dress policy for surgeons will help us to achieve that goal. ♦
Young surgeons speak up:
Stringent OR attire restrictions decrease morale without improving outcomes

by Jacob Moalem, MD, FACS;
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Nationwide and with increasing frequency, departments of perioperative services have been modifying internal policies regarding appropriate attire in the operating room (OR). This movement has gained momentum since January 2015 when the Association for periOperative Registered Nurses (AORN) published a set of recommendations on OR attire (see sidebar, page 12). Despite extensive criticism for lack of scientific rigor and the authors’ own description of many of the supportive studies as “quasi-experimental” or “non-experimental,” these were the first (and only) set of specialty society-endorsed recommendations on this issue to be accepted by regulatory agencies such as the Centers for Medicare & Medicaid Services (CMS).1,2

The surgical team responds
To comply with AORN’s recommendations, many surgery departments and health systems have adopted increasingly stringent policies designed to minimize the exposed areas of skin and hair of members of the perioperative services team as a means of reducing the risk and incidence of surgical site infections (SSIs). These policies have been implemented with marked variability in hospitals across the country. Furthermore, the rigor with which these policies are enforced has been inconsistent, with some centers lacking any mechanism to verify compliance after implementation. At other institutions, full compliance with attire protocol has been incorporated into the preoperative checklist, preventing the start of a procedure until full compliance is achieved.

Many surgeons have expressed concerns about a lack of data to support these changes, leading in some instances to vocal opposition and frustration.2,3 Surgeons and nurses alike have complained of significant infringements on their comfort, autonomy, and ability to concentrate. Some members of the perioperative team have refused to comply with these guidelines, whereas others have relented due to a perception of powerlessness.

YFA intercedes
The Young Fellows Association (YFA) of the American College of Surgeons (ACS) is composed of ACS Fellows who are 45 years old and younger.4 The YFA is structured to promote diversity, to seek feedback, and to encourage participation among young Fellows so that the ACS leadership can better understand the needs of this important and growing constituency. The YFA Governing Council (GC) comprises 15 members who are carefully selected following open nominations and who reflect the diversity of the College in terms of geography, specialty, gender, and ethnicity.5

In response to growing complaints from Fellows regarding restrictions on OR attire, the YFA GC decided to investigate the variability in perioperative policy changes and the rationale and driving forces behind them with an eye toward critical appraisal of the data upon which these policies are based. A key goal was to characterize the perception of young Fellows regarding the effect these changes will have on patient safety, SSI rates, and the morale and overall function of the operative team.
Survey development

Based on existing discussions in the online ACS General Surgery Community, the YFA GC created a Web-based electronic survey designed to collect demographic information, data related to changes in OR attire policies, and the perceived impact of these changes. To our knowledge, this study is the only formal investigation of surgeon perceptions related to these policy changes.

For this study, we asked the members of the YFA to share their opinions regarding the recent policy changes. We also asked the leadership of the YFA GC and its three Past-Chairs to voice the opinions of their constituents related to the recent policy changes, in addition to performing an independent critical appraisal of the AORN recommendations and their scientific validity. We then compared the constituent opinions of the YFA GC members with those of the YFA membership at large. The survey also contained open-ended questions to enable collection of qualitative data.

A limited version of the survey was posted online in the YFA Community, which at the time of the survey had 5,736 subscribers. Two reminder messages were posted on the Communities page, and the survey remained open for comment for two weeks.

In addition to completing the survey, members of the YFA GC were tasked with expressing the global viewpoint of their constituency after carefully reviewing the AORN guidelines to appraise their content. They also were asked to interview leaders in their perioperative services departments to determine the key factors that led to recent changes in OR attire policy.

YFA member responses

A total of 317 YFA members completed the survey. Respondents were from a mix of all surgical specialties; the highest response rate was from general surgeons (26.9 percent), followed by colon and rectal (10.4 percent), trauma (7.6 percent), plastic (6.3 percent),
and minimally invasive/bariatric surgeons (6 percent). Respondents were distributed fairly evenly among those in private practice (24 percent), part of a multispecialty group (30 percent), or at an academic institution (43 percent). Reflective of the demographics within our YFA community, most surgeons who reported an academic rank were assistant or associate professors (51 percent and 28 percent, respectively). Our surgeons are geographically diverse, representing all regions of the U.S. Of the respondents, 65 percent were male.

Commonly reported new OR attire restrictions imposed in the last year include the following:

- Ban on cloth surgical caps (70 percent)
- Prohibition of home-laundered scrubs (57 percent)
- Requirement that bouffant hats be worn in the OR (37 percent)
- Requirement that OR hats be pulled down to cover the ears such that sideburns and all facial hair are covered (27 percent)
- Requirement that all OR personnel cover arms and exposed skin (12 percent)
- Prohibition on rings (7 percent)
- Mandated use of shoe covers (7 percent)

Other respondents disclosed guidelines prohibiting mesh sneakers or mandates that socks be worn in the OR. Two participants indicated that earrings were banned from the OR. Some respondents reported guidelines prohibiting undershirts, whereas others reported requirements that undershirts be worn. Two surgeons indicated that their hospital had new requirements for plastic bags covering anything brought into the OR, including briefcases and loupe cases.

The respondents were largely skeptical of the potential benefits of these requirements. In fact, 91 percent disagreed or strongly disagreed that “disallowing cloth caps will reduce wound infections.” Similarly, 91 percent of respondents disagreed or strongly disagreed that “mandating complete coverage of ears and sideburns will reduce wound infections.” None

FIGURE 1. YFA MEMBER PERCEPTIONS REGARDING NEW OR ATTIRE POLICIES
of the respondents agreed that “recent changes in OR attire are based upon valid scientific evidence,” and 97 percent strongly disagreed or disagreed with this statement. On the other hand, 79 percent of the respondents agreed or strongly agreed that surgeon comfort is an important safety concern, and 87.5 percent indicated that surgeon discomfort could negatively affect patient outcomes. (See Figure 1, page 13.) In all, 31.9 percent indicated that they have operated while uncomfortable because of recent changes in attire regulations, and 52.8 percent indicated that they have operated while uncomfortable because of changes in OR temperature.

Overall, most respondents said that the changes in OR attire would not affect SSI rates (93 percent) or overall outcomes (96 percent) in their hospitals. Among those respondents who indicated that changes in OR attire would influence wound infection rates and overall outcomes, more believed that infection rates and outcomes would worsen rather than improve. Of the respondents, 69 percent said that these changes lessen surgeon comfort, and most indicated that these regulations lower morale among nurses (58.4 percent), anesthesiologists (52.8 percent), surgeons (71.2 percent), and the surgical team as a whole (67.1 percent). (See Figure 2, this page.)

In the comments section of the survey, respondents expressed gratitude that the YFA was conducting this study and a sense of frustration that the recent surge in policies related to OR attire is not evidence-based. Interestingly, one Fellow reported being involved in a prospective study to investigate OR attire policies that was halted because of fear of being “out of compliance” with recommendations.

**Guideline implementation**

Another prominent theme suggested by the survey was that surgeons felt poorly positioned to influence the creation and implementation of guidelines in the OR and that many of these policies were being developed by nonphysicians. Moreover, respondents expressed concerns related to differential enforcement of attire policies. One surgeon was concerned that in her hospital, patient care has been delayed because consultants are forced to completely change into scrubs before entering the OR suites (bunny suits have been disallowed), whereas noncompliant contractors and other
nonphysicians are routinely seen in the OR without changing into scrubs attire. Another surgeon expressed outrage that, by policy, the infection control personnel who round through the OR at his hospital were exempt from the attire regulations to which all other personnel are required to adhere. Finally, several surgeons expressed concern regarding an increased risk of infection in their patients because of their own perspiration dripping into the wound as a result of uncomfortably warm room requirements.

We also compared the responses of the members of the YFA GC with those of the general YFA membership. We found that the responses of the YFA GC members closely approximated the responses of members of the YFA at large.

In interviews with perioperative services leaders, compliance with regulatory mandates (such as those issued by state health departments or The Joint Commission) emerged as the “most important” reason for instituting new OR attire policies. Of 16 hospitals, 14 cited a visit from a regulatory agency as the “most important” (10) or a “very important” (four) factor in establishing new policies on OR attire. A regulatory visit at a neighboring hospital was considered a “most important” factor in the creation of new OR attire policy changes at four additional hospitals. Efforts to reduce infection rates were cited as a contributing factor in the creation of new policies by nearly all respondents, but were considered “most important” by only five.

All members of the YFA GC carefully reviewed the AORN guidelines document mentioned at the beginning of this article. The survey revealed that 17 of the 18 GC members and Past-YFA Chairs disagreed (10) or strongly disagreed (seven) that “most of the evidence cited in the AORN document is scientifically valid,” and 16 of 18 disagreed or strongly disagreed that “the evidence in that document supports the conclusions and recommendations that were made.” Likewise, 16 of 18 agreed (five) or strongly agreed (11) that the AORN recommendations were published with insufficient consideration for the complex nature of wound infections.

**Discussion**

In alignment with the College’s mission statement, the YFA is “dedicated to improving the care of the surgical patient and to safeguarding standards of care in an optimal and ethical practice environment.” Because SSI is the second most common hospital-acquired infection and associated with increased morbidity, length of stay, and costs, prevention of SSI is an important goal for all ACS members. However, research shows that SSIs are
complex in nature and arise from etiologies that are both intrinsic and extrinsic to the patient. Although many SSIs are potentially preventable, nearly half are unavoidable using existing evidence-based strategies. It is noteworthy that participation in the ACS National Surgical Quality Improvement Program (ACS NSQIP®) is related to a significant decline in SSI rates.

Our study yielded several important findings. First, it is apparent that several changes in perioperative services policies have been implemented in many hospitals or health systems over the past year, but their enforcement varies greatly. Another important finding in our study is that the overwhelming majority of respondents (93 percent and 96 percent, respectively) thought that the recent policy changes would have no impact on wound infections or overall outcomes. More than 90 percent of respondents either disagreed or strongly disagreed with specific statements in support of the implementation of specific new restrictions to attire in the OR.

A majority of respondents believed that the new changes in OR attire would either worsen (approximately two-thirds of all respondents) or have no effect (approximately one-third of all respondents) on morale among surgeons, nurses, anesthesiologists, and the team as a whole. In addition, 70 percent of respondents reported that the comfort of the operating surgeon would be reduced—a significant finding, given that more than 80 percent indicated that surgeon comfort is an important safety factor that could negatively affect patient outcomes.

The survey suggests that the most common driving force in creating new OR attire policies are visits by regulatory agencies. These agencies require OR personnel to follow a nationally recognized set of guidelines. However, when our team of surgical leaders reviewed the guidelines for perioperative practice—standards that are the foundation of most new OR attire policy changes—we were nearly unanimous that the evidence cited does not support the AORN’s recommendations and that much of the evidence lacks scientific validity in the first place. (See Figure 3, page 15.)

AORN guidelines: What is the evidence?

We carefully reviewed the literature used to develop the AORN guidelines. As stated earlier in this article, much of the evidence that formed the basis for the AORN recommendations is “quasi-scientific,” and is founded on the premise that health care workers and their apparel lead to bacterial contamination in the OR. It has been well documented that bacteria are found in human hair, on surgical attire, and on shed skin cells called squames. Many of the cited studies looked at colony-forming units (CFUs) produced by the dispersal of bacteria through the air and the number of bacterial species that were found on scrubs, but to date, no study has shown that the use of specific scrub type has a direct effect on SSI.

Recommendations also were made to completely cover arms with a long-sleeved jacket. This guideline is also based on a theoretical risk of SSI due to squame production from exposed skin. Interestingly, in 2007, the U.K. Department of Health took the exact opposite stance and implemented a “bare below the elbows” policy, which was thought to reduce patient exposure to bacteria by promoting better hand hygiene practices. Again, none of the available evidence supports either policy.

Other guidelines also lack supporting evidence. AORN recommends wearing street clothes when outside the hospital. This restriction is also based on a theoretical risk of SSI due to squame production from exposed skin. Interestingly, in 2007, the U.K. Department of Health took the exact opposite stance and implemented a “bare below the elbows” policy, which was thought to reduce patient exposure to bacteria by promoting better hand hygiene practices. Although that study did not address surgical attire worn outside of the hospital, AORN stated that this recommendation was supported by “moderate evidence.”

The restriction of briefcases and backpacks in the OR is based on data that demonstrated that those items can harbor bacteria despite the fact no data has shown that these personal items contribute to the occurrence...
of SSI. The same is true of cell phones, which the AORN recommendations call for cleaning before being brought into the perioperative setting. Finally, myriad guidelines call for eliminating cloth caps and replacing them with bouffant-style coverings. Although hair is a carrier of bacteria, no comparative studies exist on head coverings and their impact on SSI.

We reviewed the relevant scientific evidence related to OR masks and found that in the largest study, by Tunevall and colleagues, 3,088 patients undergoing general surgery showed a slightly reduced rate (3.5 percent versus 4.7 percent; $P > 0.05$) of wound infections and no change in bacterial culture results from SSI when healthy surgeons operated without masks.

Further, a Cochrane review, updated in 2014, found only three studies of a total 2,106 patients who underwent clean surgery worthy of inclusion. Interestingly, all three studies showed a trend toward a lower SSI rate in the unmasked versus the masked group.

It is noteworthy that even in the context of prosthetic joint implantation surgery, where extreme measures are taken to prevent infectious complications, supportive evidence is lacking. A recent review of nearly 90,000 joint replacements over 10 years found that the use of space suits and laminar airflow (LAF) systems in the OR was actually associated with an increased infection rate and that the rate of
revision surgery was not reduced in cases performed using either or both of these interventions. In addition, a recent systematic review included eight studies that evaluated the effect of LAF on SSI rates in patients who underwent knee or hip replacement surgery. In that study, the preponderance of the evidence pointed toward an increased SSI rate with LAF, with summary odds ratios of 1.36 and 1.71 for knee prosthesis and hip prosthesis, respectively.25

Comment

Although our study demonstrated that young surgeons oppose the recent surge of OR attire-related regulations (personal communication with Sara Morse, Manager, Legislative and Political Affairs, ACS Division of Advocacy and Health Policy, May 2016), there remain important opportunities for improved conduct in this regard. Unfortunately, it is fairly commonplace to see surgeons and other members of the OR team wearing surgical scrubs outside the hospital and in public places.26-28 Such conduct raises questions in the minds of patients as to the cleanliness of the attire worn inside the OR. In addition, unclean personal hospital garb, such as white coats, cloth scrub caps, and OR shoes, is often observed throughout the hospital. Although no studies to date prove that this practice is detrimental to our patients, this behavior fails the “sniff test” and is unprofessional. Moreover, research clearly shows that patients’ perceptions of quality of care, and their trust and confidence in their surgeon, is influenced by his or her appearance.29,30 Thus, while AORN’s guidelines are overly intrusive and unlikely to improve patient safety, surgeons are encouraged to play a leadership role in restricting OR attire to the perioperative environment.
Conclusion

Our study suggests that the overwhelming majority of young Fellows oppose the wave of new and more restrictive policies related to OR attire. They believe that these guidelines will not improve patient outcomes and may in fact increase surgeon discomfort in the OR, and may demoralize all members of the OR team. Therefore, these policy changes violate both components of the ACS mission statement: “improving the care of the surgical patient” and maintaining an “optimal and ethical practice environment.”

Based on these findings, the YFA GC strongly urged the ACS to take a leadership role in the creation of a comprehensive evidence-based set of guidelines and recommendations related to OR attire. The findings and literature review reported herein ultimately served as background materials and a major stimulus for the ACS position statement, “Statement on operating room attire” (see page 47 of this issue of the Bulletin).

We encourage all surgeons to set a positive example by wearing nonsurgical attire outside of the hospital and to seek leadership positions within their own departments of perioperative services so that they can more effectively advocate for their patients and become engaged in the creation and implementation of policies that directly affect surgeons and their patients.

REFERENCES (CONTINUED)

The new Medicare physician reimbursement system: 
Building the Quality Payment Program

by Christian Shalgian and Patrick V. Bailey, MD, FACS

For nearly 20 years, Medicare has paid physicians in the same manner. The Medicare Access and CHIP (Children’s Health Insurance Program) Reauthorization Act (MACRA) of 2015 called for major changes in the physician payment system that will begin to take effect in 2017. This new payment system—the Quality Payment Program (QPP)—continues to advance a policy goal of basing payment on value rather than on volume.

The specifics of how this new payment system will be implemented began to come to light on April 27, when the Centers for Medicare & Medicaid Services (CMS) released the proposed rule. The American College of Surgeons (ACS) Division of Advocacy and Health Policy staff carefully analyzed the proposed regulation and provided detailed feedback to the CMS in late June.* Because the final Medicare regulations will be issued in late October or early November, this article is intended to provide surgeons with the initial background on the QPP and how it is likely to affect surgical practices and the business side of the surgeon’s office.

Pathways to participation
Surgeons, and all physicians, have two pathways to participate in the QPP—participate in the Merit-based Incentive Payment System (MIPS) or in the 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.

MIPS participation
The MIPS program consists of four components: quality, resource use, advancing care information (ACI), and clinical practice improvement activities (CPIA). Each physician will receive a composite score, which will be a total of the scores from each of the four components. This score will be benchmarked against or compared with other physicians’ scores to determine whether the individual physician receives a payment penalty of as much as 4 percent or payment increase of up to 12 percent. (These percentages will change after the first year.)

Although the names of the programs have changed, most surgeons are familiar with three of the components.

Quality component
The quality component of MIPS replaces the Physician Quality Reporting System (PQRS). Fortunately, 

CMS is proposing some changes that surgeons will likely welcome.

In contrast to the previous PQRS requirement that physicians report nine quality measures, the MIPS quality component requires providers to report only six measures. One of these six measures must be an “outcome” measure and another must be a “cross-cutting” measure. Although the reporting threshold for the percentage of patients for which reports will be required is proposed to increase substantially, the ACS and other physician organizations will be advocating that the required percentage published in the final rule be close to the 50 percent level found in current programs.

A surgeon who has been participating in the PQRS program is well positioned to successfully meet the quality component requirements. A good first step for a surgeon who has not been participating in PQRS is to start using the ACS Surgeon Specific Registry (SSR).† The SSR allows surgeons to more easily participate in the PQRS and the new quality component of MIPS.

Resource use component
The resource use component replaces the value-based modifier (VBM). Surgeons will not have to fulfill any reporting requirements for the resource use component. Medicare will complete the calculations based on the claims submitted by surgeons. Beginning in 2018, CMS also plans to take into account such factors as patient condition and attribution of costs as appropriate to the relationship of the physician to the patient.

ACI component
The ACI component modifies and replaces the Electronic Health Record (EHR) Incentive Program.

The proposed overall score for this component is derived from two separate scores:

• Base score (50 percent)
• Performance score (up to an additional 50 percent)

The threshold for achieving the base score continues to be defined as “all or nothing.” Only after meeting the requirements for the base score is a physician eligible to receive the additional performance score credit, which will be based on the level of performance on a subset of the same measures required to achieve the base score.

ACI scores in 2017 are expected to be based on criteria similar to those in the 2016 requirements for the EHR Incentive Program.

CPIA component
The fourth component of MIPS is the CPIA component.

The threshold for achieving the base score continues to be defined as “all or nothing.” Only after meeting the requirements for the base score is a physician eligible to receive the additional performance score credit, which will be based on the level of performance on a subset of the same measures required to achieve the base score.

ACI scores in 2017 are expected to be based on criteria similar to those in the 2016 requirements for the EHR Incentive Program.

CPIA component
The fourth component of MIPS is the CPIA component.

This is a new component with no analogous previous program requirement. As such, this facet of MIPS is continuously evolving.

In the first year of MIPS assessment (2017), achieving full credit for the CPIA component should pose a nominal additional administrative burden, as reporting will be by simple attestation. Physicians will choose from a list of activities (the proposed rule comprises 94 possible activities) assigned two different weighted values. To receive full credit for the CPIA component, most providers will need to attest that they have participated in a minimum of three and a maximum of six of the 94 activities, depending on the weight of the activities selected, for 90 days.

As noted earlier in this article, MIPS participants will be assigned a composite performance score based on their performance in all four components. For 2017, the first year for assessment under the QPP, 50 percent of the score will be based on performance in the quality component, 10 percent will be based on the resource use component, 25 percent will be based on the ACI component, and 15 percent will be based on CPIA.

**Participation in alternative payment models**

As noted at the beginning of this article, surgeons have two options for participating in the QPP—the MIPS and the APMs. Physicians may participate in an APM that provides greater flexibility in care delivery but which carries a greater risk of financial loss if care costs exceed what is expected. Both routes have advantages and risks, but over time, there will be growing financial pressure for physicians to move to APMs.

To date, Medicare has released two APMs related to surgical care—a cardiac care bundle and a hip replacement bundle. However, very few additional options are available to surgeons who want to participate in approved Advanced APMs. MACRA encourages physician-led development of new models and has created a new Physician-Focused Payment Model Technical Advisory Committee tasked with providing feedback on APMs developed and submitted by stakeholders. The ACS has contracted with Brandeis University, Waltham, MA, and the Center for Surgery and Public Health at the Brigham and Women’s Hospital, Boston, MA, to develop surgical APMs.

**Nonparticipation in the QPP**

Physicians who choose not to participate in the QPP will receive a 4 percent cut in their Medicare payments in 2019. Note the 4 percent cut increases in subsequent years, up to 9 percent in 2022. This maximum 4 percent cut in 2019 is less severe than the 10 percent cut that physicians were receiving for not participating in the PQRS, the EHR Incentive Program, and the VBM.

**More to come**

Key points that health care professionals should bear in mind are as follows:

- The proposed regulations would have the data collection for 2017 begin on January 1. The College and other physician organizations have urged CMS to begin the 2017 data collection on July 1, 2017, to give physicians more time to understand this complex new program before beginning active participation.

As CMS rolls out the QPP, the ACS will be providing numerous resources to help Fellows understand and participate in the Medicare payment program. These resources will be available on the College’s website, at the ACS Clinical Congress, at ACS chapter meetings, and elsewhere.
The National Academy of Science released the seminal report, *Accidental Death and Disability: The Neglected Disease of Modern Society*, 50 years ago. Three Fellows of the American College of Surgeons (ACS)—Sam Seeley, MD, FACS; Alan Thal, MD, FACS; and John Howard, MD, FACS—played a critical role in the development of this document. The report was, in large measure, stimulated by and based on the experiences of these surgeons during their military deployment in the Korean War. The authors took what they learned in the military and translated those lessons into a list of recommendations to improve trauma care for injured U.S. civilians. The findings and recommendations described in *Accidental Death and Disability* were pivotal in the early development of emergency medical services (EMS), emergency medicine, trauma centers, and trauma care systems across the nation.

Today, however, the U.S. trauma system remains an incomplete patchwork. Many of the gaps identified in *Accidental Death and Disability* remain, and summary paragraphs describing areas in need of improvement in the report are as applicable today as they were when the report was written.

In an effort to develop strategies for improving the U.S. trauma system, the National Academies of Sciences, Engineering, and Medicine (NASEM) Committee on Military Trauma Care’s Learning Health System and Its Translation to the Civilian Sector released a report this spring, *A National Trauma Care System: Integrating Military and Civilian Trauma Systems to Achieve Zero Preventable Deaths after Injury*. The report was sponsored by the ACS, the U.S. Department of Defense, and other leading health care organizations dedicated to improving outcomes after injury. This new report...
calls for eliminating all preventable trauma-related
deaths in both military and civilian trauma patients.

The leadership of the ACS Committee on Trauma
(COT) is grateful for the contributions of the
National Academies and our dedicated Fellows of the
College, specifically those who produced both the
original white paper and this latest comprehensive
report. In the tradition of the original contributors
from 50 years ago, six Fellows of the College served
on the most recent committee (all MD, FACS): Adil
Haider; John B. Holcomb; Cato T. Laurencin; the
late Norman E. McSwain, Jr.; Thomas M. Scalea;
and C. William Schwab. The Academies dedicated
the report to Dr. McSwain, who died during pro-
duction of the current report.

This latest document outlines important oppor-
tunities for strengthening the relationship between
the ACS and the U.S. military. Moreover, the efforts
of the Academies committee provide a roadmap for
improving the trauma care of U.S. citizens and of our
troops in times of war.

This article outlines the events leading up to the
release of the report, summarizes its 11 recommenda-
tions, and describes how the ACS and other trauma
leaders have collaborated to promote optimal care of
the injured patient and to advance the agenda estab-
lished by the NASEM.

Events leading up to the report

Dr. Schwab set the stage for developing A National
Trauma Care System: Integrating Military and Civilian
Trauma Systems to Achieve Zero Preventable Deaths after
Injury in the Scudder Oration, which he delivered at
the ACS Clinical Congress 2014. In his presentation,
Dr. Schwab called for the establishment of “…a think
tank of senior civilian consultants to take on the
larger and more difficult issues for the readiness and
surgical mission of the Defense Health Authority and
the Department of Defense.” He went on to state
that “these subject content experts should be struc-
tured to assure relevance, impact, and value. This
think tank should be composed of the best thinkers
in academic surgery and medicine, health adminis-
tration, finance, and economics.”

In line with this vision, other key sponsors of the
NASEM report included the American College of
Emergency Physicians, the National Association of
EMS Physicians, the National Association of Emer-
gency Medical Technicians, the Trauma Center
Association of America, the U.S. Department of
Defense, the U.S. Department of Homeland Secu-
rit y, and the U.S. Department of Transportation.
Although sponsored by the ACS and these other
leading organizations, one of the strengths of the
Academies’ report is that the recommendations were
derived independently from a group of experts con-
vened by NASEM.

Donald Berwick, MD, chair of the NASEM
Committee on Military Trauma Care’s Learning
Health System and Its Translation to the Civilian
Sector, noted, “Both the military and civilian sec-
tors have made impressive progress and important
innovations in trauma care, but there are serious
limitations in the diffusion of those gains from loca-
tion to location…the successes have saved many
lives; the disparities have cost many lives. With the
decrease in combat and the need to maintain readi-
ness for trauma care between wars, a window of
opportunity now exists to integrate military and
civilian trauma systems and view them not sepa-
rately, but as one.”
Report recommendations

The report is comprehensive and broad in scope, calling for the development of a national trauma care system and highlighting 11 specific recommendations. These recommendations can be summarized as follows:

• The White House should set a national aim of achieving zero preventable deaths after injury and minimizing trauma-related disability.

• The White House should lead the integration of military and civilian trauma care to establish a national trauma care system. This initiative would include assigning a locus of accountability and responsibility that would ensure the development of common best practices, data standards, research, and workflow across the continuum of trauma care.

• The Secretary of Defense should ensure combatant commanders and the Defense Health Agency (DHA) Director are responsible and held accountable for the integrity and quality of the execution of the trauma care system in support of the aim of zero preventable deaths after injury and minimizing disability. To this end:
  - The Secretary of Defense also should ensure the DHA Director has the responsibility and authority and is held accountable for defining the capabilities necessary to meet the requirements specified by the combatant commanders with regard to expert combat casualty care personnel and system support infrastructure.
  - The Secretary of Defense should hold the Secretaries of the military departments accountable for fully supporting the DHA in that mission.
  - The Secretary of Defense should direct the DHA Director to expand and stabilize long-term support for the Joint Trauma System so its functionality can be improved and used across all combatant commands, giving players in the system access to timely evidence, data, educational opportunities, research, and performance improvement activities.

• The Secretary of the U.S. Department of Health and Human Services (HHS) should designate and fully support a locus of responsibility and authority within the department for leading a sustained effort to achieve the national aim of zero preventable deaths after injury and minimizing disability. This leadership role should include coordination with governmental (federal, state, and local), academic, and private-sector partners and should address care from the point of injury to rehabilitation and post-acute care.

• The Secretary of HHS and the Secretary of Defense, together with their governmental, private, and academic partners, should work jointly to ensure that military and civilian trauma systems collect and share common data spanning the continuum of care. Within that integrated data network, measures related to prevention, mortality, disability, mental health, patient experience, and other intermediate and final clinical and cost outcomes should be made readily accessible and useful to all relevant providers and agencies.

• To support the development, continuous refinement, and dissemination of best practices, the designated leaders of the recommended national trauma care system should establish processes for real-time access to patient-level data from across the continuum of care and just-in-time access to high-quality knowledge for trauma care teams and those who support them.

• To strengthen trauma research and ensure that the resources available for this research are commensurate with the importance of injury and the potential for improvement in patient outcomes, the White House should issue an Executive Order mandating the establishment of a National Trauma Research Action Plan requiring a resourced, coordinated, joint approach to trauma care research across the Department of Defense (DoD), HHS (including the National Institutes of
Health, Agency for Healthcare Research and Quality, Centers for Disease Control and Prevention, Food and Drug Administration, and Patient-Centered Outcomes Research Institute), the Department of Transportation, the Department of Veterans Affairs, and others (academic institutions, professional societies, and foundations).

• To accelerate progress toward the aim of zero preventable deaths after injury and minimizing disability, regulatory agencies should revise research regulations and reduce misinterpretation of the regulations through policy statements—that is, guidance documents.

• All military and civilian trauma systems should participate in a structured trauma quality improvement process.

• Congress, in consultation with HHS, should identify, evaluate, and implement mechanisms that ensure the inclusion of prehospital care (for example, emergency medical services) as a seamless component of health care delivery, rather than merely a transport mechanism.

• To ensure readiness and to save lives through the delivery of optimal combat casualty care, the Secretary of Defense should direct the development of career paths for trauma care—for example, foster leadership development, create joint clinical and senior leadership positions, remove any relevant career barriers, and attract and retain a cadre of military trauma experts with financial incentives for trauma-relevant specialties. Furthermore, the Secretary of Defense should direct the Military Health System to pursue the development of integrated, permanent joint civilian and military trauma system training platforms to create and sustain an expert trauma workforce.

Commitment to better trauma care
The ACS COT and the Military Health System Strategic Partnership ACS (MHSSPACS) strongly support and endorse the findings and recommendations in the report. In an invited commentary published in 2015 in the Journal of the American College of Surgeons, Margaret “Peggy” Knudson, MD, FACS, Director of MHSSPACS, noted, “Dr. (Col.) Edward D. Churchill is quoted as saying, ‘Surgeons in a current war never begin where the surgeons in the previous war left off; they always go through another long learning period.’ Dr. Churchill, we will do our best to not let that be the case going forward.” The ACS—through the COT, the MHSSPACS, the ACS Division of Advocacy and Health Policy, and the Coalition for National Trauma Research (CNTR)—is committed to effective implementation of the NASEM recommendations as a means of responding to Dr. Churchill’s concerns.

The ACS COT’s activities are administered through an 85-member national committee that oversees a field force of more than 3,500 trauma care professionals nationwide. These individuals work together to develop and implement meaningful trauma care programs in local, regional, national, and international arenas. The COT was established in 1922 and has worked to continuously improve the care of injured patients. The COT is dedicated to preventing injuries, improving all phases and systems of care that are important to the injured patient, and to actively cooperating with other national organizations that have similar strategic goals.

Since its founding, the ACS has been dedicated to promoting the highest standards of surgical care through the pillars of education, quality, and advocacy. The ACS COT has formally adopted this pillar approach to national leadership in trauma and has championed trauma systems strength, as depicted in Table 1, page 27.

Education
To advance trauma education with respect to A National Trauma Care System: Integrating Military and Civilian Trauma Systems to Achieve Zero Preventable Deaths after Injury, the ACS COT’s Trauma Systems Committee has partnered with NHTSA to convene the Innovations in Trauma Care Conference, which is scheduled to take place in spring 2017. The conference will highlight the
findings of the NASEM report, generate information and knowledge aimed at implementation of the report’s recommendations, and stimulate further innovation in trauma systems.

Advocacy
Working with the American Association for the Surgery of Trauma (AAST), the National Trauma Institute (NTI), the Eastern Association for the Surgery of Trauma (EAST), the Western Trauma Association (WTA), and their respective memberships, the ACS COT helped establish the CNTR. Bill Cioffi, Jerry Jurkovich, Tim Fabian, Thomas Scalea, Don Jenkins, Chris Cocanour, and Kim Davis (all MD, FACS) played crucial early roles in the establishment of the coalition. As a result of the joint advocacy efforts of CNTR members, Congress appropriated $10 million in 2016 for the development of a national trauma clinical trials network and has authorized an additional $10 million for the 2017 budget to further support that initiative.8

Quality
Three key programs form the foundation of the COT’s Quality Pillar, which is poised to help make the NASEM quality goals a reality. The Trauma Quality Improvement Program (TQIP®), the Verification, Review, and Consultation Program (VRC), and the Performance Improvement and Patient Safety (PIPS) programs provide an integrated comprehensive approach to quality improvement, as called for in the report. The COT’s Trauma System Committee is currently partnering with the Department of Defense and the MHSSPACS to comprehensively address the goals outlined in the latest Academies’ report.

Moving forward together with key partners
Along these lines of partnership and to advance the goals of a national trauma system described in the report, the ACS COT, MHSSPACS, and CNTR are moving forward together to further coordinate and integrate civilian and military trauma systems and to improve the quality and impact of trauma-related research.

The CNTR is developing the National Trauma Research Repository and recently received its first major project aimed directly at reducing prehospital deaths in a manner recommended in the NASEM

### TABLE 1. NATIONAL TRAUMA LEADERSHIP PILLARS

<table>
<thead>
<tr>
<th>ADVANCE TRAUMA EDUCATION</th>
<th>ENSURE QUALITY PATIENT CARE</th>
<th>CHAMPION TRAUMA SYSTEMS STRENGTH</th>
<th>DRIVE ADVOCACY</th>
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| Accredited continuing education programs that support medical professionals across the continuum of trauma care:  
• Advanced Trauma Life Support® Course  
• Trauma Evaluation and Management  
• Advanced Trauma Operative Management  
• Rural Trauma Team Development Course  
• Disaster Management and Emergency Preparedness  
• Advanced Surgical Skills for Exposure in Trauma  
• “Stop the Bleed” campaign  
• Basic Endovascular Skills for Trauma (BEST) | A verification program helps trauma centers confirm that they have adequate resources, ensures readiness, and improves trauma care. The quality cycle continues with TQIP, a risk-adjusted local and national benchmarking program to measure and inform the improvement of outcomes, and a PIPS program that continuously measures and evaluates in order to improve care.  
*Resources for Optimal Care of the Injured Patient*  
  VRC  
  TQIP  
  PIPS | Comprehensive expert assessment and consultative guidance for the improvement or development of state and regional trauma systems  
Integrates and partners with multidisciplinary teams in each locality or region  
Trauma Systems Consultation for counties, regions, states, or systems  
Benchmarks, indicators, and scoring facilitations | Advocacy activities at the federal and state level focused on prevention as well as socioeconomic, legislative, and regulatory issues that affect trauma care  
Develop and advocate health care policies that are in the best interests of trauma patients, such as the Stop the Bleed campaign (bleeding control or BCon)  
Promote injury prevention and control programs aimed at reducing needless injury, death, and suffering |

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The ACS COT has committed to assist CNTR by using the National Trauma Data Bank® and the TQIP® systems to enhance the efficacy of clinical trials in these networks. Making the report’s research agenda a reality remains the top goal of the CNTR. The AAST, NTI, EAST, and WTA have been great partners to the ACS COT in advancing our combined efforts to improve the care of the injured patient.

The ACS COT and CNTR have both created position statements outlining support for specific implementation strategies aligned with the NASEM guidelines. These statements are scheduled to be published in the October issue of the Journal of Trauma and Acute Care Surgery. Creating this implementation strategy is vital, as the charge of the Academies’ committee is essentially complete once the report is fully released in November. This is a critical project for the ACS, CNTR, and other partner organizations. This past August, the American College of Emergency Physicians and the COT collaborated on the development of a national database that would enable an immediate preventable death analysis following active mass casualty incidents. A commitment to working together is at the heart of the COT’s approach to making zero preventable deaths a reality.

Conclusion

We believe the NASEM report will have a tremendous impact on the care of the injured patient, and the ACS COT is committed to making this belief a reality.

Grace Rozycki, MD, FACS, AAST President, commented: “The AAST has a long history of promoting, evaluating, and leading innovation in trauma systems. We are committed to dissemination, implementation, and working with our CNTR partners to create the research agenda called for in this latest report.” And, as Dr. Scalea, a founding member of CNTR and a contributor to the current recommendations, added, “It was a pleasure and an honor to serve on the Military Trauma Care’s Learning Health System and its Translation to the Civilian Sector Committee. I am confident that, working together, we can meet the goal of zero preventable deaths called for in our report.”

REFERENCES

Legislative and regulatory policies can directly affect surgeons and patients. Fellows who take action and leverage their voices through political advocacy help to demonstrate the profession of surgery’s position and allow the American College of Surgeons (ACS) to serve as a valuable resource to policymakers while helping to effect real change in health policy.

The 2015–2016 election cycle is proving to be one of the most unpredictable, yet critical, U.S. elections in recent years, which is why it’s so important to get out the vote. Candidate platforms include proposals pertaining to Medicaid and Medicare, health information technology, research, funding, and many more health care-related issues that have the potential to affect the future of surgery and the surgical patient. Both inside the halls of Congress and locally back home, it is crucial that the College’s surgeon advocates engage with their representatives, educate them about issues affecting their patients and practice, and provide feedback to the ACS Division of Advocacy and Health Policy’s federal legislative team.

Make your voice heard

The ACS and the ACS Professional Association (ACSPA) work to ensure that issues of concern to surgery remain top priorities on Capitol Hill. To uphold the College’s stance on promoting and protecting the future of surgical practice, members are encouraged to register to vote prior to Election Day.

According to the National Conference of State Legislatures (NCSL), more than two-thirds of the states (37), plus the District of Columbia, offer some form of early voting. Many proponents argue that early voting makes the process easier, and, as a result, increases turnout, which may be significant come November. Additionally, the Pew Research Center’s July and August 2016 studies examining this year’s presidential election suggest that while many voters appear conflicted about this election process—with respondents’ views ranging from more interested in politics than they were four years ago to completely turned off by this year’s campaigns—it appears that turnout can be relatively high even when voter satisfaction with the candidates is low, and vice versa.¹
Before you cast your vote, visit SurgeonsVoice.org, the College’s nationwide, interactive advocacy program, to get up to speed with the lawmakers in your state and district. SurgeonsVoice has several resources to assist you, including an interactive map and toolkit. The interactive map allows you to learn about the key players from your state on Capitol Hill and important legislation in your state legislature.

The SurgeonsVoice toolkit is the College’s most comprehensive pre-election education resource. Issue briefs, talking points, and PowerPoint presentations are available to assist you in evaluating where your candidates stand in terms of the ACS legislative priorities.

For an insider’s perspective on races within your congressional district, contact the ACS Washington office staff at ahp@facs.org or 202-337-2701.

Surgery’s success starts with ACSPA-SurgeonsPAC

Although the ACSPA’s political action committee (ACSPA-SurgeonsPAC) does not participate in presidential elections, gauging how it and other health care PACs disburse contributions to candidates can be helpful in benchmarking which members of Congress are advocating for the future of health care.

Standing together as surgeons allows surgeons to make a difference when it comes to the issues they care about most. ACSPA-SurgeonsPAC, in conjunction with the College’s federal legislative team and surgeon advocates, works to establish relationships with surgical champions on Capitol Hill. The more champions we have in Congress, the greater success we will have leveraging our issues and establishing surgeons as leaders and partners in finding legislative solutions to complex issues. The following guidelines shape the ACSPA-SurgeonsPAC disbursement strategy for candidates:

- Leadership position. Candidates who serve as ranking members of their parties have a greater ability to move legislation forward and influence his or her party’s position on the issues.
- Committee assignment. Candidates who serve on key committees are better positioned to advance health policy legislation in support of surgeons and the surgical patient.
- Record on issues. ACSPA-SurgeonsPAC evaluates candidates’ service as champions for surgery and the surgical patient.
- Medical professional. Candidates with medical degrees, especially surgeons who are Fellows of the ACS, are recognized leaders in health policy.
- Political viability. The candidate should have an organized campaign with demonstrated potential to win.

Candidates and incumbents supported by ACSPA-SurgeonsPAC

To enhance the probability of electing and re-electing candidates who are sympathetic to the concerns of surgeons and their patients, the ACSPA-SurgeonsPAC has contributed more than $900,000 to key U.S. House and Senate races across the country. In addition to supporting 14 physician incumbents, ACSPA-SurgeonsPAC has contributed to seven physician and dentist candidates’ campaigns, including two Fellows of the College. The following are a few examples of candidates and incumbents whose races ACSPA-SurgeonsPAC has supported to date:

- Rep. Ami Bera, MD (D-CA). Representative Bera is one of the few Democratic incumbents facing a tougher race than expected this year. Since being elected to California’s Seventh Congressional District in 2012, he has worked his way up the ladder, gaining respect and support from key Democratic leadership and is one of the few Democratic liability reform
champions in Congress. Representative Bera’s first political event was held in the ACS Washington, DC, Office board room, and he has championed many efforts important to members of the College.

• Neal Dunn, MD, FACS (R-FL). Dr. Dunn is on the National Republican Congressional Committee (NRCC) “young guns” list, which means he is running for one of the most competitive congressional seats in the 2016 election cycle. Dr. Dunn is a urologist and Fellow of the College who is running in Florida’s Second Congressional District. This is an open seat vacated by Rep. Gwen Graham (D-FL). Dr. Dunn has support from former Florida House Speaker Allan Bense (R), the Florida Medical Association, and several physician groups in Washington, DC.

• Drew Ferguson, DMD (R-GA). Dr. Ferguson is a dentist running for Rep. Lynn Westmoreland’s (R) seat in Georgia’s Third Congressional District. In Georgia, the winner of the primary (held this year on May 24) must take 50 percent plus one. If this goal is not accomplished, the top two candidates—in this case, Dr. Ferguson and state Sen. Mike Crane (R)—enter a runoff, which Dr. Ferguson won July 26 with 54 percent of the vote. Dr. Ferguson is strongly favored to win the general election in this heavily Republican district.

• Raja Krishnamoorthi (D-IL). Mr. Krishnamoorthi, considered to be one of the Democratic Party’s emerging leaders, is running in Illinois’ Eighth Congressional District as Representative Tammy Duckworth (D-IL) vies for the Senate seat. Mr. Krishnamoorthi is still the clear frontrunner, receiving critical endorsements from President Barack Obama, Representative Duckworth, and more than 20 other members of Congress, including Sen. Dick Durbin (D-IL), House Democratic Leader Nancy Pelosi (D-CA), and Rep. Jan Schakowsky (D-IL).

• Roger Marshall, MD (R-KS). Dr. Marshall, an obstetrician-gynecologist from Great Bend, won the August 2 Kansas First Congressional District Republican primary with 57 percent of the vote against incumbent Rep. Tim Huelskamp. This win is significant, as Representative Huelskamp is the first House Republican in this election cycle to lose a primary for reasons unrelated to redistricting. Whereas this district is solidly Republican, Dr. Marshall is the projected winner for the general election.

• Rep. Tom Price, MD, FACS (R-GA). Representative Price is an ACS Fellow who has risen through the congressional ranks. Serving on the advisory group to House Speaker Paul Ryan (R-WI), Rep. Price is typically in the room when key decisions are made. He played a critical role in inserting the global codes provision in the sustainable growth rate formula, as well as advocating that future payment models should be physician-centric.

To view a complete list of candidates supported by ACSPA-SurgeonsPAC in your state, visit SurgeonsVoice.org. To learn more about ACSPA-SurgeonsPAC’s disbursement process, contact ACSPA-SurgeonsPAC staff at surgeonspac@facs.org or 202-672-1520.

Many of this year’s congressional races have proven competitive, and the November election results may change the political climate of the U.S.
Approximately one-third (34) of U.S. senators are up for re-election in November. Members of Congress within both parties are concerned that the current political climate may cause a shift in power. At present, the Senate is composed of 44 Democrats, 54 Republicans, and two Independents. According to recent polls and race ratings, including The Cook Political Report, a nonpartisan online analysis of electoral politics, the U.S. Senate has several vulnerable “toss-up” seats; two are held by Democrats and seven by Republicans.2,3 (See sidebar, page 31.)

At present, Republicans have a 54–46 majority in the Senate. To gain a majority in the Senate, Democrats would need a net gain of five seats. Sources such as The Rothenberg and Gonzales Political Report indicate that Democrats are likely to gain 3–6 seats.4

In terms of the House, although Republicans have a 247–188 majority, recent polling analyses predict Democrats are likely to pick up at least 10 seats, but larger numbers are conceivable.5 The possibility of Democrats gaining control of the House also continues to grow as Democrats only need to win 15 races to obtain majority status. Some of the most contested House races nationwide include three Democratic and 16 Republican seats. Toss up seats in the House appear in the sidebar on page 31.

To influence election outcomes, many political groups have recently increased their presence in some of these contentious races, including the National Republican Senatorial Committee and the Democratic Senatorial Campaign Committee, both of which are investing staff, time, and money in Arizona, Colorado, Florida, Illinois, Iowa, Maryland, Missouri, Nevada, New Hampshire, North Carolina, Ohio, Pennsylvania, and Wisconsin. Similarly, the Democratic Congressional Campaign Committee and the NRCC are promoting their respective “emerging races,” “red-to-blue” candidates, and “young guns” to increase contributions. From investing in ads in battleground states to adopting the use of Snapchat to expand their demographic reach via custom filters and videos, party committee tactics are proving to be almost as competitive as some of the races themselves.

ACS continues to fight for surgery
In this unpredictable election year, one fact is certain: the ACS continues to have strong working relationships with both Democrat and Republican members of Congress and will continue to successfully advocate on behalf of all of surgery during the remainder of the 114th Congress and beyond.

REFERENCES
OUTREACH IN KURDISTAN, IRAQ

Two decades of humanitarian surgical outreach and capacity building in Kurdistan

by Quyen D. Chu, MD, MBA, FACS; Gazi B. Zibari, MD, FACS; and A. Anand Annamalai, MD, FACS
Approximately 5 billion people, or two-thirds of the world’s population, lack access to safe, affordable surgical and anesthesia care; and of the 313 million procedures that are performed globally each year, only 6 percent are done in the poorest countries. These staggering statistics speak volumes to the need for intensive capacity building in many parts of the world.

After decades of oppression, the people of Kurdistan, Republic of Iraq, have sought to build an independent nation—one with a self-sustaining health care system. This article describes how several Fellows of the American College of Surgeons (ACS) provided care to the victims of the malevolent regime led by Saddam Hussein and assisted in the establishment of a sustainable health care system.

Background on Kurdistan
The Republic of Iraq borders six countries in the Middle East—Jordan, Syria, Turkey, Iran, Kuwait, and Saudi Arabia. Iraq encompasses approximately 168,753 square miles (437,072 square kilometers), which is three-fifths the size of Texas. In 2015, the population was 36,575,000, making it the fourth-most populated country in the Middle East. Iraq’s current borders were drawn in 1920 under the Treaty of Sèvres, which allowed the League of Nations to partition the collapsed Ottoman Empire. For Iraq, the treaty had essentially amalgamated three different groups of people—the Arab Shi’ites and Sunnis and the non-Arab Kurds—into one nation. A plethora of other minority groups, such as the Assyrians, Turks, and Kurdish Yazidis, also inhabit the country. The Yazidi Kurds practice their ancient religion, Zoroastrianism, and have been persecuted by the Islamic State in Iraq and Syria (ISIS), also known as the Islamic State in Iraq and the Levant (ISIL), since June 2014.

The Kurds are descended from the Indo-European tribes who resided in Iraq (Ararat Mountains of Mesopotamia) in the fourth century BC. An estimated 45 million Kurds live in Kurdistan, an area that is spread throughout the bordering states. Approximately 6.5 to 7 million Kurds reside in northern Iraq (Kurdistan of Iraq), comprising about 17 percent of the population of Iraq. The Kurds have their own culture and language; very few self-identify as Arabs. In fact, their history demonstrated fierce resistance against Arab expansion in the sixth century. The Kurds may be the largest ethnic group in the world that does not have its own nation.

In June 1992, Kurdistan formed its own parliament for the first time in its history. Members of parliament are freely elected, and the government has an appointed cabinet and functions under a ratified regional constitution. From our multiple trips to Kurdistan, we have found the Kurds to be extremely gracious people. They were quick to embrace and thank the U.S. for liberating them from Saddam Hussein’s regime.

Early trips to Kurdistan
Dr. Zibari, a co-author of this article, was one of the fortunate Kurds who survived Mr. Hussein’s atrocities; more than 50 percent of his high school classmates were murdered during the Iraq/Iran war and the Iraqi/Kurdish war. On May 1, 1976, Dr. Zibari immigrated to the U.S. after graduating from high school in an Iraqi Kurdish refugee camp in Kurdistan of Iran.

Like many other exiled Kurds, Dr. Zibari was forbidden from returning to Iraq, with a threat of immediate execution by Mr. Hussein. However, after 16 years in absentia and immediately after the first Gulf War, he returned to his native land in June 1992 after completing a solid abdominal organ transplant fellowship at the Johns Hopkins University School of Medicine, Baltimore, MD. His return was possible due to the no-fly zone over Kurdistan, which the North Atlantic Treaty Organization (NATO) established to protect the mass exodus of Kurdish refugees who had fled Mr. Hussein’s
brutality following their uprising in northern Iraq, and the Shi’ite uprising in southern and central Iraq.

Dr. Zibari's initial visit to Kurdistan in 1992 was a fact-finding mission. It was a historic time for the region, as 1992 represented the first year that the Kurds were allowed to vote freely and elect a Kurdish Parliament. The parliament met for the first time in June 1992 under NATO and United Nations (UN) protection. At that time, Dr. Zibari visited the only public hospital in Duhok, a city 50 miles from Mosul, which, at present, is under ISIL control. The hospital, Azadi Hospital of Duhok/Freedom Hospital, which had replaced Saddam Hussein Hospital, became the main center of Dr. Zibari's humanitarian medical outreach program for nearly 25 years.

As would be expected following decades of war, Dr. Zibari discovered that the Kurdish medical community had a severe lack of resources and feeble system infrastructure. By his estimate, the Kurds' medical system was at least two to three decades behind the American health care system. Examples of the multiple challenges that needed to be addressed included filling empty pharmacy shelves; updating antiquated ultrasound and X-ray machines; supplementing the shortage of allied health care personnel and physicians; establishing Internet service; replacing obsolete medical texts and journals; and compensating for a dearth of medical, dental, nursing, and allied health schools. Furthermore, the central government in Baghdad, which was still maintained by Mr. Hussein at that time, had refused to pay salaries to any employees who lived in the no-fly zone.

Compounding these adverse conditions, the Kurds also had to endure a double embargo—one from the UN against Iraq and the other imposed by Mr. Hussein—which resulted in further isolating the Kurdish medical community. Despite these adversities, the Kurdistan/Duhok medical community approached the development of a revitalized health care system with dedication, energy, and optimism. With the assistance of U.S. volunteers, they were able to make great strides in rebuilding their medical infrastructures.

Building the foundation for future trips
Most of the earlier trips to Kurdistan were spent meeting and achieving buy-in from major stakeholders, such as the local health care leaders, the mayor of the town, the Kurdish political leadership, and the Kurdish Regional Government (KRG). Dr. Zibari sought advice from these parties, supported the founding committee for the creation of Duhok Medical School, and was instrumental in creating plans for the new medical school. The governor of Duhok and the prime minister of the Kurdish regional government donated a significant portion of land to the Azadi Hospital of Duhok to build the medical school and for future medical center expansion. Six years later, Dr. Zibari attended the first graduation ceremony for
the medical school in June 1998. These successes led to the establishment of the University of Duhok, which now comprises 12 colleges.

Before each trip, we assembled a cadre of volunteers from different disciplines. This team included general surgeons, ophthalmologists, surgical oncologists, transplant surgeons, hepatopancreato-biliary (HPB) surgeons, laparoscopic surgeons, traumatologists, otolaryngology–head and neck (ENT) surgeons, neurosurgeons, emergency physicians, medical oncologists, nephrologists, surgical residents and fellows, and nurses. On each trip, we also organized an academic surgical symposium where each volunteer gave a formal presentation on a specific topic lasting at least half an hour. We also invited local surgeons to speak on a topic of their choice. One such presentation was titled Review of Renal Transplantation at Azadi Hospital of Duhok and Abdominal Cocoon: A Cause of Intestinal Obstruction. The symposium was well attended and stimulated interesting discussion.

The total length of each trip to Kurdistan was a little more than a week. The first day began with the team arriving at the hospital and being greeted by hospital administration and heads of the different medical and surgical departments. A camera crew videotaped this event and broadcast it to the people in Kurdistan. After the introduction and discussion with the leaders of Duhok Hospital, the physicians split into three groups: neurosurgery; trauma/emergency care, otolaryngology, and ophthalmology; and general surgery, laparoscopy, HPB, and transplant. We treated a large number of cases that varied in complexity. Between cases, the teams saw patients and performed pre- and postoperative evaluations.

Like many regions of the developing world, patients would come to see us with folders containing their medical records and images. Unlike U.S. health care facilities, a centralized area dedicated to maintaining medical records does not exist in Kurdistan. Because on some missions we did not have a particular specialty surgeon with a certain area of expertise, we had to turn away some patients—specifically those with major orthopaedic and gynecologic disorders, as well as other patients whose medical diseases exceeded our level of expertise. Even then, the patients were grateful that we had taken the time to see them. Many patients had traveled on foot for days to come and see the “surgeons from the U.S.”

After each exhausting day, we would head back to our hotel to share a nice dinner with our Kurdish colleagues. This was probably one of our favorite times because we all had a chance to unwind, get to know each other better, and share war stories. On each trip, our Kurdish colleagues would reserve a day for us to go sightseeing and visit Dr. Zibari’s brother, General Babakir Zebari.

On our more recent trips in 2014 and 2015, we visited refugee camps to care for the people who had escaped ISIS’ atrocities. We employed the VSee system—a Health Insurance Portability and Accountability
Act-compliant telehealth platform—to consult with our colleagues in the U.S.

**Capacity building**

For many years, Dr. Zibari has spent his vacation months traveling to Duhok to assist the medical community with capacity building. It was not until Mr. Hussein’s toppling that he felt comfortable enough traveling to the country to solicit help from medical colleagues who could provide the support needed to launch a capacity-building effort. For more than a decade, Dr. Zibari has consistently brought a dedicated and committed team of eight to 12 clinicians to assist with capacity building. These teams have been cosponsored by the Americas-Hepato-Pancreato-Biliary Association (AHPBA), the International Hepato-Pancreato-Biliary Association (IHPBA), Operation Hope, the World Surgical Foundation (WSF), the American Kurdish Medical Group, the Kurdish Regional Government, the Barzani Foundation,
Dr. Zibari and Dr. Chu (left and right, respectively, upper left photo) operate on a young man with a painful extremity sarcoma that did not respond to neoadjuvant chemotherapy. He underwent a successful quarter amputation.

and other organizations. Through the years, the team has been able to achieve a number of notable accomplishments, including the following:

- Developed the resources, personnel, and facilities needed to offer basic and advanced laparoscopic operations. The first laparoscopic cholecystectomy was performed in Duhok in 2005. Laparoscopic cholecystectomies are performed more than 80 percent of the time over open cholecystectomies. Other advanced laparoscopic operations now include adrenalectomy, splenectomy, nephrectomy, Nissen fundoplication, gastric sleeve resection, and gynecologic procedures.

- Established a living-related renal transplantation program. More than 1,500 renal transplantations have been performed since Dr. Zibari established the program in June 2004. Today, an average of two renal transplants are done weekly in Duhok, and four are done in Erbil.

- Trained local surgeons to perform complex neurosurgical procedures such as craniotomy for temporal lobe tumor, resection of sphenoid wing meningioma, and spinal decompression/stabilization for traumatic fracture/dislocation.

- Trained local surgeons to perform complex HPB and oncologic operations such as the Whipple procedure, major liver resections (central hepatectomy, formal lobectomy), radical cholecystectomy, esophagectomy, and gastrectomy with lymphadenectomy; and the team introduced them to modern technology and surgical devices such as the Ligasure, staplers, and modern laparoscopic instruments.
A man who presented with a locally advanced squamous cell carcinoma. He underwent a successful resection and adjacent tissue flaps.

• Supported the first medical journal in Duhok, *Duhok Medical Journal*.

• Engaged surgeons in the global surgical community by assisting them with obtaining membership to professional organization such as the ACS and AHPBA.

• Established an annual Joint Operation Hope, AHPBA, and World Surgical Foundation Surgical Symposium to update the medical community on innovations and technologies.

• Established a trauma team—composed of trauma surgeons, critical care clinicians, a neurosurgeon, and an emergency medicine clinician—who taught the local surgeons prehospital patient care, mass casualty triage, and management of patients exposed to chemical weapons.

At present, efforts are under way to establish telemedicine and tele-fellowship programs. The purpose of this endeavor is to train clinicians to use telemedicine as a means to remotely evaluate patients. A memorandum of understanding was signed between the Duhok University president, the director of the health system of Duhok, and the surgical team.

**Lessons learned through the decades**

In the course of our efforts in Kurdistan, we have learned several lessons that may be of value to other health care professionals interested in providing surgical care to patients in underdeveloped countries, including the following:

• Plan far in advance (at least nine months to a year).

• Start with a fact-finding mission to assess patient needs to determine the specialties that are in greatest demand.

• Have a reliable contact person at the host institution.

• Travel with the support of a recognized health care outreach organization, such as the ACS Operation Giving Back Program, AHPBA, Operation Hope, or World Surgical Operation.

• Do your homework, and contact the state department and the embassy. Make sure to inform the U.S. embassy once you arrive at your destination.

• Obtain adequate vaccinations and go to the state department Web page to learn more about the host country.

• Obtain medical/airlift insurance in case of an emergency medical evacuation.

• Learn as much as possible about the culture and customs of the country where you will be providing care. The last thing you want to do is to offend the patients whom you are trying to help.

• Ship supplies ahead of your scheduled arrival, and make sure a contact person in the host country can verify that necessary equipment clears customs and is available for use.

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With proper help, time, dedication, and, most importantly, good intentions and perseverance, health care providers can help build advanced surgical programs, such as renal transplantation, advanced laparoscopy, HPB surgery, and esophageal surgery, in a developing nation.

VOLUNTEER HEALTH CARE PROFESSIONALS

The following health care volunteers have donated their talents to bringing surgical care to the people of Kurdistan:

- Patricia Arledge, MD
  Plastic surgery
  Lubbock, TX

- Gene Bolles, MD
  Neurosurgery
  Boulder, CO

- Christine Butts, MD
  Emergency medicine
  Houma, LA

- Horacio D’Agostino, MD
  Interventional radiologist
  Shreveport, LA

- Bill Day, MD, FACS
  General surgeon
  Florence, OR

- Marc Dean, MD
  Otolaryngology
  Fort Worth, TX

- Blaine Enderson, MD, FACS
  Critical care surgery
  Knoxville, TN

- Shawn Gibbs, PA
  Orem, UT

- Bharat Guthikonda, MD
  Neurosurgery
  Shreveport

- Jamal J. Hoballah, MD, FACS
  Vascular
  Beirut, Lebanon

- Monirul Islam, MD
  Critical care medicine
  Danville, PA

- Andrew J. Kosmowski, MD
  Colonel, U.S. Military
  Emergency medicine

- P. Kirk Labor, MD, FACS
  Ophthalmology
  Grapevine, TX

- Thomas R. McCune, MD
  Colonel, U.S. Military
  Transplant nephrologist

- Michael Moore, MD
  Hematology
  Shreveport

- Lisa Moreno-Walton, MD
  Emergency medicine
  New Orleans, LA

- Ashor Odisho
  Family medicine
  Shreveport, LA

- Chris Porter, MD
  General surgeon
  Phoenix, AZ

- Lou Smith, MD, FACS
  Trauma/critical care
  Knoxville

- Byron Turkett, PA
  Trauma/critical care
  Knoxville

- John Thomas, MD, FACS
  Minimally invasive surgery
  Lubbock

- Susan Shattuck, MD, FACOG
  Obstetrics/gynecology
  Shreveport

- Deborah Ross
  Operating room nurse supervisor
  Shreveport

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surgical journal if one is not available, so they can better share their research and best practices.

**Conclusion**

With proper help, time, dedication, and, most importantly, good intentions and perseverance, health care providers can help build advanced surgical programs, such as renal transplantation, advanced laparoscopy, HPB surgery, and esophageal surgery, in a developing nation. It is important to keep in mind that the care of the patients of the host country should be no different than that in the U.S. It is advisable to provide care only for those cases with which the surgeon is comfortable, and it is also important to ensure that patients can be cared for by the local clinicians when a surgical team, like the one described in this article, has departed the country. The work that we have accomplished in Kurdistan is a testament of the effective and meaningful effect that can be achieved through collaboration with major stakeholders.

**Acknowledgements**

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**REFERENCES**


Statement on distractions in the operating room

This statement was developed by the American College of Surgeons (ACS) Committee on Perioperative Care and approved by the ACS Board of Regents at its June 2016 meeting.

There are many opportunities for distraction in the operating room (OR). Some can be attributed to the introduction of new technology, such as smartphone and mobile technology, and some are a function of noise levels, unnecessary conversation, and other variables that dilute the focus of perioperative team members because their attention is drawn “to… different object[s] or different directions at the same time.”1,2 Because of the deleterious effects of distraction on cognitive processing and the performance of complex tasks and because of the potential impact of distraction on patient safety, it is important to recognize and mitigate the risks of distraction in the OR.

Distraction can result from both intrinsic sources, including alarms, noise from surgical devices, shift changes, and necessary communications, as well as extrinsic sources such as cell phones, beepers, computers and personal electronic devices, calls from outside the OR, communication that is not relevant to the case, visitors, and traffic in and throughout the OR. All members of the surgical team may be affected.

The surgical checklist was developed as an analogy to flight crew checklists, which is a series of procedures performed preliminary to takeoff that are intended to ensure safety during flight operations. By extension, the concept of the “sterile cockpit” has been introduced to describe protocols intended to limit distraction during critical periods in the OR. The sterile cockpit protocol is designed to limit activities that might “distract any flight crew member from the performance of his or her duties or which could interfere in any way with the proper conduct of those duties.”3,4 One important difference between the OR and the cockpit, however, lies in the timing of critical events. They are much more tightly concentrated during flight. In the OR, critical events can and do occur throughout the operation.

When the timing of critical events, such as the clipping of an intracranial aneurysm or the initiation of a cardiopulmonary bypass, can be predicted, a structured communication protocol should be implemented to reduce the risk of distraction and miscommunication. The identification of critical phases of surgery has been shown not only to reduce miscommunication and distraction, but also operating time and costs.5

Distractions arising from technology

Newer technologies, including smartphones and other handheld electronic devices, have become ubiquitous. In many hospitals, they have been integrated into routine hospital communications and serve as access points to patient data and images. As useful and as important as they may be when used correctly, the undisciplined use of these devices may enhance distractions such as social media, e-mail, and other forms of electronic communication for health care personnel.

As a practical matter, many surgeons have come to rely on digital devices, including smartphones, for voice and data communication outside the office. Some institutions have established restrictive policies regarding the use of digital devices whereas others have not.

Therefore the ACS recommends that the use of smartphones in the OR be guided by the following considerations:

- The undisciplined use of smartphones in the OR—whether for voice, e-mail, or data communication, and whether by the surgeon or by other members of the surgical team—may pose a distraction and may compromise patient care.
- Surgeons should be considerate of the duties of personnel in the OR suite and refrain from engaging them unnecessarily in activities, including assistance in cellular communication, that might divert attention from the patient or the conduct of the procedure.
• Smartphones must not interfere with patient monitoring devices or with other technologies required for patient care.

• Whenever possible, members of the OR team, including the operating surgeon, should only engage in urgent or emergent outside communication during an operation. Personal and routine calls should be minimized. All phone calls should be kept as brief as possible.

• Whenever possible, incoming calls should be forwarded to the OR desk or to the hardwired telephone in the OR to minimize the potential distraction of smartphones.

• Whenever possible, incoming calls and data transmissions should be forwarded to voice mail or to memory. The ring tone should be silenced. An inaudible signal may be employed.

• Whenever possible, a distinct signal for urgent or emergent calls should be enabled. This signal may be implemented via a “page” option in most smartphones. Callers should be advised to use this function only for urgent and emergent calls if the phone is unanswered.

• The use of electronic and mobile devices or their accessories (such as earphones or keyboards) must not compromise the integrity of the sterile field. Special care should be taken to avoid sensitive communication within the hearing of awake or sedated patients.

• Communication using hardwired phones in the OR is subject to the same discipline as communication using electronic device technology.

• The use of electronic mobile devices to take and transmit photographs should be governed by hospital policy on photography of patients and by government regulations pertaining to patient privacy and confidentiality.

**Distractions due to noise**

There are many sources of noise in the OR. Some, like music, may be relaxing or distracting, depending on the circumstances.

Critical alarms are distracting but crucial. They are meant to focus attention, rather than to distract attention, even though they do both. False alarms are problematic.⁶ The reduction of harm associated with clinical alarms was identified as a 2014 National Patient Safety Goal by The Joint Commission.⁷ The introduction of “smart alarms,” which are individualized to each patient’s needs, has been recommended as one solution.⁸

Surgical equipment noise, noise from visitors entering the OR from corridors, and noise transmitted into the OR from other areas may be more difficult to control. The problem of transmitted noise is an architecture-based issue and must be addressed when ORs are designed and maintained. Surgical equipment noise cannot be controlled easily once a piece of equipment has been installed but should be a consideration when equipment is selected.

Therefore the ACS recommends the following protocols to reduce noise:

• Surgeons should be sensitive to all members of the OR team when selecting the music played during an operation (volume, genre, lyrics).

• Tools to assist in establishing alarm safety protocols are widely available and should be implemented institution-wide, not just in the OR or perioperative areas.⁹

• Traffic in and out of the OR should be controlled both because of the potential for distraction and for purposes of infection control.
The importance of designing health care facilities to reduce transmitted noise into the OR should be emphasized when facilities are being conceived and maintained.

Conclusion
The risks of distraction in the OR and the tools to overcome distraction should be incorporated in training programs for surgeons and for perioperative personnel. The importance of designing health care facilities to reduce transmitted noise into the OR should be emphasized when facilities are being conceived and maintained. Noise levels should be considered when surgical and anesthetic devices and instrumentation are selected.

Disclaimer
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REFERENCES
Statement on documentation and reporting of accidental punctures and lacerations during surgery

The following statement was developed by the American College of Surgeons (ACS) Committee on Perioperative Care and approved by the ACS Board of Regents at its June 2016 meeting.

The Agency for Healthcare Research and Quality (AHRQ) patient safety indicator (PSI) for accidental puncture or laceration (PSI #15) is a quality measure that reports the rate of inadvertent cuts, punctures, perforations, and lacerations to a patient during a procedure. This quality measure is intended to capture a patient injury that was entirely unintended and caused by medical management rather than by the underlying disease or condition of the patient. These injuries have adverse consequences for patients and are often preventable. Although the indicator has been externally validated, it has been shown to be less predictive of injuries that could be considered clinically important. As a provider-level measure, it is important that surgeons as well as hospital and office coding staff understand how to correctly report this quality measure.

Therefore the ACS recommends the following guidelines for documenting and reporting accidental punctures and lacerations:

• By definition, PSI #15 is limited to accidental punctures and lacerations that are not intrinsic or inherent to a major procedure. Punctures or lacerations that occur in surgical procedures often are incorrectly coded as “accidental” when the puncture or laceration was, in fact, a natural consequence or part of the operation. Injuries inherent to a procedure or that are unavoidable due to the structure of the patient’s anatomy or underlying disease process should not be coded with the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes that are covered under PSI #15.* Determination should be based upon the nature of the operative field and operation performed.

• Although an injury, tear, or repair that was reasonably necessary to perform an operation may not meet the criteria for PSI #15, surgeons should document all intraoperative events. The College encourages surgeons to carefully word operative reports to make it clear whether a puncture or incision is accidental or expected.

• Regardless of whether codes that are covered under PSI #15 are used, the surgeon should document whether the tear or laceration was significant, whether it required repair, and whether it affected patient care or the patient’s course of treatment or recovery. Documentation in the operative report of tears and lacerations should contain clear, detailed, and specific terminology to communicate the circumstances under which the injury occurred, including the following:

  – A description of the consequences of the laceration or injury
  – Documentation of increased operating time and changes to the intended procedure(s)
  – Documentation of potential increased length of stay due to the complication
  – If an injury was present prior to an operation, that information should be clearly stated in the medical record.

*To view a complete list of codes encompassing PSI #15 under ICD-10, go to www.qualityindicators.ahrq.gov/Downloads/Modules/PSI/V50-ICD10/TechSpecs/PSI%2025%20Accidental%20Puncture%20or%20Laceration%20Rate.pdf.
Surgeons should be available to coding professionals for clarification of the medical record. If the postoperative documentation conflicts with the procedure report, the attending surgeon who performed the procedure must be queried for clarification. Accurate coding is ultimately the responsibility of the surgeon of record.

ICD-10-CM has 21 codes indicating accidental puncture and laceration specifying organ or body system and will require increased levels of documentation. As such, surgeons are strongly encouraged to work with hospital staff to ensure proper documentation and coding.

Educating surgeons and others to code accurately will result in improved accuracy and enhanced value of this important quality measure. It is highly recommended that coding of this measure by institutions be done in consultation with the primary surgeon to ensure accurate documentation.

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BIBLIOGRAPHY


Statement on operating room attire

The following statement was developed by an American College of Surgeons (ACS) task force on operating room (OR) attire and approved by the ACS Board of Regents in July 2016.

The values of the ACS include professionalism, excellence, inclusion, innovation, and introspection. Appropriate attire is a reflection of professionalism and is integral to establishing and maintaining a patient-physician rapport based on trust and respect. In addition, insofar as clean and properly worn attire may decrease the incidence of health care-associated infections, it also speaks to a desire and drive for excellence in clinical outcomes and a commitment to patient safety.

The ACS guidelines for appropriate attire are based on professionalism, common sense, decorum, and the available evidence on this topic. Specific guidelines are as follows:

- Soiled scrubs and hats should be changed as soon as feasible, particularly before speaking with family members after a surgical procedure.

- Scrubs and hats worn during dirty or contaminated cases should be changed prior to subsequent cases, even if not visibly soiled.

- Masks should not be allowed to hang or dangle around the neck at any time.

- OR scrubs should not be worn in the hospital facility outside of the OR area without a clean lab coat or appropriate cover-up worn over them.

- OR scrubs should not be worn at any time outside of the hospital perimeter.

- OR scrubs should be changed at least daily.

- During invasive procedures, the mouth, nose, and hair (skull and face) should be covered to avoid potential wound contamination. Large sideburns and ponytails should be covered or contained. There is no evidence to suggest that leaving ears, a limited amount of hair at the nape of the neck, or modest sideburns uncovered contributes to wound infections.

- Earrings and other jewelry worn on the head or neck where they might fall into or contaminate the sterile field should all be removed or appropriately covered during procedures.

- The ACS encourages clean, appropriate, professional attire (not scrubs) to be worn during all patient encounters outside of the OR.

The skull cap is symbolic of the surgical profession. The skull cap may be worn when close to the totality of hair is covered by it and when only a limited amount of hair on the nape of the neck or modest sideburns remains uncovered. Like OR scrubs, cloth skull caps should be cleaned and changed daily. Paper skull caps should be disposed of daily and following every dirty or contaminated case. Religious beliefs regarding head wear should be respected without compromising patient safety.

Many different health care providers (surgeons, anesthesiologists, certified registered nurse anesthetists, laboratory technicians, aides, and so on) wear scrubs in the OR setting. The ACS strongly suggests that scrubs should not be worn outside the perimeter of the hospital by any health care provider. To facilitate enforcement of this guideline, the ACS suggests the adoption of distinctive, colored scrub suits for OR personnel.

The ACS emphasizes patient safety and quality of care and prides itself on leadership in an ever-changing and increasingly complex health care environment. As stewards of our profession, we must retain an emphasis on key principles of our culture, including proper attire, since attention to what we wear inside and outside the OR helps to uphold the public’s perception of surgeons as highly trustworthy, attentive, professional, and compassionate.
Revised statement on health care industry representatives in the operating room

The following statement was revised by the American College of Surgeons (ACS) Committee on Perioperative Care and was reviewed and approved by the ACS Board of Regents at its June 2016 meeting.

The ACS recognizes the need for a structured system within the perioperative setting to allow for education, training, and introduction of procedures, techniques, technology, and equipment to the surgical health care team. Health care industry representatives (HCIR), by virtue of their training, knowledge, and expertise, often can provide technical assistance to the surgical team. Such assistance may expedite the procedure and may facilitate the safe and effective application of surgical products and technologies.

The purpose of this statement is to supply guidelines to health care facilities and members of the perioperative care team to ensure optimal surgical outcomes, to ensure patient safety, and to protect patients’ rights to privacy and confidentiality when an HCIR is present during a surgical procedure.

Therefore the ACS recommends the following:

Institutional policies

Surgical department administrators in all facilities, including the acute care hospital, ambulatory surgery facility, and office-based operating room (OR) settings should be aware of all relevant institutional policies and incorporate them into specific written policies governing the presence of HCIRs in the OR.

These policies should define the requirements and procedures for manufacturer representatives to be present in the OR and the role and limitations of the HCIR in the perioperative setting.

These policies should comply with applicable state laws and regulations and be consistent with the institution’s existing policies, those promulgated by the OR, and those established by credentialing and privileging committees.

Institutional policies should include but not be limited to the following elements:

- Facility requirements and procedures for manufacturers’ representatives to be present in the OR are as follows:
  - The institution should designate an authority for approving an HCIR’s presence in the OR. A time frame for securing this approval should be established. Among other responsibilities, the authority should do the following:
    - Establish a time limit and appropriate identification (to be worn at all times) for the HCIR.
    - Ensure orientation to the facility is provided.
    - Verify the education and training of the HCIR in the following areas:
      - Health Insurance Portability and Accountability Act (HIPAA) compliance and all other matters related to patients’ rights and confidentiality
      - Appropriate conduct and attire in the OR environment
      - Aseptic principles and sterile technique
      - Infectious disease and blood-borne pathogens
      - Occupational safety standards for biohazardous waste, fire risk and...
The purpose of this statement is to supply guidelines to health care facilities and members of the perioperative care team to ensure optimal surgical outcomes, to ensure patient safety, and to protect patients’ rights to privacy and confidentiality when an HCIR is present during a surgical procedure.

Roles and limitations of the HCIR in the OR:
The HCIR is present as an advisor to the perioperative team. The presence of the HCIR in the OR cannot substitute for preoperative training of the surgical team. The surgical team should have received training and demonstrated competence in the application of surgical devices and technologies used in the OR before the procedure.

The HCIR serves as an educator and facilitator. In this role, the HCIR:

- Should not engage in the practice of surgery, nursing, or medical decision making

- Should not scrub in or be involved in direct patient contact

- May be involved in the remote calibration or adjustment of medical devices (for example, pacemakers, laser technology) to the surgeons’ and manufacturers’ specifications

- Should have his or her activities monitored and supported by the surgeon or at the surgeon’s discretion by the perioperative nurse responsible for the patient’s care

A clearly defined institutional mechanism should exist to address any departures from these established policies. ♦

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Revised statement on the prevention of unintentionally retained surgical items after surgery

The following statement was revised by the American College of Surgeons (ACS) Committee on Perioperative Care and was reviewed and approved by the ACS Board of Regents at its June 2016 meeting.

The ACS recognizes patient safety as an issue of the highest priority and strongly urges individual hospitals and health care organizations to take all reasonable measures to prevent the unintended retention of surgical items in the surgical wound.

Surgical procedures take place within a system of perioperative care composed of surgeons, perioperative registered nurses, surgical technologists, and anesthesia professionals. These health care providers share a common ethical, legal, and moral responsibility to promote an optimal patient outcome.

Prevention of unintentionally retained surgical items after surgery requires good communication among perioperative personnel and the consistent application of reliable and standardized processes of care.

Therefore the ACS recommends the following guidelines that can be adapted to various practice settings, including traditional operating rooms (OR), ambulatory surgery centers, surgeons’ offices, and other areas where operative and invasive procedures are performed:

• Recommendations to prevent the retention of sponges, sharps, instruments, and other designated miscellaneous items include:
  - Consistent application and adherence to standardized counting procedures
  - Performance of a methodical wound exploration before closure of the surgical site
  - Use of X-ray-detectable items in the surgical wound
  - Maintenance of an optimal OR environment to allow focused performance of operative tasks
  - Use of X-ray or other technology (such as radiofrequency detection and bar coding) as indicated to ensure that no unintended item remains in the operative field
  - Suspension of these measures may be necessary in certain life-threatening situations

• Documentation should include, but not be limited to, results of surgical item counts, notification of the surgical team members, instruments or items intentionally left as packing, and actions taken if count discrepancies occur.

• Surgical facilities must provide resources to ensure that necessary equipment and personnel are available to support these perioperative surgical safety measures.

• Policies and procedures for the prevention of retained foreign bodies should be developed, reviewed periodically, revised as necessary, and available in the practice setting.

• Disclosure of the event to patients and family members should follow the institution’s adverse event policy.

The ACS also endorses the National Quality Forum’s definition of “end of surgery” as the moment “…after all incisions or procedural access routes have been closed in their entirety, device(s) such as probes or instruments have been removed, and, if relevant, final surgical counts confirming accuracy of counts
Prevention of unintentionally retained surgical items after surgery requires good communication among perioperative personnel and the consistent application of reliable and standardized processes of care.

and resolving any discrepancies have concluded and the patient has been taken from the operating/procedure room,” where applicable. ♦

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The ACS recognizes patient safety as an item of the highest priority and strongly urges individual hospitals and health care organizations to develop guidelines and checklists to ensure correct patient, correct site, and correct procedure surgery.

Therefore, the ACS recommends the following guidelines to eliminate wrong site surgery:

- Verify that the correct patient is taken to the operating room (OR). This verification can be made with the patient or the patient’s designated representative if the patient is underage or unable to answer for him/herself.

- Verify that the correct procedure is on the OR schedule.

- Verify with the patient or the patient’s designated representative the procedure that is expected to be performed, as well as the anatomic location of the procedure.

- Confirm the submission of a consent form with the patient or the patient’s designated representative.

- In the case of a bilateral organ, limb, or anatomic site (for example, hernia location of melanoma), the surgeon and patient should be in agreement and the operating surgeon should mark the site before giving the patient narcotics, sedatives, or anesthesia. For spine cases, level should be verified.

- If the patient is scheduled for multiple procedures that will be performed by multiple surgeons, all the items on the surgical checklist must be verified for each procedure.

- Ensure that all relevant records, imaging studies, equipment, and implants are available as needed.

- Conduct a briefing prior to administering anesthesia and call for a final time out before skin incision. These two steps should include verification with members of the surgical team to confirm the correct patient, site, and procedure. If any verification process fails to confirm the correct site, all activities should be halted until verification is confirmed to be accurate by the surgeon and team.

- Conduct a debriefing prior to the patient leaving the OR; the debriefing should include verbal discussion of sponge and needle counts.

- In the event of an emergency, these steps may be modified according to local hospital guidelines.

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Revised statement on sharps safety

The following statement was revised by the American College of Surgeons (ACS) Committee on Perioperative Care and was reviewed and approved by the ACS Board of Regents at its June 2016 meeting.

Sharps injuries and surgical glove tears continue to expose surgeons and operating room (OR) personnel to the risk of infection. Patients’ blood makes contact with the skin or mucous membranes of OR personnel in as many as 50 percent of operations, with cuts or needlesticks occurring in as many as 15 percent of operations. Surgeons and first assistants are at highest risk for injury, sustaining up to 59 percent of the injuries in the OR. Scrub personnel have the second highest frequency of injuries in the OR (19 percent), followed by anesthesiologists (6 percent), and circulating nurses (6 percent). Of the estimated 384,000 needlestick injuries that occur in hospitals each year, 23 percent occur in surgical settings.

Published literature indicates that while needlestick injury rates have been decreasing among nonsurgical health care providers, they have not declined among health care professionals who work in surgical settings. According to a 2010 article published in the Journal of the American College of Surgeons and citing data from a 1998 study, more than half of needlestick injuries involving suture needles occur during the suturing of fascia or muscle. For surgeons, suture needles are the most frequent source of sharps injuries.

The ACS supports work practices that are designed to eliminate, protect, or standardize the use of sharp instruments in the OR. The ACS also recommends the use of structured evaluations and user-based criteria that include performance standards, task analysis, simulation, and training programs for devices intended to reduce sharps injuries in the OR.

A team approach is critical to reduce the risk of blood-borne infections resulting from sharps injuries in the OR. Hospitals and health care facilities should make sharps injury reduction techniques and instruments available to surgeons and OR personnel.

OR work practices
Glove barrier failure is common, with reported perforation rates as high as 61 percent for surgeons and 40 percent for scrub personnel. Double gloving reduces the risk of exposure to patient blood by as much as 87 percent when the outer glove is punctured. However, double gloving has certain disadvantages, such as decreased tactile sensation. In certain types of operations (such as neurosurgery procedures), where delicate manipulation of instruments and tissues is required, double gloving may impair the surgeon’s ability to optimally perform the procedures. Despite a large body of data documenting the benefits of double gloving, this technique has not received wide acceptance among surgeons. In many cases, a period of adaptation and “retraining” appears to be necessary before practitioners feel comfortable with the technique. Specially designed undergloves are available to make the process of double gloving more acceptable to surgeons.

Therefore the ACS recommends:

- The universal adoption of the double glove (or under-glove) technique to reduce exposure to body fluids resulting from glove tears and sharps injuries. In certain delicate operations, and in situations where it may compromise the safe conduct of the operation or safety of the patient, the surgeon may decide to forgo this safety measure.

Blunt tip suture needles
Suture needle injuries pose the greatest risk of sharps injury to the surgeon and scrub personnel. The effectiveness of the use of blunt-tip suture needles in reducing sharps injuries is supported by a number of randomized studies and case series that demonstrate a decrease in the rate of glove puncture from 38 percent down to 6 percent—and down to zero in some cases—following the adoption of blunt-tip suture needles.
Recently published studies show that using blunt-tip suture needles reduces the risk of needlestick injuries from suture needles by 69 percent. Although blunt-tip suture needles cost approximately 70 cents more than their standard suture needle counterparts, the benefits of reducing the risk of serious and potentially fatal blood-borne infections for health care personnel support their use when clinically appropriate.

A 2007 report suggests that the slight difference in costs of blunt- and sharp-tip suture needles is balanced by the economic savings associated with needlestick injury prevention. This report, which assessed the costs of managing occupational exposures to blood and body fluids, concluded that the cost of managing a needlestick injury can range from $376 to $2,456 per reported incident. In addition, personnel who receive needlestick injuries may experience anxiety and a loss of productivity as they await the results of blood tests.

The use of blunt-tip suture needles does not require the surgeon to change their work practices. In fact, a new generation of blunt-tip suture needles is now on the market with a slightly more tapered tip profile that may provide for easier suturing compared with the earlier needles used in the referenced studies. The College recognizes that specific procedures may preclude the use of blunt-tip suture needles.

Therefore the ACS recommends:

- The universal adoption of blunt-tip suture needles for the closure of fascia and muscle in order to reduce needlestick injuries in surgeons and OR personnel.

**The neutral zone**
The hands-free technique (HFT) requires the surgical team to designate a sharps neutral zone (for example, a towel, Mayo stand, magnetic pad) for the pickup and release of surgical sharps such as needle-holders, scalpels, and syringes with needles. With this technique, there is no direct handing of instruments from scrub person to surgeon and back. If the surgeon must not break eye contact with the surgical field during critical parts of the operation where patient safety or workflow might be compromised, a partial HFT may be used whereby sharps are directly handed from the scrub person to the surgeon but then returned to the scrub person via a neutral zone.

The use of the neutral zone to transfer sharps is supported by the Occupational Safety and Health Administration and the Association of periOperative Registered Nurses as a method to reduce health care workers’ risk of sharps injury during surgery. The data supporting the use of HFT are inconclusive at present, with one large study reporting lower needlestick rates more than 75 percent of the time when the HFT technique was used, and another, smaller randomized
controlled trial reporting no difference in needlestick rates with HFT use.

Therefore the ACS recommends:

- The use of HFT as an adjunctive safety measure to reduce sharps injuries during a surgical procedure except in situations where it may compromise the safe conduct of the operation, in which case a partial HFT may be used.

Engineered sharps injury prevention devices

Engineered sharps injury prevention (ESIP) mechanical devices may provide varying degrees of mechanical protection from sharps injuries involving suture needles and scalpel blades. Manufacturers of ESIP devices approved by the U.S. Food and Drug Administration have been permitted to claim prevention of sharps injury as a feature of their use. No study published to date demonstrates the clinical effectiveness of ESIP devices. The design and quality of these devices has been variable and their acceptance among surgeons limited. Nevertheless, these devices may contribute to minimizing sharps injuries in the OR.

Therefore the ACS recommends:

- The use of ESIP devices as an adjunctive safety measure to reduce sharps injuries during surgery except in situations where it may compromise the safe conduct of the operation or safety of the patient. ♦

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The use of blunt-tip suture needles does not require the surgeon to change their work practices.... The College recognizes that specific procedures may preclude the use of blunt-tip suture needles.

BIBLIOGRAPHY


Surgical technologists are individuals with specialized education who function as members of the surgical team in the role of a scrub person. With additional education and training, some surgical technologists function in the role of surgical first assistant.

Surgical technology programs are accredited by the Accreditation Review Council on Education in Surgical Technology and Surgical Assisting—a collaborative effort between the Association of Surgical Technologists and the ACS, under the auspices of the Commission on Accreditation of Allied Health Education Programs. Accredited programs provide both didactic education and supervised clinical experience based on a core curriculum for surgical technology.

Graduates of accredited surgical technology programs are eligible for certification by the National Board of Surgical Technology and Surgical Assisting—a collaborative effort between the Association of Surgical Technologists and the ACS composed of representatives including certified surgical technologists, a surgeon, and a member of the public.

Therefore the ACS strongly supports the following:

- Adequate education and training of all surgical technologists, the accreditation of all surgical technology educational programs, and the examination for certification of all graduates of accredited surgical technology educational programs ♦

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Another 3:00 am phone call left me struggling toward wakefulness. This time it was the obstetrician. He went on too long, explaining how he had produced a large laceration in a patient’s bladder in the course of performing a cesarean delivery. Finally awake enough to interrupt, I said, “Whatever it is, I’ll take care of it.” For general surgeons in small rural hospitals, this is what we do—we take care of it, whatever it is.

Growing demand for rural surgeons
In the approximately two-thirds of the 1,300 critical access hospitals (CAH) located across the U.S. where general surgeons still operate, we engage in a scope of practice that has largely disappeared in metropolitan areas. As one contributor to the American College of Surgeons rural listserv wrote, “You know you are a rural surgeon when your OR [operating room] list for the day would require five subspecialists in a larger hospital.”

In light of the decline in general surgeons practicing in rural areas (an estimated 8.1 per 100,000 population in 1981, declining to 5 per 100,000 in 2005, and likely even fewer today), there is no shortage of patients in need of surgical services. In comparison with their urban counterparts, of whom there are approximately 7.7 per 100,000 patients, rural surgeons take responsibility for 50 percent more lives. Case loads are higher for surgeons practicing in both small and large rural hospitals by a similar proportion, as documented by analysis of the American Board of Surgery (ABS) recertification case logs. Analysis of the Dakota Database for Rural Surgery yielded an average of 1,071 surgical procedures annually among the 43 rural surgeons participating. Case distribution included 48 percent of cases considered general surgery, 40 percent endoscopy, and 12 percent subspecialty. When it comes to the volume part of the volume/outcome equation, overall number of cases is rarely an issue for rural surgeons.

Unfortunately, outcomes research evaluating a variety of medical diagnoses has shown poorer results in CAHs than in larger hospitals. Surgical services suffer from guilt by association. Several recent publications have confirmed that as rural surgeons, we do well those procedures we do regularly. Gadzinski and colleagues, in a 2013 publication from the University of Michigan Center for Healthcare Outcomes and Policy, Ann Arbor, compared results using administrative data sets from 1,283 CAHs and 3,612 non-CAHs for eight common procedures in general surgery, obstetrics and gynecology, and orthopaedics, including the following: appendectomy, cholecystectomy, colorectal cancer resection, cesarean delivery, hysterectomy, knee replacement, hip replacement, and hip fracture repair. Length of stay was statistically significantly shorter at CAHs for four procedures and risk-adjusted mortality rates were...
As one contributor to the American College of Surgeons rural listserv wrote, “You know you are a rural surgeon when your OR list for the day would require five subspecialists in a larger hospital.”

equivalent, with the exception of hip fracture in Medicare beneficiaries. The 2015 report of the Rural Health Research Center at the University of Washington, Seattle, showed that for a variety of common general surgery, obstetrics and gynecology, and orthopaedic procedures, patients treated in rural hospitals had fewer serious complications than their urban counterparts, although the rural hospital cohort appeared to have a lower risk profile.

Most recently, Ibrahim and colleagues published an analysis of surgical outcomes and expenditures among Medicare beneficiaries treated in 828 CAHs and 3,676 non-CAHs in a retrospective review of 1,631,904 admissions. Four common general surgery procedures were included: appendectomy, cholecystectomy, colectomy, and hernia repair. The investigators concluded, “Among Medicare beneficiaries undergoing common surgical procedures, patients admitted to critical access hospitals compared with noncritical access hospitals had no significant difference in 30-day mortality rates, decreased risk-adjusted serious complication rates, and lower adjusted Medicare expenditures, but were less medically complex.”

Higher risk, more diverse cases
The debate over the relationship between volume and outcomes is certainly much older than the modern era of research, which dates to the seminal article of health care economist Harold Luft, published in the New England Journal of Medicine in 1979. The list of procedures across multiple surgical specialties where a relationship between volume and outcomes has been documented in the surgical literature is much larger than the eight complex procedures listed in the “Volume Pledge.” Few common procedures have escaped such analysis; from inguinal herniorrhaphy to open heart surgery, the nearly universal result has been the documentation of a correlation. Luft recognized that “practice makes perfect” was only one possible explanation. Another would be “selective referral”; that is, patients are more likely to be referred to surgeons and facilities with a good reputation for a particular procedure and that low-volume providers are low volume because they produce inferior results. The factors leading to better outcomes are more nuanced than surgeon and institutional volumes and include training, specialization, cumulative experience, and technical surgical skill.

In another study, a 2.5-fold difference in risk-adjusted mortality rates between institutions for six high-risk procedures was explained on the basis of failure to rescue; that is, lack of recognition or optimal management of surgical complications. When I relocated to a CAH 17 years ago, I decided the days of performing high-complexity oncology procedures were over for me. This realization was not because I had developed selective amnesia after crossing the Hudson River, but because a 25-bed hospital with no full-time medical or surgical subspecialists cannot provide the level of support necessary to provide the postoperative care that patients need when undergoing high-morbidity procedures. The trip to a staffed surgical intensive care unit with a full complement of subspecialty consultants is not an elevator ride for CAH patients, but often a helicopter ride.
Rural surgical practices tend to generate diverse case loads, unlike the niche practices common in major metropolitan areas. Looking over the case log I submitted last year for ABS recertification, few of the procedures listed would pass muster individually by volume metrics. As individuals, it is rarely possible to accumulate sufficient data to prove that we are producing excellent results.

In an analysis of 5,033 colectomies performed over three years by 345 surgeons in the Michigan Surgical Quality Collaborative (MSQC) Colectomy Quality Improvement Intervention Project, a valid risk-adjusted surgeon-specific complication rate could be calculated for only one surgeon.\textsuperscript{13} A caseload of 168 colectomies over three years was required to calculate a reliable result. The average number of cases per surgeon annually calculates to 4.86. In the Ibrahim study cited earlier, average annual Medicare colectomies per CAH were 2.46.\textsuperscript{6} If one assumes an equal number of colectomies in non-Medicare beneficiaries (extrapolating from the MSQC data), the same number results. A single mortality after a colectomy by the average surgeon in a CAH would require six years of cumulative data without a mortality to come down to the 3.3 percent reported in Ibrahim’s study. We will not be much helped by individual scorecards.

Some health care policymakers would have rural surgeons give up doing all but the most basic of surgical procedures in favor of regionalization. However, this situation would present a number of problems for patients, hospitals, and surgeons. Rural patients on average are older, poorer, and less mobile than patients in larger metropolitan areas. Lack of mobility, whether as a result of economic, psychological, or physical limitations, represents a real barrier for poor and elderly patients. Some patients have such a strong preference for local care that they will opt for a local provider even in the face of greatly increased risk of mortality.\textsuperscript{14}

At the hospital level, CAHs are dependent on the revenue generated by surgical services to sustain their financial viability. Recruitment and retention of general surgeons in rural areas is difficult already. Were the scope of practice of rural surgeons to be constrained by widespread restriction of surgical privileges on the basis of numerical quotas or mandated regionalization, fewer general surgeons would find rural practice attractive, further limiting access to emergency and elective surgical care.

\textbf{Suggestions for rural surgeons}

What, then, ought we do as rural surgeons to overcome these challenges? Here’s what I do. First, I try to “color inside the lines.” That is, I try to manage my patients according to accepted guidelines and the current literature. Clinical practice guidelines are available online from a variety of sources, including the American College of Surgeons, National Comprehensive Cancer Network, American Society of Breast Surgeons, Society of American Gastrointestinal and Endoscopic Surgeons, American Society of Colon and Rectal Surgeons, American College of Obstetrics and Gynecology, and others. These professional guidelines serve as “guardrails” to keep me on track.

Second, I try to maintain currency of knowledge and technical skills appropriate to my scope of practice. When
The trip to a staffed surgical intensive care unit with a full complement of subspecialty consultants is not an elevator ride for CAH patients, but often a helicopter ride.

your OR schedule on any given day might include a total thyroidectomy, an ultrasound-guided partial mastectomy with sentinel node biopsy, a laparoscopic cholecystectomy with common bile duct exploration, a components separation incisional hernia repair, or a laparoscopic hysterectomy, staying current can be daunting. Without the Internet, I could never manage. I limit the patients I treat and the procedures I perform to those I believe are within my areas of competence and the capabilities of my facility. When complications occur, I try to recognize and admit them and arrange for transfer to an appropriate level of care, whether across the hall to our intensive care unit or across the state to a tertiary care facility.

Finally, we have begun to expand the measurement of outcomes and to participate in collaborative quality improvement projects through the Illinois Surgical Quality Improvement Collaborative, a major new initiative for my facility.

To paraphrase Vince Lombardi, perhaps perfect practices will make perfect.

REFERENCES

Moving the needle toward TNT in locally advanced rectal cancer

by Thomas J. George, Jr., MD, FACP; Christina Wu, MD; and Y. Nancy You, MD, MHSc, FACS

Colorectal cancer remains a leading cause of cancer-associated deaths in the U.S., and rectal cancer represents nearly one-third of this burden. For patients with stage II or III rectal cancer, the paradigm of preoperative chemoradiotherapy (chemoRT), followed by complete surgical resection (ideally in the setting of sphincter preservation), followed by adjuvant chemotherapy, represents the current standard of care in the U.S.\textsuperscript{1-3} This paradigm is supported by national consensus guidelines and major cancer professional societies.\textsuperscript{4} Through the use of quality controlled external beam radiotherapy and subsequent total mesorectal resection, local control rates remain consistently greater than 90 percent. Today, most patients who succumb to rectal cancer do so through distant failure and systemic metastases.

It is plausible to speculate that a treatment regimen that ensures all patients with high-risk rectal cancers receive optimal systemic therapy could lead to meaningful improvements in survival. Furthermore, for most patients today, systemic therapy (and thus potential eradication of occult micro-metastatic disease) does not begin until after recovery from surgery—close to three months from the time of initial diagnosis. However, little data are available to show that adjuvant systemic chemotherapy reduces the risk of distant failure in rectal cancer, as opposed to colon cancer. Interestingly, most contemporary randomized controlled trials show that 25 percent to 70 percent of rectal cancer patients never receive or complete their intended adjuvant systemic chemotherapy. This statistic is in contrast to most adjuvant colon cancer clinical trials, in which more than 75 percent of patients routinely receive the intended therapy. Even at NCCN centers (a network of regional centers with the capacity to provide comprehensive multimodality cancer therapy), nearly 20 percent of patients do not receive their intended rectal cancer adjuvant chemotherapy.\textsuperscript{5} It is thus likely that, for a variety of reasons, the rate of adjuvant therapy administration is similarly suboptimal among patients treated off trial and in general practice.

One way to effectively ensure that all patients receive intended and earlier systemic therapy is induction or neoadjuvant chemotherapy. Thus, a new clinical trial paradigm is emerging that uses total neoadjuvant therapy (TNT), which typically includes four months of FOLFOX systemic chemotherapy, followed by chemoRT, and ending with surgical resection (see Figure 1, page 62). In a randomized phase II study, this approach has demonstrated a significant improvement in compliance with delivery of all therapy and no untoward surgical complications.\textsuperscript{6} Postoperative recovery is thus unabated by the need to continue anti-cancer treatments.

Study approach and aims
The NRG Oncology TNT clinical trial (NRG-GI002) is a randomized phase II platform study with parallel, non-comparative experimental arms with a single comparative control arm of neoadjuvant chemotherapy and chemoRT in locally advanced and high-risk rectal cancer (see Figure 1, page 62). Additional arms testing novel agents and unique hypotheses will be added through protocol amendments and compared with the continuously running control arm. Any novel arm demonstrating success against the control arm will be further
tested in larger and more definitive randomized controlled trials. The primary endpoint is a novel pathologic endpoint of the neoadjuvant rectal (NAR) score, which measures pathologic response to TNT and has been shown to predict long-term survival endpoints. Such a pathologic endpoint allows trial outcomes to be assessed rapidly. The platform design of the trial allows for a systematic approach to study novel radiosensitizers, such as the poly(ADP-ribose) polymerase inhibitor veliparib; personalized treatment selection using novel targeted systemic therapeutics; and identification of patients at exceptionally high risk for recurrence. Hence, the TNT protocol will provide a clinical trial to support the testing of multiple parallel hypotheses and help justify more definitive randomized controlled studies only after the demonstration of substantive activity.

Eligibility criteria
Patients must have biopsy-proven clinical stage II/III rectal adenocarcinoma. The disease must be clinically determined as “locally advanced” by any one of the following criteria:

- Distal location: cT3-4 ≤ 5 cm from the anal verge, any N
- Bulky: Any cT4 with the majority of tumor < 12 cm from the anal verge or evidence that the tumor is adjacent to (defined as within 3 mm of) the mesorectal fascia
- High risk for metastatic disease with four or more regional lymph nodes (cN2)
- Not a candidate for sphincter-sparing surgical resection prior to neoadjuvant therapy (as planned by the primary surgeon)

Associated translational studies will correlate clinical outcomes with molecular, biomarker, and imaging interrogation.

Study status
The study is currently undergoing the pre-activation phase at the National Cancer Institute Cancer Trials Support Unit. It is expected to be available for all sites to open in October 2016. The study is endorsed by all cooperative groups, including the Alliance for Clinical Trials in Oncology. For more information, contact thom.george@medicine.ufl.edu.

REFERENCES:
Maximize your visibility and the benefits of Fellowship with the My Profile Web page

by Elizabeth McAllister

The online gateway to all of your American College of Surgeons (ACS) benefits is your online ACS Member Profile.

Maximum visibility
You can maximize your Web presence by regularly updating your Member Profile. The information is automatically formatted to serve as your personal ACS Web page. You have the option of including a photo, describing your practice, specifying your areas of concentration, and highlighting your training, board certifications, society memberships, and academic and hospital appointments.

You can customize your privacy settings to determine what information remains confidential, is viewable only by other ACS members, or may be viewed by the public through the Find A Surgeon site. On average, more than 10,000 individuals visit the Find A Surgeon page each month. Maintaining a complete profile increases your visibility when patients are searching by specialty, procedure, or location, or are validating your credentials and looking for a second opinion. It also allows colleagues to easily connect with you, as your page can be linked to your practice website and to social media.
Communicate
You also may use your online Member Profile to link to the ACS Communities that are of interest to you. At present, the ACS has more than 100 members-only Communities. The ACS Communities have multiple layers of security to allow members to freely discuss cases and issues. Visit the ACS Communities to participate in discussions relevant to your specific interests, engage with experts, and share documents, photos, and videos.

Comply with regulatory requirements
Your profile includes a link that allows users to manage and track their continuing medical education (CME) credits. You can track both ACS and non-ACS CME credits, print CME certificates, and transfer your CME credits directly to the American Board of Surgery through the MyCME site.

Members also may access the ACS Surgeon Specific Registry (SSR). The SSR online software application and database allows you to track your cases and outcomes, as well as meet a number of regulatory requirements, including the Centers for Medicare & Medicaid Services Physician Quality Reporting System mandates and Maintenance of Certification requirements issued by the surgery boards.

Take advantage of ACS programs
From your profile page, you may contact your ACS representatives, including the Board of Governors, your Advisory Council Chair, join your state or local chapter, print your ACS membership ID card, pay your membership dues, and sign up for the wide variety of ACS Insurance Programs and other discount programs. Fellows also may download FACS artwork for use on their website, letterhead, lab coat, and more.

Visit your ACS Member Profile page and make sure you are taking advantage of everything your ACS membership has to offer. You may access your profile page by logging into the facs.org website using your member login information. Once you have logged into the site, select “My Profile” from the menu bar, and then “My Profile Overview.” If you do not know your member login information, you can retrieve it securely through the facs.org login page. Contact ms@facs.org or call 1-800-621-4111 for assistance.
Workplace bullying is a real problem in health care

by Carlos A. Pellegrini, MD, FACS, FRCSI(Hon), FRCS(Hon), FRCSEd(Hon)

B ullying and workplace violence, in any setting, are unacceptable. These behaviors are of particular concern in the health care setting, as they pose a risk not only to our colleagues and peers, but also to patient safety.

Too common a problem
According to an article in The International Journal of Environmental Research and Public Health, “Workplace bullying among healthcare workers” by Antonio Ariza-Montes and co-authors, the most frequent victims of violent events in the health care sector are 40 years old or younger. The article also states that women physicians and unmarried women employees with less education and with children at home are more likely to endure bullying.1

In addition, a recent Occupational Safety and Health Administration (OSHA) report indicates that 21 percent of registered nurses or nursing students said they have been physically assaulted, and more than 50 percent said they have been verbally abused—a form of workplace violence that includes bullying.2 Meanwhile, 12 percent of emergency nurses reported physical violence and 59 percent experienced verbal abuse during a one-week period.

The Workplace Bullying Institute defines workplace bullying as “repeated, health-harming mistreatment of one or more persons by one or more perpetrators.”3 This bullying may manifest as verbal abuse, threats, intimidation, humiliation, or even work interference.

The institute estimates 65.6 million workers in the U.S. either have been bullied in the workplace or have witnessed bullying. A 2014 survey showed that 69 percent of bullies were men, and 57 percent of targets were women; it also showed that 68 percent of women bullies targeted other women.3

Effects on patient care
In the health care arena, bullying occurs most frequently in behavioral health units, emergency departments, and intensive care units. Bullying also is fairly common in perioperative areas, including the pre-anesthesia room, the operating room, and the recovery room. Whether it is exercising the power of authority or misusing the hierarchical structure, some surgeons have been known to intimidate other coworkers, sometimes with the excuse of doing so “on behalf of their patients.” Circumstances that are particularly suited to spurring this type of behavior include emergencies, which are common in surgery; difficult situations faced during the course of an operation that require prompt attention; new instrumentation; and changes in the patient care plan.

Bullying under these circumstances poses an immediate and direct threat to the safety of the patient, as those who are bullied are nervous and will most likely underperform because of their anxiety. In the long term, the impact on bullied employees can include lower morale, productivity, and attendance. This, in turn, can lead to more organizational turnover, causing talented workers to leave the profession—which can directly affect patient safety.

The Journal of Community & Applied Social Psychology categorizes workplace violence as the following:4

- Threat to professional status
- Threat to personal standing
- Isolation
- Overwork
- Destabilization

Workplace bullying—which is more common than sexual harassment—tends to happen to employees who don’t have good support systems or who are unable to defend themselves from their aggressors. Factors that contribute to workplace bullying include the following:

- A bullying culture
- Poor staffing levels
- Excessive workloads
- Power imbalances
Health care organization leaders also can play a role in battling bullying by creating a safety culture that doesn’t tolerate bullying behaviors, confronts bullies, and supports their victims.

- Poor management skills
- Role conflict or ambiguity
- Stress
- Lack of autonomy

Gerry Hickson, MD, and colleagues at Vanderbilt University Medical Center, Nashville, TN, determined that a common barrier in the fight against bullying was underreporting of the issue. In response, they created a Co-Worker Observation Reporting System to encourage accountability and respect among coworkers. This reporting system allows coworkers to document observed acts of bullying, which provides an inventory of such events and an opportunity for administrators to address these issues through education and compliance-related initiatives.

Health care organization leaders also can play a role in battling bullying by creating a safety culture that doesn’t tolerate bullying behaviors, confronts bullies, and supports their victims.

The Joint Commission also highlighted some safety actions to consider in Sentinel Event Alert, Issue 40, which include the following:

- Educating team members on appropriate behaviors
- Holding team members accountable
- Developing anti-bullying policies

Surgeons must lead

I believe that surgeons can play a substantial role in the fight against bullying in the health care field. Not only do I believe that we should always self-monitor to ensure that our statements, our actions, and our attitudes are not interpreted as bullying, but that we also have an obligation to observe and counsel our colleagues who may exhibit those behaviors.

Surgeons should leverage their visibility, their position in the hierarchy of an organization, the way that other health care providers perceive the role of surgeons, and their capacity to influence institutional policies and procedures to create and maintain an environment that is positive—for the health care workers, the surgeons and, most importantly, the patients.

For more, read a Quick Safety report on workplace bullying at bit.ly/2KusuG.

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.

REFERENCES

Stairway to heaven

“Stairway to Heaven,” a song by the British rock band Led Zeppelin and composed by guitarist Jimmy Page and vocalist Robert Plant, was released in 1971 and became one of the most popular rock songs of all time. The lyrics describe a mythical “lady” buying a stairway to heaven to ascend on a spiritual quest. In the last two decades, this fascination with heavenly stairways has spilled over to the real world. The world’s highest escalators are 39 stories tall (one takes passengers up and the other takes them down) and are located in Osaka, Japan, in a glass-enclosed structure at the Floating Garden Observatory in the Umeda Sky Building.¹

An escalating problem

The concept of the escalator dates back to 1859, when Nathan Ames of Massachusetts patented his idea of a moving staircase; however, Mr. Ames did not successfully build a working model. At the end of the 19th century, several other inventors patented similar ideas but never actually built a working model. In 1899, Otis Elevator Company introduced the first working escalator.

The word escalator is derived from the Latin word “scala,” meaning steps, and the word elevator, coined by Otis for the name of their moving lift. A Frenchman in 1898 invented a “step-less” escalator for the Harrods department store in London, England, using a continuous leather belt. Customers that were shaken by the experience were revived with free smelling salts and cognac.²

Today, escalators are ubiquitous. It would be difficult to go to any urban area, shopping mall, transportation facility, airport, or large convention center and not find moving stairs that will take you from one floor to the next. The U.S. has an estimated 35,000 escalators that serve an average of 12,000 people per escalator, amounting to 105 billion passenger trips annually.³

However, use of this conveyance convenience carries with it potential harm. According to the U.S. Consumer Product Safety Commission’s (CPSC) National Electronic Injury Surveillance System (NEISS), a system designed to collect data on all injuries seen in emergency departments, an estimated 12,774 patients were injured using escalators in 2014.⁴

To examine the occurrence of escalator injuries contained in the National Trauma Data Bank® (NTDB®) research dataset for admission year 2014, medical records were searched using the International Classification of Diseases, Ninth Revision, Clinical Modification codes. Specifically searched were records that included the diagnosis code E880.0 (Accidental Fall on or from Escalator). A total of 431 records were found, of which 363 contained a discharge status, including 234 patients discharged to home, 56 to acute care/rehab, and 57 sent to skilled nursing facilities; 16 died. Half of these patients (50 percent) were women, on average 63.9 years of age, had an average hospital length of stay of 5.8 days, an intensive care unit length of stay of 4.1 days, an average injury severity score of 9.5, and were on the ventilator for an average of 4.7 days. Of those tested for alcohol, almost one-third (56 out of 180) tested positive (see Figure 1, page 68).
Watch your step
Escalator injuries can be averted by taking a few simple steps. Avoid carrying heavy packages, hold the handrail, stay away from the lines at the edge of each step that identify an entrapment risk, do not take strollers or wheelchairs onto the steps, and be aware of other riders in case someone ahead of you falls. Next time you get on an escalator and think that it is a stairway to heaven, make sure you heed these safety measures—or it just may be.

Throughout the year, we will highlight these data through brief monthly reports found in the Bulletin. The NTDB Annual Report 2015 is available on the ACS website 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.

REFERENCES
In memoriam:
Barrett G. Haik, MD, FACS

by James W. Gigantelli, MD, FACS

Barrett George Haik, MD, FACS, Hamilton Professor of Ophthalmology and director, the University of Tennessee Health Science Center Hamilton Eye Institute (HEI), Memphis, unexpectedly died in his sleep on July 22 while visiting his much-loved family and friends in his hometown of New Orleans, LA. He was 64 years old. A dedicated teacher, insightful researcher, skilled surgeon, and proven cultivator of philanthropy, Dr. Haik leaves a legacy to his students, colleagues, and patients to live by his example: to treat all with kindness, warmth, and respect, and to continue to believe that any vision can be achieved.

**Born into ophthalmology**

Dr. Haik was born into ophthalmology. The son of George M. Haik, Sr., MD, and Isabelle Saloom Haik, Barrett could count 14 ophthalmologists in his extended family. When reminiscing about his childhood, he once recalled jokingly, “We didn’t go on family vacations; we traveled with my father to visit colleagues in other cities.” To Barrett, medicine was not a career; it was woven into the fabric of his life. He obtained his undergraduate degree at Centenary College, Shreveport, LA, and worked as a research fellow at the Oak Ridge National Research Laboratory, TN, before earning his medical degree and master's degree in anatomy from the Louisiana State University (LSU) Medical School, New Orleans. He moved to New York, NY, to complete his residency in ophthalmology at the Edward S. Harkness Eye Institute at Columbia-Presbyterian Medical Center. Thereafter, he joined the faculty of Cornell University Medical College and staff of Memorial Sloan Kettering Cancer Center, New York, soon becoming the associate director of its ophthalmic oncology service.

To Barrett, family and friendships were deep-rooted, so it came as no surprise that in 1986, he returned to New Orleans as a professor of ophthalmology and director of the ophthalmic oncology and orbital disease service at Tulane University. He was soon program and medical director of the Eye, Ear, Nose and Throat Hospital, and was appointed to serve as Tulane’s first endowed chair in ophthalmology, the George M. Haik, Sr., MD–St. Giles Foundation Professor of Pediatric and Adult Ophthalmic Oncology.

**Passion for teaching, humanitarianism**

Barrett was a natural mentor, supervising resident physicians from programs at Tulane, Louisiana State University, and the Oschner Foundation. He not only taught residents how to practice medicine, but also nurtured them into compassionate caregivers. Caring for others was Barrett’s life mission, and he found dignity and worth in every person. At Tulane, Barrett would take his pediatric cancer patients to the Audubon Zoo as part of the healing process. To his students or colleagues, he was generous with his time and advice. You left a coaching...
session with Barrett with renewed appreciation of your abilities and a confidence to pursue what had seemed unattainable.

In 1995 the University of Tennessee Health Science Center recruited Dr. Haik to lead its department of ophthalmology. During his extraordinary 17-year span as department chair, Dr. Haik transformed the small department with four faculty members into the HEI, a world-class eye center that is home to more than 40 faculty members, acclaimed clinical programs, and a strong core of basic scientists.

He also built the ophthalmic oncology service at St. Jude Children’s Research Hospital, Memphis, saving the lives of children, both at home and abroad, with ophthalmic tumors. Retinoblastoma is a pediatric eye cancer that once had a mortality rate of 90 percent in low-resource nations, but through Dr. Haik’s outreach initiatives to establish centers of excellence throughout the developing world, that mortality rate is now less than 10 percent in many countries. He equated identifying retinoblastoma in children to saving their lives.

Dr. Haik’s true passion was helping people. For the better part of his career, Barrett traveled semiannually to Panama with colleagues to operate field clinics serving local residents. His commitment to the Panamanian patients and physicians resulted in First Lady Marta Linares de Martinelli bestowing Barrett with the National Award of the Grand Officer in the Order Vasco Núñez de Balboa in 2012. He also was presented with the Keys to Panama City by its mayor.

In 2012, Dr. Haik stepped down as chair of HEI to serve as director and chair emeritus. A prolific fundraiser, Dr. Haik raised more than $100 million for HEI’s research and global eye care programs. His success was due to a rare combination of tremendous intellect, unclouded vision, a gentleman’s demeanor, and unfailing kindness. He exhibited the same warmth and appreciation for everyone—janitors and plumbers, professors and businessmen, students and residents. He led not only through genius and vision, but through the day-to-day example set by how he treated others.

**Committed surgeon volunteer**

Dr. Haik was a tireless advocate of the American College of Surgeons (ACS) and its mission, voluntarily contributing to a range of ACS committees and governing bodies. Dr. Haik was a leading member of the Board of Regents (2004–2013), the Board of Governors (2000–2005), and the ACS Committee on Emerging Surgical Technology and Education (member, 2006–2007; Chair 2007–2013). He also served on the Advisory Council for Ophthalmic Surgery (1998–2013, Chair, 2002–2004), the Program Committee (2007–2011), the Committee on Education (2007–2013), the Member Services Liaison Committee (Chair, 2012–2013), the Committee on Research and Optimal Patient Care (2004–2012), and the Health Policy Steering Committee (2006–2009).

Dr. Haik also served as an officer or board member of numerous other medical and scientific societies, including the American Academy of Ophthalmology (AAO), Association of University Professors of Ophthalmology, American Eye Study Club, American Society of Ophthalmic Ultrasound, and New York Academy of Medicine. He received a Lifetime Achievement Award from the Memphis Business Journal and the AAO. A prolific author and editor, Dr. Haik was also a highly sought-after lecturer in national and international forums.

Barrett loved caring for patients and teaching others, but he also enjoyed the company of friends and his bloodhound Maddie. Recreationally, he enjoyed golfing and fishing the waters of the Louisiana delta and gulf. He is survived by his companion, Bianca Phillips; son, Christopher Barrett Haik of Quito, Ecuador; daughter, Claire Marie Haik of Philadelphia, PA; two brothers, George M. Haik, Jr., MD, and Kenneth Haik, MD, both of New Orleans; and a sister, Suzanne Haik Terrell.
The American College of Surgeons (ACS) Foundation Board of Directors will present the 2016 Distinguished Philanthropist Award to Mary H. McGrath, MD, MPH, FACS, professor of surgery, University of California, San Francisco (UCSF), at its annual Donor Recognition Luncheon Monday, October 17, at Clinical Congress 2016 in Washington, DC. Dr. McGrath will be recognized for her generous contributions to the College, her service to the larger philanthropic community, her longstanding record of ACS volunteerism, and a career-long dedication to the quality of surgical patient care.

A graduate of St. Louis University School of Medicine, MO (1970), she completed her general surgery residency at the University of Colorado Medical Center, Denver (1976), and trained in plastic surgery at the Yale University School of Medicine (1976–1978), New Haven, CT.

Contributions to the profession
Since then, Dr. McGrath has made outstanding clinical and academic contributions to the field of plastic surgery, especially in the areas of breast and hand surgery, wound healing, introduction of new technology, and workforce issues. Her career as an academic surgeon started at Yale in 1978 with a position as assistant professor of surgery in the school of medicine’s division of plastic and reconstructive surgery. In 1980, she became assistant professor of surgery, division of plastic and reconstructive surgery, Columbia University College of Physicians and Surgeons, New York, NY. In 1984, she moved to the George Washington University Medical Center, Washington, DC, where she began as chief, division of plastic and reconstructive surgery, and director, residency training program, and ultimately ascended to professor of surgery. She has held her current position at UCSF since 2003. She has held many national positions in plastic surgery and is currently president-elect of the American Association of Plastic Surgeons.

A Fellow of the College since 1983, Dr. McGrath has provided exceptional service to the ACS and has served for 25 years in leadership roles, including First Vice-President (2007–2008); Vice-Chair, Board of Regents (2005–2006); member, Executive Committee, Board of Regents (2002–2006); Regent (1997–2006); and Chair, Committee on Ethics (2003–2006).

She served on the Board of Governors Executive Committee and as a Governor-at-Large representing the District of Columbia and is a member of the ACS Foundation Board. In 2009 the ACS appointed her to serve on the Board of Commissioners of The Joint Commission; she is currently serving her third term in this capacity. For this remarkable service, Dr. McGrath received the College’s highest honor, the Distinguished Service Award, in 2011.

Generous philanthropist
As an ACS donor since 1994, Dr. McGrath’s generous philanthropy has elevated her to the Fellows Leadership Society Legacy Circle, one of the top giving tiers that ACS Foundation donors may achieve. Remarking on her reasons for supporting the ACS, she said, “The surgical profession and other surgeons have enabled me to be personally and financially successful, for which I am tremendously grateful. I encourage other Fellows to consider making their own contributions and join the community of colleagues planning to see surgery survive successfully in the future.” ♦
Check out the new interactive version of the *Bulletin*, which gives you the same reading experience as the print edition of the *Bulletin* with the convenience of being able to access it on your smartphone, tablet, or computer *before your issue arrives in the mail*.

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The pursuit of quality improvement (QI) is what drives surgeons and other health care professionals to attend the American College of Surgeons Annual Surgical Quality Improvement Program (ACS NSQIP®) conference, said Clifford Y. Ko, MD, MS, MSHS, FACS, Director, ACS NSQIP and ACS Division of Research and Optimal Patient Care, in his welcoming remarks at the 11th annual ACS NSQIP Annual Conference. The theme of this year’s conference, July 16−19 at the San Diego Bayfront Hilton, CA, was Innovate to Make a Difference.

“Everybody wants to innovate, but few want to change,” Dr. Ko told the gathering of nearly 1,500 surgeon champions (SCs), surgical clinical reviewers (SCRs), and other QI leaders. “What we’re fighting is the attitude that, ‘We’ve always done it this way.’ Our goal is to find better ways to do things and to make changes in the way we approach standards of care,” he said. Comparing the QI task to moving an immense boulder, Dr. Ko said, “Every day, we’re working to move that boulder uphill.”

Dr. Ko said that New York Times blogger Pauline Chen, MD, FACS, got it right years ago when she called ACS NSQIP “a better way to keep patients safe.” Speakers throughout the conference described steps they take to ensure patient safety. The conference offered a variety of sessions aimed at reducing surgical complications, applying QI concepts to difficult surgical problems, and maximizing efficiency and resource use in health care. Many sessions also offered strategies for adapting to a changing health care environment and using evidence-based tools and case studies to improve organizational culture.

This year’s meeting was co-chaired by E. Patchen Dellinger, MD, FACS, professor and vice-chairman, and chief, division of general surgery, University of Washington Medical Center, Seattle; and Molly Clopp, RN, MS, strategic leader, patient safety, Kaiser Permanente, San Francisco, CA.

Keynote address: Resilience

Surgery is all-consuming—from training to practice—but it also can be highly rewarding, said Julie A. Freischlag, MD, FACS, Past-Chair, ACS Board of Regents, in her keynote address, Career Satisfaction by Way of Resilience. An academic health care leader, Dr. Freischlag oversees the University of California (UC) Davis Health System’s academic, research, and clinical programs, including the School of Medicine, the Betty Irene Moore School of Nursing, the 1,000-member physician practice group, and UC Davis Medical Center.

“Surgeons fret and we worry because we care,” Dr. Freischlag said. “Despite our best efforts, someone’s going to return to the hospital, and as a surgeon, you need to generate ways to bounce up.” Lack of resilience often leads to burnout, which manifests itself as anxiety, depression, broken marriages/relationships, alcoholism, substance abuse, and suicide. “Surgeons have to learn how to reboot, so they don’t drive the people around them crazy,” she said.

She offered suggestions for avoiding burnout, including staying connected to other people. “When things are not going well, take the time to see a friend,” she said. “People are what will get you through the toughest times.” Find mentors and be a mentor, she advised. Be a good colleague, and try to help your colleagues who are experiencing burnout. “Do not hesitate to have those difficult conversations,” Dr. Freischlag said.
“What we’re fighting is the attitude that, ‘We’ve always done it this way.’ Our goal is to find better ways to do things and to make changes in the way we approach standards of care,” Dr. Ko said.

Dr. Freischlag noted that the health care paradigm has changed, with patients driving quality improvement, and surgeons need to be resilient in response to these changes, as well.

“As surgeons, we’ve got to move forward,” she said. Earlier in her career, when she worked for the Veterans Health Administration (VHA), Dr. Freischlag recalls that members of the operating room (OR) team worried that if they reported their complications they would create problems for the VHA and their colleagues. Today, reporting problems and understanding why they occur are considered part of the solution.

ACS NSQIP is based on the premise that members of the surgical team can learn from their mistakes—that they can be in a state of continuous quality improvement. According to Dr. Freischlag, surgeons should be judged not by their mistakes, but by their resilience—how well they recover from an error. “I don’t measure success by how high a surgeon climbs, but how that surgeon bounces back from rock bottom,” Dr. Freischlag said.

Culture trumps everything, Dr. Freischlag added. “You have to understand your culture in order to change it,” she said. “Learn to be resilient. When they tell you that you can’t, tell them that you can, and make sure you’re right.”

**Town Hall**

New at this year’s conference was a Town Hall with ACS Executive Director David B. Hoyt, MD, FACS, moderated by Bruce L. Hall, MD, PhD, MBA, FACS, professor of surgery, Washington University; vice-president of quality, Barnes Jewish Hospital, St. Louis, MO; and ACS NSQIP Consulting Director. Dr. Hoyt reviewed legislative and regulatory issues affecting surgery and the role of ACS Quality Programs in influencing these initiatives and their implementation.

A key factor driving health care reform in the U.S. is cost, according to Dr. Hoyt. “The cost of health care has woken us up,” he said, and there is pressure to lower it. Many of the legislative and regulatory responses to rising health care spending have focused on physician payment reform.

Most recently, the Medicare Access and CHIP (Children’s Health Insurance Program) Reauthorization Act (MACRA) of 2015 established a new Quality Payment Program (QPP). Physicians have two pathways to participation in the QPP: the Merit-based Incentive Payment System (MIPS) or advanced Alternative Payment Models (APMs). (See related story, page 20 of this issue.) Surgeons who put the patient at the center of care should do well under MACRA, Dr. Hoyt said.

Surgeons are well-positioned to lead QPP implementation, as they have been leading the charge toward patient-centered, evidence-based care for more than a century. “Surgeons have been the most aggressive among health care professionals in engaging quality improvement,” Dr. Hoyt said. “We now have to be accountable to our patients, and surgeons are as ready as anyone for this challenge.”

Performance is going to be measured, and without valid, robust data that flow from QI initiatives, hospitals cannot accurately compare their performance with other hospitals or between patients. “We’ve got to create the intellectual trust, because if we do, important people will follow,” Dr. Hoyt said.

Other ACS quality-related activities that Dr. Hoyt discussed included the development
and release of statements on perioperative care and OR attire; efforts to ensure that general surgery residents are adequately prepared for surgical practice when they finish training, including the ACS Transition to Practice program; and the changing surgical culture.

“I think it’s an exciting time to be a surgeon,” Dr. Hoyt said. “We’ve got to change the culture, and we’ve got to have the right tools.”

Managing change
In a preconference session, SCs, SCRs, and other attendees reviewed a case study involving a hospital that had received an ACS NSQIP report showing that its surgical site infection (SSI) rates were increasing. Session participants determined that this problem could be attributed to a range of factors, including miscommunication during patient handoffs, conflicts between the surgical staff and the circulating nurses, administrative pressures to cut costs, a shortage of intensive care beds, and changes in leadership in anesthesiology. The group determined that many of these issues would remain unresolved without a change in the institutional culture.

“Leading and managing change is a lot harder than it looks,” according to session moderator Nestor F. Esnaola, MD, MPH, MBA. Surgical leaders must guide the change management process, said Dr. Esnaola, associate director, cancer health disparities and community engagement; attending surgeon, gastrointestinal oncology, hepatopancreaticobiliary surgery; and sarcoma professor, department of surgical oncology, Fox Chase Cancer Center, Temple University, Philadelphia, PA.

“Change is not an event,” he said. It’s a planned and structured process, and it only can occur when change champions get buy-in across the department and institution, preferably from people who are in high-power/high-influence positions initially.

To motivate health care professionals to accept change, you have to “shock them out of the status quo.” Show them high-quality data that point to a real problem, Dr. Esnaola said. Communicate a vision and strategy for change, and empower broad-based action. Start with small improvements that people can see and appreciate. Then, explain the gains to drive more change, and hardwire the changes into the culture.

Surgeon champions
In a breakout session for new SCs, Charles A. Lane, MD, FACS, a general and laparoscopic surgeon, Maryville, IL, urged SCs not to “criticize, condemn, or complain. The challenge is to engage and influence your colleagues,” he said.

“You will become the face of [your institution’s] quality improvement program, and they’ll be counting on you to be the change agent.” He advised: Take the softer approach. Always ask them to consider something. Don’t show anger or frustration. Good opening phrases include “Tell me more about it,” and “What are your thoughts?” Show humility, he said. Listen more, and talk less.

Pierre F. Saldinger, MD, FACS, chairman, department of surgery, surgeon-in-chief, New York-Presbyterian, Queens, discussed local organizational culture. “Culture is what people do when no one is looking,” he said. A cynical attitude toward change and a lack of faith in the organization’s ability to transform itself are examples of barriers to change.
“Despite our best efforts, someone’s going to return to the hospital, and as a surgeon you need to generate ways to bounce up,” said Dr. Freischlag.

In another session for SCs, Robert E. Glasgow, MD, FACS, professor of surgery, University of Utah School of Medicine; section chief, gastrointestinal and general surgery, division of general surgery; and vice-chairman, clinical operations and quality and chief value officer, department of surgery, University of Utah, Salt Lake City, emphasized the importance of actively using ACS NSQIP reports to drive change. Allan Siperstein, MD, chair of endocrine surgery; program director, general surgery residency program and endocrine surgery fellowship; and SC, Cleveland Clinic, OH, noted that his institution sought to reduce SSIs. They succeeded in this effort by implementing standardized steps in the OR.

Joseph B. Cofer, MD, FACS, professor of surgery and surgery residency program director at the University of Tennessee College of Medicine, Chattanooga, has been involved in ACS NSQIP and an SC for 11 years. To be an effective SC, he said, “You have to be passionate about surgery and surgical outcomes, and you have to be willing to try to change the culture [in your institution].”

SCs also need to have some standing within the institution and have demonstrable leadership skills, Dr. Cofer said. They need to be magnanimous and effective communicators, and they need the support of an effective infrastructure.

Collaboratives must collaborate
Many successful ACS NSQIP participants are part of collaboratives. Karl Y. Bilimoria, MD, FACS, led a pre-conference workshop on the growing number of ACS NSQIP collaboratives. Dr. Bilimoria is a surgical oncologist and director, Surgical Outcomes and Quality Improvement Center, Feinberg School of Medicine, Northwestern University, Chicago, IL. Participants gathered at roundtables and provided overviews of their collaboratives, sharing stories about their successes and challenges.

Buy-in from the collaborative’s institutional leadership will largely determine the group’s success, said Olakunle Ajayi, MD, a colon-rectal surgeon, Kaiser Permanente, Oakland, CA. “The leaders are very interested in the return on their investment, so I keep them continually informed about how much money we’ve saved the hospital over time.”

Learning from mistakes
Panelists at a general session described what they learned from projects that did not go according to plan.

Saulat S. Sheikh, MB, BS, general surgery resident, York Hospital, PA, noted that SSIs account for approximately $8.6 billion in health care spending, according to a report from The Joint Commission Center for Transforming Health Care.* The goal at York Hospital was to bring the colorectal infection rate in line with the national average. The hospital implemented an SSI prevention bundle and monitored the change in SSI rate. After initial success, the hospital witnessed a substantial jump in SSIs. According to Dr. Sheikh, the lessons learned are that success does not always occur continuously, and failure can lead SCs to ask the right questions. All stakeholders must be involved, and a clear implementation plan and measures for compliance must be in place, he added.

Other speakers included the following:

- **Elizabeth C. Wick, MD, FACS**, a colorectal surgeon and assistant professor of surgery, Johns Hopkins University Medicine, Baltimore, MD, who discussed readmissions after complex abdominal operations

- **Jyotirmay Sharma, MD, FACS**, director, thyroid and endocrine surgery, Emory University Hospital; associate professor of general and endocrine surgery, division of general and gastrointestinal surgery, department of surgery, Emory University School of Medicine; and SC, Emory University Hospital, Atlanta, GA, who discussed his institution’s efforts to prevent hypothermia during complex procedures

- **Ryan D. Macht, MD**, a general surgery resident at Boston University Medical Center, MA, who spoke on patterns of failure identified in a standardized venous thromboembolism prophylaxis protocol

### ERAS

**Efren E. Rosas, MD**, assistant physician-in-chief, hospital operations and OR, Kaiser Permanente San Jose Medical Center, CA, and **Paul Preston, MD**, anesthesiologist, Kaiser Permanente, San Jose, offered a view of enhanced recovery after surgery (ERAS) programs at Kaiser.

The Kaiser team promoted the ERAS tagline, “Get up, get moving, get better,” and developed a detailed plan for each patient, including specific pre- and postoperative instructions for pain control, diet, exercise, and other factors that affect recovery. Kaiser targeted colorectal and hip fracture patients for the ERAS program and used ACS NSQIP data to evaluate outcomes. The protocol included preoperative counseling, nutritional guidance, and administration of prescription painkillers. Kaiser found that ERAS reduced the length of stay for patients with hip fractures by 39 percent and for colorectal patients by 19 percent. Patient care improved based on multiple metrics, including pain management; occurrence of transfusion, urinary tract infection, and venous thromboembolism; and patient satisfaction.

**Vanita Ahuja, MD, FACS**, WellSpan York Hospital, PA, spoke on barriers to implementing ERAS in small and community hospitals. Rural and small hospitals serve approximately 23 percent of the U.S. population, and 20 percent of their patient population is age 65 and older, Dr. Ahuja said. The challenges of providing quality care to these patients include remote location, which can make it difficult to recruit skilled staff; surgeons with less experience than their counterparts in larger hospitals because of the low volume of certain procedures done; and distance to tertiary centers.

#### Improving pediatric and geriatric surgical care

The ACS has developed two programs to address the unique needs of pediatric surgical patients: the Children’s Surgery Verification™ (CSV) Quality Improvement Program and ACS NSQIP Pediatric.

**Keith T. Oldham, MD, FACS**, professor and chief, division of pediatric surgery, Medical College of Wisconsin, Milwaukee, and Chair, CSV program, noted that pediatric surgery patients require different resources than their adult counterparts. However, “even today, a large segment of children receive care in nonspecialized environments.”
Dr. Oldham said. These general hospitals often lack the proper instrumentation and specialists needed to provide effective pediatric care. The CSV program seeks to ensure that all hospitals are equipped to address the needs of pediatric patients and that “every child in need of surgical care in North America today will receive care in an optimal environment,” Dr. Oldham said.

That vision culminated earlier this year with the release of *Optimal Resources for Children’s Surgical Care*—the nation’s first and only multispecialty standards for children’s surgical care. The ACS developed the standards with the Task Force for Children’s Surgical Care with an eye toward ensuring hospitals follow the College’s four guiding principles of QI—set the standards; build the right infrastructure; use the right data; and don’t trust, verify.

Diana L. Farmer, MD, FACS, FRCS, pediatric surgeon and chair, department of surgery, UC Davis, and a member of the ACS Board of Governors Executive Committee, said her institution served as a pilot site for the CSV program. Participation in the pilot created early quality benefits for pediatric patients at UC Davis, including enhanced efficiency, safety, and performance, she said. Specific changes included implementation of standards defining who can operate on children without the supervision of a pediatric specialist, adverse event analysis, and increased pediatric on-call care.

These changes happened through the work and guidance of a multidisciplinary children’s surgical performance and patient safety committee, Dr. Farmer said, allowing multiple departments and key personnel within the hospital at-large to collaborate, which was paramount to the program’s success.

Similarly, Texas Children’s Hospital, Houston, another pilot site, established a multidisciplinary surgical quality committee (SQC), according to director of strategic projects Laura Higgins, Esq. The SQC provides the infrastructure necessary to support QI initiatives, Ms. Higgins said. It has helped to improve accountability, prevent duplication of efforts, and ensure availability of optimal resources.

Jacqueline M. Saito, MD, FACS, assistant professor of surgery, division of pediatric surgery, Washington University School of Medicine, and a pediatric surgeon at St. Louis Children’s Hospital, said. Specific changes included implementation of standards defining who can operate on children without the supervision of a pediatric specialist, adverse event analysis, and increased pediatric on-call care.

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“What makes surgery unique is that it requires harm in order to heal,” Dr. Angelos said. “Healing cannot occur without actions that would be illegal in any other context. It is an intensely physical relationship.”

Hospital, MO, described how that institution used ACS NSQIP Pediatric data reports as a “prompt for a deeper dive” into adverse outcomes. This in-depth analysis was carried out through a multidisciplinary performance improvement and patient safety (PIPS) program. The PIPS group reviewed surgical deaths, complications, and other adverse events and compared quality performance metrics to national benchmarks. These findings were used to address outliers.

In addition, R. Lawrence Moss, MD, FACS, surgeon-in-chief, Nationwide Children’s Hospital, Columbus, OH, spoke on the importance of rare patient safety events as a measure of performance. In fact, analysis of such events led to the development of a Wake Up Safe anesthesia program.

Several sessions examined geriatric surgery. Thomas N. Robinson, MD, FACS, a member of the ACS Task Force on Geriatric Surgery and associate professor of surgery, University of Colorado, Aurora, and Ronnie A. Rosenthal, MD, FACS, Chair, Task Force on Geriatric Surgery, and professor of surgery, Yale University School of Medicine, New Haven, CT, led a session on Elderly Surgery and Outcomes. The session examined gauging patient frailty and other signs of readiness for surgery.

“Despite recent improvements in surgical technique, patient selection, and perioperative care pathways, 25 percent to 40 percent of patients undergoing liver resection develop a postoperative complication,” partly because they are too frail to withstand the procedure and recovery, said Timothy M. Pawlik, MD, MPH, PhD, FACS, a colon and rectal surgeon, Johns Hopkins University School of Medicine. Dr. Pawlik and his colleagues at Hopkins developed a frailty index based on routine preoperative clinical characteristics to predict postoperative complications and postoperative mortality following liver surgery.

Blair C. Baldwin, DO, a general surgery resident at Berkshire Medical Center, Pittsfield, MA, and colleagues sought to determine whether inguinal hernia repair can be performed effectively in elderly patients. Their research shows that surgeons should offer elective inguinal hernia repair to their elderly patients, although they endorsed further study of whether watchful waiting or

BEST PRACTICES

Each year, ACS NSQIP issues a call for abstracts to participating hospitals to submit presentation topics on how they have used ACS NSQIP to improve patient care. Awards honored authors in three abstract areas:

- Clinical Abstract Competition: David D. Odell, MD, MMSc, assistant professor of surgery, Northwestern University Feinberg School of Medicine, Chicago. The Impact of Hospital Safety Culture on Surgical Outcomes

- Resident Abstract Competition Winner: Mary M. Mrdutt, MD, Texas A&M College of Medicine, Temple. Where Are We Now? Two-Year Review of a Single-Institution Experience Implementing a Pilot Quality In-Training Initiative Curriculum

- Surgical Clinical Review Abstract Competition Winner: Lori E. Abel, RN, ONC, MEd, surgical quality expert, Lancaster General Health System/Penn Medicine, PA. Post-Operative Pneumonia Reduction in Surgical Patients
elective surgery is more effective in patients ages 80 and older.

Jennifer Dwyer, MD, Nebraska Medical Center, Omaha, reported on a study designed to determine whether the risk analysis index score—a measure of frailty—correlates with complications after urologic operations. The study indicated that frailty affects both primary (mortality and pulmonary, cardiac, and infectious complications) and secondary (length of stay, readmission, return to the OR, discharge destination) outcomes.

Luis A. de la Cruz, MD, MBA, Baptist Hospital of Miami, described how a strategy combining risk stratification, protective intraoperative interventions, and postoperative renal function monitoring significantly reduced the incidence of acute renal failure in noncardiac surgery patients.

Beth Turrentine, PhD, RN, trauma care coordinator, acute care nurse practitioner instructor, University of Virginia, Charlottesville, offered insights into a study that tested the hypothesis that sarcopenia, as measured by preoperative computed tomography scans, predicts morbidity and mortality in emergent laparotomy.

Jonathan S. Abelson, MD, a general surgery resident at New York Presbyterian Hospital, New York, described a study of his institution's use of the ACS NSQIP Surgical Risk Calculator in weekly morbidity and mortality conferences. The study showed that the risk calculator can be particularly effective in predicting patients with “above average” risk of complications.

Julia Berian, MD, an ACS Clinical Scholar in Residence who has played a significant role in the ACS and the John A. Hartford-supported Coalition for Quality in Geriatric Surgery, also spoke, offering insights into future directions in this growing surgical arena.

ACS Strong for Surgery

To ensure that all patients are in optimal condition for operative care, the College will be leading a national ACS Strong for Surgery initiative. Each year, approximately 210,000 preventable deaths occur in U.S. hospitals—half during some phase of surgical care, according to Thomas K. Varghese, Jr., MD, MS, FACS, head, general thoracic surgery, University of Utah; associate professor, department of surgery, University of Utah School of Medicine; and co-director, Huntsman Cancer Institute’s thoracic oncology program, Salt Lake City.

According to Dr. Varghese, under the ACS Strong for Surgery model, health care providers use a series of checklists and tools first developed at the University of Washington, Seattle, in four modifiable areas to ensure the patient’s optimal readiness for operative care: nutrition, blood sugar, smoking status, and medication use.

Surgical ethics

Peter Angelos, MD, PhD, FACS, Linda Kohler Anderson Professor of Surgery, chief, endocrine surgery, and associate director, MacLean Center for Clinical Medical Ethics, University of Chicago Medicine, explored the concept of professionalism. Surgical professional ethics centers on three factors: the surgeon-patient relationship, the invasive nature of surgery, and informed consent for surgery.

“What makes surgery unique is that it requires harm in order to heal,” Dr. Angelos said. “Healing cannot occur without actions that would be illegal in any other context. It is an intensely physical relationship.”
Informed consent in surgery allows patients to actively participate in the medical decision-making process and is rooted in respect for patient autonomy, Dr. Angelos said. Informed consent involves more than ticking off the risks, benefits, and alternatives to the patient; it also involves building trust. “Good data are essential for informed consent, but that is not enough,” Dr. Angelos said. “People don’t want to be operated on by people who can’t talk to them. The responsibility of surgeons goes beyond what happens in the OR.” It is the surgeon’s job to educate the patient about the condition, to clarify the goals of the operation, and to ensure that the patient is aware of risks, he added.

**Personal perspectives**

Several presenters at this year’s conference focused on personal stories, which they offered in a more conversational style. Thomas A. Aloia, MD, FACS, asked, “Should zero [errors] be the goal?” According to Dr. Aloia, SC and associate professor of surgical oncology, division of surgery, University of Texas MD Anderson Cancer Center, Houston, perfection is not a workable concept in surgery. If it were, high-risk patients would never receive surgical care.

“The surgeon has to balance issues of safety and quality,” he said. Safety has to do with the absence of harm to the patient, whereas quality has to do with efficient, effective, purposeful care that gets the job done at the right time for the right cost. Safety focuses on avoiding bad events. Quality focuses on doing things well. “Safety can drain a provider’s morale, but quality builds provider morale,” he said. “That’s why enhanced recovery has taken off.”

Kimberly McKinley, BSN, RN, quality leader, BC [British Columbia] Patient Safety and Quality Council, Penticton, BC, spoke about physician-patient communication. “We’ve all heard the expression, ‘It’s not what you say—it’s how you say it,’” she said. “But I truly believe that what we say matters. Nothing can override the power of a few poorly chosen words. Think of the power of your language, and take ownership of it.”

Rachel R. Kelz, MD, MSCE, FACS, an endocrine and oncologic surgeon and associate program director of the general surgery residency program, University of Pennsylvania, Philadelphia, spoke on the privilege of being a surgeon and of forming relationships with patients when they often are at their most vulnerable. Dr. Kelz noted that she has the privilege of being able to reassure them that they will be okay, and that they are not alone.

“All of us in this room have the potential to lead extraordinary lives,” Dr. Kelz said. By providing compassionate, quality care to surgical patients, she said, “we have the opportunity to extend our lives. We have the opportunity to be extraordinary.”

Offering advice for the modern surgeon was Oscar D. Guillamondegui, MD, MPH, FACS, professor of surgery medical director, trauma intensive care unit; director, Vanderbilt Multidisciplinary Traumatic Brain Injury Clinic; and vice-chairman, surgical quality, safety, and professionalism, Vanderbilt University School of Medicine, Nashville, TN. “Surgeons graduate from the school of anxiety,” Dr. Guillamondegui said, pointing to the high rates of depression and suicide among
surgeons. “Stop comparing yourself to other surgeons. We’re all good, but learn from your mistakes,” he said. Vulnerability is what allows surgeons to do that.

Residents as leaders
The conference closed with a session aimed at the future of surgical innovation—surgical residents—which Dr. Kelz moderated. In this session, young surgeons described how their roles in other arenas have prepared them for surgical leadership.

John F. Sweeney, MD, FACS, chair, department of surgery, Emory University, described the lessons he learned as a high school and collegiate football player as follows:

• Culture begins at the top.
• Know and understand the legacy of your organization; an institution’s legacy informs its culture.
• If you prepare and work hard, opportunity will present itself.
• Celebrate success, but don’t get cocky.
• Be confident in your abilities and be optimistic about the outcome.

Importantly, “Don’t be concerned who scores the touchdown,” he added. “Just score the touchdown.”

Lillian Kao, MD, FACS, professor, department of surgery, division of acute care surgery, Lyndon Baines Johnson General Hospital and Clinic, University of Texas, Houston, explained what she learned about “cultivating culture” as president of the Association for Academic Surgery:

• Diagnose the current state of the team culture.
• Discuss results and brainstorm for possible improvements.
• Create a staff compact.
• Create opportunities for interaction.
• Meet regularly.
• Strengthen the team by focusing on individual development.
• Get to know team members.
• Teach leaders to be mentors, not just managers.
• Create an environment that encourages learning.
• Find a way to foster new membership.

Joseph V. Sakran, MD, MPH, MPA, FACS, who at the time of the conference was associate professor of surgery, division of general surgery, Medical University of South Carolina, Charleston, said his experience as a firefighter taught him the importance of camaraderie. Dr. Sakran defines organizational culture as “civilization in the workplace.” Each organization’s culture is unique. “Anyone can copy a company’s strategies, but you can’t copy its culture,” he said.

Dr. Sakran outlined the following core concepts that he promotes in his organization:

• Engage your patients.
• Communicate effectively and “listen with intent to understand.”
• Encourage camaraderie building by having team huddles and debriefings and spending time with the team outside of the OR.
• Move away from management structures.
• Demonstrate humility.
• Coach with clarity.
• Provide flexibility.
• Offer real-time feedback.

The next ACS NSQIP Annual Conference will take place July 21–24, in New York, NY. ♦
INTRODUCING

A Mirror Reflecting Surgery, Surgeons, and their College:
The Bulletin of the American College of Surgeons

Copies of this recently published book will be for sale during Clinical Congress 2016 in Washington, DC. Please visit the Logo Shop, which will be located in the ACS Resource Center in the Exhibit Hall. The book is also available for purchase from amazon.com. The first 100 people to purchase a book from the Logo Shop will receive a signed copy.

David L. Nahrwold, MD, FACS, wrote this engaging account of the rich history of the Bulletin of the American College of Surgeons.

Dr. Nahrwold served as a Regent, Chairman of the Board of Governors, First Vice-President, and Interim Director of the American College of Surgeons, and received its Distinguished Service Award. He is co-author, with Peter J. Kernahan, MD, PhD, FACS, of A Century of Surgeons and Surgery: The American College of Surgeons 1913–2012.

Price: $15.95

Published by the American College of Surgeons.
The American College of Surgeons (ACS) recently issued an updated Statement on health care industry representatives in the operating room (OR) (see page 48, this issue), the purpose of which is to “supply guidelines to health care facilities and members of the perioperative care team to ensure optimal surgical outcomes, to ensure patient safety, and to protect patients’ rights to privacy and confidentiality when [a health care industry representative] is present during a surgical procedure.”

The College has had an active interest in this matter for some time. At Clinical Congress 2015, the ACS Committee on Ethics hosted a Town Hall meeting that brought together roughly 30 surgeons and representatives of the pharmaceutical and device industries in a session titled, Do You Want (or Need) the Sales Rep in Your OR? In light of the updated statement, this article reviews some of the issues discussed at that meeting.

Role of industry in patient care
The Town Hall participants agreed that relationships between surgeons and industry representatives are beneficial for both parties. Industry representatives can provide surgeons with important technical information and assistance. Furthermore, at a time when funding for continuing medical education and medical research is decreasing, the pharmaceutical and device industry should be a transparent partner with the medical and scientific community. Conflicts of interest need to be avoided, or at least identified and managed appropriately. Guidelines governing how to structure and operationalize the relationship also need to be established.

The conversation at the Town Hall meeting highlighted some of the realities, ethical issues, and best practices that can guide the interaction between the surgeon and the industry representative in the OR. Participants generally agreed that more open avenues of communication would help define the optimal relationship between the two.

Participants concluded that industry representatives fall into one of two categories: technical and sales. Some surgical specialties rely on the presence of the industry technical representative in the OR; vascular surgery is an example. When a graft is needed, the caliber and length of the graft selected before surgery can change based on intraoperative findings. The OR may stock only a limited number of grafts because it is financially prohibitive for the OR to stock a large selection. The industry representative has access to and can supply a selection of grafts that will accommodate the needs of the patient. Similar examples of this symbiotic relationship between the surgeon and the industry technical representative can be found in other surgical specialties, such as orthopaedics.

This relationship benefits all involved parties, including the patient. However, the patient has the right to self-
The College recognizes the importance of the health care industry representative and the benefits that the relationship between these individuals and the surgeon can provide patients.

determination and therefore should be informed if an industry representative will be in the OR. One of the challenges is timing. Informing the patient on the day of surgery in the preparation area may make it difficult for the patient to refuse. In addition, to preserve the patient’s privacy, the industry representative should not enter the OR until the patient is fully draped.

The introduction of new surgical equipment and technology also can benefit the patient. Surgeons usually are introduced to new devices and technology by industry sales representatives. Even when the surgeon has become proficient in the use of the new equipment or technology, the industry representative may be needed in the OR to help troubleshoot unexpected difficulties. The policies or guidelines of each hospital will facilitate the interaction between the surgeon and the industry representative without disrupting patient privacy and safety. This interaction should be transparent and organized.

Another mechanism by which surgeons become familiar with new equipment and technology is through Continuing Medical Education (CME) programs. However, some of the current regulations have made contacts between industry and the CME-sponsoring organization onerous, which has caused both parties to shy away from such interaction. It has been suggested that the ACS and other professional education organizations look for mechanisms that will avoid conflict of interest, real or perceived, which would allow industry to support CME activities for the advancement of surgical care. It also was suggested that the industry breakfast that brought industry representatives and surgical leadership together at the annual Clinical Congress in the past be reinstated.

Recommendations
Some of the suggestions and/or guidelines discussed at the Town Hall meeting and incorporated into the College’s policy statement include the following:

• Industry representatives should not have access to private patient or surgeon information (such as access to the full OR schedule).

• Invited industry representatives should make an appointment and not just show up in the OR.

• Many hospitals have “industry fairs,” where industry representatives can demonstrate their equipment and devices in an area outside the OR.

• Surgeons who participated in the Town Hall meeting were of the opinion that industry representatives should not have access to the surgeons’ lounge.

• Industry representatives should be registered, verified, and distinctively identifiable. In many hospitals, the industry representatives wear different colored caps or scrubs.

• Some hospitals include in their informed consent forms for surgery that an industry representative may be present in the OR at the surgeon’s discretion.

The College recognizes the importance of the health care industry representative and the benefits that the relationship between these individuals and the surgeon can provide patients, and the revised statement on this topic provides guidelines on how to structure the relationship.
The ACS Practice Management Course for Residents and Young Surgeons, Volumes I, II, and III are designed to educate and equip participants with basic practice management skills and the knowledge to manage a surgical practice.

Using an interactive/lecture format, the three separate courses cover a variety of topics, including:

- Pros and cons of a career in private practice
- Surgical practice organization
- Coding for surgical residents
- Surgical financial management reports
- Insurance processing
- Accumulation planning
- Goal planning and risk management
- Negotiation
- Liability equation changes

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- **Volume 2**: Professionalism—A Critical Risk Management Tool
- **Volume 3**: Postadverse Event Communication—The Key!

To access the ACS Practice Management Course today, visit [www.facs.org/education/resources/elearning](http://www.facs.org/education/resources/elearning).

For more information, contact Olivier Petinaux, Senior Manager, Distance Education and E-Learning, at elearning@facs.org or 866-475-4696.
Dr. Ajit Sachdeva takes helm of the Society for Academic Continuing Medical Education

Ajit K. Sachdeva, MD, FACS, FRCSC, Director of the American College of Surgeons (ACS) Division of Education, was inducted earlier this year as president of the Society for Academic Continuing Medical Education (SACME) at the World Congress on Continuing Professional Development in San Diego, CA. Dr. Sachdeva previously served as SACME president-elect and vice-president.

SACME plays a key national and international leadership role in advancing Continuing Medical Education (CME) through research and scholarship. Membership in SACME includes deans of CME from medical schools throughout the U.S. and Canada, CME directors from academic health centers, doctoral-level professional educators, vice-presidents and directors of education from medical and surgical specialty societies, and other stakeholders involved with the fields of CME, quality improvement, and patient safety.

Dr. Sachdeva has made landmark contributions to the evolving field of CME and has focused specifically on the education and training needs of surgeons in practice. His vision and work have led to the development and dissemination of a broad spectrum of standard-setting education, training, verification, validation, and accreditation programs that are aimed at promoting excellence and expertise in surgery. He is currently pursuing the development of a national system to address the training and retraining needs of surgeons at various stages of their professional careers. Dr. Sachdeva also is adjunct professor of surgery at the Feinberg School of Medicine, Northwestern University, Chicago, IL.

Dr. Sachdeva received his medical training at the All-India Institute of Medical Sciences, New Delhi. He completed a surgery residency at the Hospital of the Medical College of Pennsylvania (MCP), Philadelphia, and has held specialty certification in surgery since 1981. Dr. Sachdeva has participated in the Harvard Macy Institute Program for Leaders in Medical Education. Before joining the College, Dr. Sachdeva was the Leon C. Sunstein, Jr., Professor of Medical and Health Science Education and professor and vice-chairman for educational affairs, department of surgery, at the MCP Hahnemann School of Medicine, Philadelphia, PA. He also was associate dean for medical education and director of the Academic Center for Educational Excellence at that institution. In addition, Dr. Sachdeva served as chief of surgical services at the Philadelphia Veterans Affairs Medical Center (dually affiliated with the University of Pennsylvania and MCP Hahnemann School of Medicine) for 10 years. Dr. Sachdeva has served as chair of the Committee on Surgical Education of the Society of University Surgeons and as chair of the Education Subcommittee (Study Section) of the National Cancer Institute. Dr. Sachdeva has received many prestigious awards for his contributions to surgical and medical education. He has published widely in eminent peer-reviewed journals on educational topics and has delivered invited presentations across the U.S. and in Canada, Europe, Australia, and Japan.

Dr. Sachdeva has served as president of several national professional organizations, including the Association for Surgical Education, American Association for Cancer Education, Alliance for Clinical Education, and Council of Medical Specialty Societies. ♦
National Medical Association honors Dr. Turner with Service Award

Patricia L. Turner, MD, FACS, Director of the American College of Surgeons Division of Member Services, received the 2016 National Medical Association (NMA) Council on Concerns of Women Physicians (CCWP) Service Award. Dr. Turner received the award July 31 at the CCWP Annual Muriel Petioni, MD, Awards Luncheon, which took place at the NMA’s 114th Annual Convention and Scientific Assembly in Los Angeles, CA.

This award honors women physicians who, through research, community service, and activism, strive to eliminate health care disparities, provide people of color with quality health care, and address women’s health and professional issues. The awards program, the most highly attended event of the convention, continues to grow in popularity. This year’s program featured award-winning actress and television director Regina King. Read more about the NMA and the award at www.afassanoco.com/nma/ccwpprogram.html.

TQIP now in all 50 states and Washington, DC

The American College of Surgeons (ACS) Trauma Quality Improvement Program (TQIP®) is now in all 50 states and Washington, DC. The ACS TQIP program reached this milestone August 2 with the addition of Meritus Medical Center in Hagerstown, MD, a Level III TQIP Site.

The TQIP pilot program began in 2009 with 23 centers, and the full TQIP program launched in 2010 with 65 centers. In 2014, Pediatric TQIP was added, and on July 1 of this year, Level III TQIP was launched. As of September 20, TQIP has 602 enrolled sites (434 Level I and II Adult Sites, 59 Level III Sites, and 109 Pediatric Sites) and anticipates continued growth this year.

TQIP standardizes the collection and measurement of trauma data to generate quality improvement strategies and reduce disparities in trauma care nationwide. TQIP collects data from trauma centers, provides feedback about center performance, and identifies institutional improvements for better patient outcomes. TQIP provides hospitals with risk-adjusted benchmarking for accurate national comparisons. In addition, TQIP provides education and training to help trauma center staff improve the quality of their data and accurately interpret their benchmark reports. The program fosters clinical improvements with tools such as the Patient Listing Application, the TQIP Driller, and the expert-generated Best Practice Guidelines. TQIP provides opportunities for networking and sharing of best practices at the TQIP annual meeting, in Web conferences, and through the TQIP Google Group.

For more information, visit the TQIP website at acstqip.org.
Associate Fellows of the American College of Surgeons (ACS) who are interested in pursuing the next level of membership—full Fellowship—are encouraged to apply by December 1, 2016. The ACS admits into its Fellowship only those physicians who devote their practice entirely to surgical services and who agree to practice in accordance with the professional and ethical standards of the College.

The College’s standards of practice are outlined in the Fellowship Pledge and the Statements on Principles found on the ACS website at facs.org. All Fellows of the College and applicants for Fellowship are expected to adhere to these standards.

Surgeons request and voluntarily submit applications for Fellowship. In so doing, they are inviting an evaluation of their practice by their peers. In evaluating the eligibility of applicants for Fellowship, the College investigates each applicant’s entire surgical practice. Applicants for Fellowship must provide to the appointed committees all information deemed necessary for the investigation and evaluation of their surgical practice.

It is the College’s intention that all Associate Fellows consider applying for Fellowship within the first six years of their surgical practice. To encourage that transition, Associate Fellowship is limited to surgeons who have been in practice less than six years.

The following is a brief summary of the qualifications for Fellowship and the steps necessary to apply:

• Certification by an appropriate American Board of Medical Specialties surgical specialty board, an American Osteopathic surgical specialty board, or the Royal College of Physicians and Surgeons in Canada

• One year of surgical practice after the completion of all formal training (including fellowships)

• A current appointment at a primary hospital with no reportable action pending

A full list of the requirements can be accessed at facs.org/member-services/join/fellows.

Associate Fellows who are current with their membership dues may submit a waived-fee application online by visiting facs.org/member-services/join and clicking on the link for either Fellow or International Fellow. You will need your log-in information to access your application. If you do not have your log-in, contact the College staff at 800-293-9623 or via e-mail at facsapplications@facs.org for assistance.

The application requests basic information regarding licensure, certification, education, and current hospital affiliations. Applicants also are asked to provide the names of five Fellows of the College, preferably from your current practice location, to serve as references for your application. Applicants do not need to request letters; just list the names on your application and the College staff will contact your references.

If you need assistance finding ACS Fellows in your area, view a list on our website at facs.org (click on the “Find a Surgeon” button).

Applications must be submitted by the December 1 deadline to be considered for induction at Clinical Congress 2017 in San Diego, CA. When your application is processed, you will receive an e-mail notification providing details about the application timeline along with a request for your surgical case list. The College provides several options for the submission of your surgical case list.

U.S. and Canadian Fellowship applicants are required to attend a personal interview by an ACS committee in their local area. Exceptions are made for military applicants and in certain rural areas. You will receive notification by July 15 of the action taken on your application. Approved applicants are designated as Initiates to be inducted as Fellows during the Convocation Ceremony at the Clinical Congress.

Contact Member Services with questions at any time throughout the application process. We look forward to having you become a Fellow of the American College of Surgeons.

Associate Fellows: Apply now for ACS Fellowship

OCT 2016 BULLETIN American College of Surgeons
Purchase the **ACS Pearls in General Surgery 2016 Audio Package** today!

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For more information and to find a full listing of audio recordings, visit facs.org/education/resources/elearning. Click on “Pearls in General Surgery Audio Package” under Programs for Purchase.

**Questions?** Please contact us at elearning@facs.org or call us at 312-202-5400.
ACS joins effort to increase colorectal screening rates to 80 percent by 2018

A total of 1,000 health care organizations in the U.S., including the American College of Surgeons (ACS) and the Commission on Cancer, are joining a National Colorectal Cancer Roundtable effort to reach “80% by 2018.” The goal of the campaign is to reduce colorectal cancer as a major public health problem and, to this end, promote the screening of 80 percent of adults ages 50 and older for colorectal cancer by 2018. The ACS joined with the American Cancer Society, the American Gastroenterological Association, the American College of Gastroenterology, and the American Society for Gastrointestinal Endoscopy in developing an online brochure titled What Can Gastroenterologists and Endoscopists Do to Advance 80% by 2018? available at nccrt.org/wp-content/uploads/IssueBrief_GIs_WebFinal7.pdf. The detailed brochure provides information on joining the effort.

Apply now for 2017 ACS-UW Surgical Education Research Fellowship

The American College of Surgeons (ACS) Division of Education and the department of surgery at the University of Wisconsin (UW), Madison, are seeking applicants for a two-year fellowship in surgical education. The fellowship begins July 1, 2017, and is designed so that surgery residents who have completed two or three years of postgraduate training can attain leadership skills in surgical education. Fellowship recipients also have the option of participating in the UW School of Education master’s degree program. Faculty from the ACS and UW will guide the participants through the completion of a mentored surgical education research project.

Applications for the UW fellowship will be accepted until the positions are filled. Find additional details and contact information online at www.surgery.wisc.edu/uw-acs.

Coming in November in JACS, and online now

Development and Evaluation of the American College of Surgeons NSQIP Pediatric Surgical Risk Calculator

Yaoming Liu, PhD; Mark E. Cohen, PhD; Bruce L. Hall, MD, PhD, MBA, FACS; and colleagues write in the November issue of the Journal of the American College of Surgeons (JACS) about a quick and easy way to provide patients and families with individualized information on surgical risk during consultations in the office and hospital settings. The American College of Surgeons National Surgical Quality Improvement Program (NSQIP®) pediatric surgical risk calculator can be used as a tool in the shared decision-making process by providing clinicians, families, and patients with useful information about common operations.

This article and all other JACS content is available at www.journalacs.org.
National Surgical Patient Safety Summit participants stress teamwork, communication, and standards

More than 100 representatives of medical professional associations, insurers, health care systems, payors, and government agencies convened August 4–5 in Rosemont, IL, for the inaugural National Surgical Patient Safety Summit sponsored by the American College of Surgeons (ACS) and the American Academy of Orthopaedic Surgeons (AAOS). Patient safety before, during, and after a surgical procedure requires an appropriately educated, committed, and empowered health care team, according to recommendations presented at the conference.

Summit participants agreed that both technical and nontechnical skills are important for successful and safe surgical procedures. Program organizers sought to develop surgical care and surgical education curricula standards and to prioritize safety research. The surgeon, anesthesiologist, nurses, and supporting staff must ensure consistent use of surgical safety strategies and tools throughout surgical care, including patient-centered, shared decision making and timely informed consent; standardized surgical site marking procedures; accurate surgical information transfer; integrated electronic medical records; and effective team communication and coordination.

Workgroups met before the summit to draft recommendations to be adopted by surgical team members, surgical institutions, medical and nursing schools, surgical residency and fellowship programs, and surgical credentialing organizations. Read the joint ACS-AAOS press release for a full list of the recommendations at facs.org/media/press-releases/2016/skills-080516. The recommendations will be used to finalize national surgical patient safety standards, develop surgical safety education curriculum proposals, and identify surgical safety knowledge gaps and research priorities. ♦

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**Chapter news**

**Inaugural combined symposium held in Washington, DC**

The Metropolitan Washington, DC, Chapter of the American College of Surgeons (ACS) held the inaugural combined symposium with the Virginia Chapter and the Virginia Surgical Society April 30–May 1 at the Liaison Capitol Hill Hotel, Washington, DC.

J. David Richardson, MD, FACS, 2015–2016 ACS President and surgeon-in-chief, University of Louisville School of Medicine, KY, was the keynote speaker. He delivered an update on the current state of care of the surgical patient in the U.S.

L.D. Britt, MD, MPH, DSc(Hon), FACS, FCCM, FRCSEng(Hon), FRCSEd(Hon), FWACS(Hon), FRCSI(Hon), FCS(SA)(Hon), FRCSGlasc(Hon), ACS Past-President, and Henry Ford Professor and surgeon-in-chief, Eastern Virginia Medical School, Norfolk, also was a keynote speaker, highlighting research and recent initiatives by the ACS in addressing disparities in health care in his speech, What Are the Real Challenges and Threats in Healthcare?

Legislative updates were given by Sara Morse, Manager, Legislative and Political Affairs, ACS Division of Advocacy and Health Policy (DAHP); Justin Rosen, Congressional Lobbyist, DAHP; and Leonard Weireter, MD, FACS, Vice-Chair, ACS Committee on Trauma.

The Metropolitan Washington, DC, Chapter of the Association of Women Surgeons held its 8th Annual Resident Research Poster Competition, under the direction of Mary Maniscalco-Theberge, MD, FACS, Deputy Medical Inspector, Office of the Medical Inspector, Department of Veterans Affairs, and associate professor of surgery, Uniformed Services University of Health Sciences (USUHS), Bethesda, MD.

A poster session highlighting the research of residents from a number of training programs also took place at the meeting, as well as several resident-delivered talks.

The Virginia Surgical Society also contributed significantly to the program, with speakers addressing such issues as obesity...
and foregut diseases, evaluation of adrenal incidentalomas, enhanced recovery programs, the correlation of venous thromboembolism prophylaxis and electronic health records, and morbidity and mortality after gastrectomy.

Annesely Copeland, MD, FACS, associate professor of surgery, USUHS, spoke on the topic of The Opportunity of Adversity: Reflections on a Surgical Career. A highlight of the two-day conference was the Resident Jeopardy Competition, which was both entertaining and educational.

The chapter continues its tradition of offering mock orals to postgraduate year (PGY)-5 residents who are preparing for board certification. In addition, a series of educational sessions to prepare residents for the administrative aspects of clinical practice, Business of Surgery Series, is in its third year under the leadership of Amy Vertrees, MD, FACS, associate program director, Walter Reed National Military Medical Center, Bethesda.

The incoming 2016–2017 chapter officers are as follows:

• President: Norma Smalls-Mantey, MD, MBA, FACS, FCCM, assistant professor of surgery, Howard University Hospital, Washington, DC

• President-Elect: Jonathan Dort, MD, FACS, general surgeon, Inova Medical Group, Fairfax, VA

• Treasurer: Sharon Bachman, MD, FACS, general surgeon, Inova Medical Group, Falls Church, VA

• Governor: H. David Reines, MD, FACS, general surgeon, surgical critical care, Inova Fairfax Hospital

Jordan Chapter holds first annual meeting

The Jordan Chapter of the ACS held its first annual meeting May 5–8 at the Le Royal Hotel Amman under the patronage of the Ministry of Health in Jordan, Ali Al Hyasat, MD, FACS. Courtney M. Townsend, Jr., MD, FACS, ACS President-Elect, attended the meeting.

The theme of the conference was Optimal Surgical Education for Better Care and was chosen based on the needs of the Jordanian surgical community. Before the official start of the meeting, Dr. Townsend met with Jordanian officials, focusing the discussion on collaboration with the ACS to improve the Jordanian surgical education system.

The scientific meeting included three concurrent sessions that covered a range of general surgery and surgical subspecialty topics. In addition, concurrent sessions were held for residents and medical students, including the following:

• Advanced Trauma Life Support® (ATLS®) in collaboration with the ATLS Jordan Chapter, Royal Medical Services, and the Jordan National Emergency Medical Services Educational Center

• Inaugural ACS Comprehensive General Surgery Review Course with support from the ACS Division of Education; Patricia L. Turner, MD, FACS, Director, ACS Division of Member Services; and Prof. Jamal Hoballah, MD, FACS, in collaboration with the Lebanon Chapter of the ACS

• Trauma Evaluation and Management Course for Medical Students

• Inaugural Surgical Jeopardy competition with assistance from the ACS Resident and Associate Society (RAS-ACS)
Inaugural Women in Surgery Session

There was a strong social media presence, and the Communications Committee was live tweeting via the official ACS Jordan Chapter Twitter account @ACSJordan and the hashtag #ACSJO2016 and posting on the chapter’s official Facebook page. Visit the Jordan Chapter Twitter and Facebook pages for details on the live coverage that took place during the meeting at twitter.com/acsJordan and www.facebook.com/Jordan-Chapter-of-the-American-College-of-Surgeons-940107526074681/, respectively.

Alabama and Mississippi Chapters hold joint meeting

The Alabama and Mississippi Chapters of the ACS held their annual joint conference June 9–11 at The Grand Hotel Marriott Resort in Point Clear, AL. Surgeons from both states gathered to listen to panel discussions on topics such as Acute Care Surgery, Adopting New Technologies, Cancer Updates, Colorectal Carcinoma, and Hot Topics in General Surgery.

The chapters welcomed Frank G. Opelka, MD, FACS, whose presentation was titled Welcome to the Future: How Will We Measure Performance?

Dr. Opelka is Medical Director, Quality and Health Policy, ACS DAHP, Washington, DC.

A total of 14 residents presented posters to attendees. Laura Stafman, MD, a PGY-3 resident at the University of Alabama at Birmingham, received the top award for her presentation on UAB30, A Novel Proprietary Retinoid, Decreases Viability and Tumor Initiating Cell Maintenance in Human Neuroblastoma Patient-Derived Xenografts. William O. Richards, MD, FACS, was recognized for his year of service as President of the Alabama Chapter. E. Shields Frey, MD, FACS, was installed as 2016–2017 Alabama Chapter President.

The 2017 joint meeting is scheduled for June 8–10, 2017, at The Grand Hotel Marriott Resort in Point Clear.

Nigeria Chapter holds inaugural annual meeting

The Nigeria Chapter of the ACS held a successful meeting and Comprehensive General Surgery Review Course July 4–8 at the Nnamdi Azikiwe University Teaching Hospital in Nnewi. The meeting took place in conjunction with the Nigerian Surgical Research Society and the Association of Surgeons of Nigeria. The highlight of the opening ceremony was the ACS Update presented by current Chapter Governor Emmanuel A. Ameh, MB, BS, FACS, on behalf of Dr. Richardson. In addition, the chapter hosted its first Comprehensive General Surgery Review Course with a focus on preoperative care, surgical practice issues, and oncology. More than 65 senior residents and fellows attended the course.

Italy Chapter holds competition and training project

The second edition of Italian Surgical Jeopardy was offered in Naples, Italy, June 11 under the auspices of the ACS Italy Chapter. The event was organized in collaboration with the European Society of Surgery and the European Meeting of the Residents and PhDs in Surgery. Prof. Antonio di Cataldo, MD, FACS, Governor, ACS Italy Chapter, and Prof. Giuseppe Nigri, MD, FACS, Treasurer and Chapter Administrator, chaired the conference, and two general surgery residents moderated: Paolo Magistri, MD, and Giamauro Berardi, MD, Sapienza University of Rome. Judges of the competition were Gabriele De Sena, MD, FACS, from Naples, and Antoni Szczepanik, MD, president.

continued on page 97
Nigeria Chapter: Participants of the ACS Nigeria Chapter General Surgery Review Course

Italy Chapter: Attendees at the meeting included (from left) Dr. Magistri; Lorenzo Scardina, MD, FACS; Fabio Longo; Alessandro Mazzotta; Antonio Di Cataldo, MD, FACS, Governor, ACS Italy Chapter; Antoni Szczepanic, MD, president-elect of the European Society for Surgery; Dr. Nigri; Alfonso Barbarisi, MD, President, European Society for Surgery; and Dr. Berardi

Alabama and Mississippi Chapters: Dr. Shields Frey (left) presents Dr. Richards with plaque of appreciation for his year of service as President of the Alabama Chapter

Nigeria Chapter: Stanley N. C. Anyanwu, MB, BS, FACS, President, ACS Nigeria Chapter (left), and Dr. Ameh
Residents from across Italy, Poland, and Moldavia attended the meeting. The team from Modena and Reggio Emilia won the competition. They were awarded with an invitation to attend the September 2017 XXI Annual Meeting of the European Society of Surgery in Krakow, Poland.

At press time, the next annual meeting of the ACS Italy Chapter was scheduled for September 25–29 in Rome.

More than 300 health care professionals attended a meeting on Lymph, Lymphatics, and Lymph Nodes in Surgery Best Practice: State-of-the-Art May 27 in Genoa under the aegis of the ACS Italy Chapter.

The event, recognized as a “training project” of the Italian Society of Surgery (SIC), was organized in collaboration with the regional Societies of Surgery Società Ligure di Chirurgia, Società Siciliana di Chirurgia, and Società Lombarda di Chirurgia, and with the participation of the Latin-Mediterranean Chapter of the International Society of Lymphology, the European Society of Lymphology, the Italian Society of Lymphangiology, the Italian Society of University Surgeons (including the College of Professors of General Surgery), the Italian Society of Surgical Pathophysiology, the Italian Society of Digestive System Pathology, the Polyspecialist Italian Society of Young Surgeons, the Italian Society of Surgical Research, the Triveneto’s Society of Surgery, and the Coordination Committee Associazione Chirurghi Ospedalieri Italiani—Regione Liguria.

Corradino Campisi, MD, FACS, Chapter President; Ferdinando Caffiero, MD, FACS, president, Società Ligure di Chirurgia; Stefano Puleo, MD, FACS, president, Società Siciliana di Chirurgia, and of the Italian Society of Surgical Research; and Giovanni Sgroi, MD, president, Società Lombarda di Chirurgia, chaired the conference.

Many ACS Fellows attended the event, among them Prof. Antonio Di Cataldo, MD, FACS, Governor, Catania; Prof. Achille Lucio Gaspari, MD, FACS, Past-Governor, Rome; Prof. Francesco Puccio, MD, FACS, Past-President, Brescia; Prof. Biagio Ravo, MD, FACS, Second Vice-President, Rome; and Prof. Dalila Patrizia Greco, MD, FACS, Women Surgeons Committee, Milan.

Dr. Nigri played an integral role in contributing to the event organization, along with the SIC. Held in the historic and architecturally significant setting of Genoa’s monumental Palazzo della Borsa, the conference mainly focused on the leading role of prevention techniques and early treatment of lymphatic complications in different fields of oncological surgery. Much attention was paid to lymph vessel-sparing techniques, and to clinical applications of lymphatic microsurgery.

Tennessee Chapter holds 2016 meeting

The Tennessee Chapter of the ACS (TNACS) 2016 Annual Meeting took place July 22–24 in Memphis. Approximately 100 surgeons and other health care professionals gathered for the event. The chapter welcomed ACS President Dr. Richardson and Georgia ACS Chapter Executive Director Kathy Browning as two of the guest speakers for the event. Plans are already under way for the August 2017 meeting in Nashville.
The Tennessee Surgical Quality Collaborative provided a report on ongoing quality improvement initiatives with surgeons from the state. Surgical Jeopardy was a highlight of the event, with the team from the University of Tennessee College of Medicine, Memphis, winning the competition.

Thailand Chapter supports academic organizations

The Thailand Chapter of the ACS continues to support postgraduate surgical education through a variety of national and international academic activities. The chapter has been involved in the planning and execution of educational programs and conferences, including the Royal College of Surgeons’ Surgical Skills Competition and the Second International Symposium in Colorectal Disease.

In the last year, the chapter supported the World Congress of Surgery, which took place at the Bangkok Convention Centre at Central World, and included the involvement of the Royal College of Surgeons Thailand and the International Society of Surgery. The scientific program featured state-of-the-art lectures, live operations, plenary sessions, roundtable discussions, and paper and poster presentations.

The winning article was titled "Is Concomitant Cholecystectomy with Bariatric Surgery in Asymptomatic Patient Necessary?" by Narong Boonyagard, MD, general surgeon, department of medicine, Chulalongkorn University, Bangkok.

The chapter also supported the Second International Symposium in Colorectal Disease, which took place at the Hilton Phuket Arcadia Resort & Spa, December 5–7, 2015. This subspecialty academic activity involved many world-renowned colorectal surgeons and included a comprehensive hands-on workshop, live operations, interactive lectures, panel discussions, and multidisciplinary symposia covering state-of-the-art technology, knowledge, controversies, innovations, and new surgical techniques in colorectal surgery.

The chapter organized a basic science paper competition, and the winning article was titled "Is Concomitant Cholecystectomy with Bariatric Surgery in Asymptomatic Patient Necessary?" by Narong Boonyagard, MD, general surgeon, department of medicine, Chulalongkorn University, Bangkok.

Connecticut Chapter develops Skills Competition

The Connecticut Chapter has been preparing for its Eighth Annual Surgical Skills Competition at the October 28 chapter meeting at the Marriott Hotel in Farmington, CT. In this unique partnership with industry, the competition provides an interactive, game theory-based educational experience for our residents. Each program fields a team comprising an intern, a mid-level resident, and a chief to compete head-to-head with other programs in challenges that help to reinforce the skills they are learning in their programs.

The Connecticut Surgical Quality Collaborative (CtSQC) is a joint annual meeting of the Connecticut Chapter, the Connecticut Surgical Quality Collaborative (CtSQC) and the Connecticut Chapter of the American Society of Metabolic and Bariatric Surgery. The CtSQC, an ACS National Surgical Quality Improvement Program (ACS NSQIP®)-based collaborative, incorporated in March 2016. Collaborative members presented several talks and posters at the ACS NSQIP Conference in July in San Diego, CA. The CtSQC has reached critical mass with all hospitals in Connecticut agreeing to participate in its educational programs. The collaborative’s new website, www.ctsqc.org, should be up and running by the end of the third quarter.
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MEETINGS CALENDAR

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.

OCTOBER

Rhode Island Chapter
October 20
Providence, RI
Contact: Megan Turcotte, mturcotte@rimed.org, www.riacs.org

Italy Chapter
October 21–24
Rome, Italy
Contact: Giuseppe Nigri, giuseppe.nigri@uniroma1.it, www.facsitaly.org

Connecticut Chapter
October 28
Farmington, CT
Contact: Christopher Tasik, info@ctacs.org, www.ctacs.org

Arkansas Chapter
October 29
Little Rock, AR
Contact: Linda Gist, lagist@uams.edu

Wisconsin Surgical Society
November 4–5
Kohler, WS
Contact: Terry Estness, wisurgical@att.net, www.wisurgicalsociety.com

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

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

Keystone Chapter
November 18
Danville, PA
Contact: Lauren Newmaster, lnewmaster@pamedsoc.org, www.keystonesurgeons.org

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

NOVEMBER

San Diego Chapter
November 1
San Diego, CA
Contact: Jim Cox, elcajonjim@cox.net, www.sdcacs.org

South Korea Chapter
November 3–5
Seoul, Korea
Contact: Sun-Whee Kim, sunkim@plaza.snu.ac.kr

Wisconsin Surgical Society
November 4–5
Kohler, WS
Contact: Terry Estness, wisurgical@att.net, www.wisurgicalsociety.com

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

Philippines Chapter
December 6
Manila, Phillipines
Contact: Vicky Pamintuan, Dial: 011-63-632-7432119

Brooklyn-Long Island Chapter
December 7
Uniondale, NY
Contact: Teresa Barzyz, acsteresa@aol.com, www.bliacs.org/

FUTURE CLINICAL CONGRESSES

2016
October 16–20
Washington, DC

2017
October 22–26
San Diego, CA

2018
October 21–25
Boston, MA

DECEMBER

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