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Looking forward  
David B. Hoyt, MD, FACS; Carlos A. Pellegrini, MD, FACS, FRCSI(Hon); FRCS(Hon), FRCS(Hon); and Dawn Davis

Coding and practice management corner: ACS responds to frequently asked questions about CPT coding  
Samuel Smith, MD, FACS; Megan McNally, MD, FACS; Jayme Lieberman, MD, FACS; and Jan Nagle, MS

ACS quality and safety case studies: New protocol leads to improved trauma decannulation rate  
Michael S. Farrell, MD, MS; Tom Gillin, RRT; John Emler, RRT; Richard Caplan, PhD; Michael S. Johns, DO; Mark Cipolle, MD, PhD; and Kevin M. Bradley, MD, FACS, FCCM
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Faculty Research Fellowships for 2020 available
2019 ACS Traveling Fellow to Australia and New Zealand reports on experience
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Calendar of events
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*Titles and locations current at press time.

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For the last few years, leaders of the American College of Surgeons (ACS) have been visiting countries outside the U.S. to learn about their health care systems—both the challenges and the achievements. ACS Past-President Carlos A. Pellegrini, MD, FACS, FRCSI(Hon), FRCS(Hon), FRCSEd(Hon), co-author of this month’s column, has led this effort with Dawn Davis of World Learning, a not-for-profit organization that arranges professional exchanges to encourage cross-cultural dialogs and networking.

To date, as part of this program ACS delegations have visited Cuba, Israel, and Kosovo. We will be traveling to Morocco in March 2020 to learn about the kingdom’s expanding health care system. This column focuses on what we have learned through these trips—the purpose of which is to establish relationships with our counterparts in other countries. Participants in these visits pay their own way and work full days, meeting with government leaders, surgeon colleagues, and other health care professionals.

**Cuba**
A delegation of 51 ACS leaders visited Cuba in spring 2017 in an effort to strengthen ties with surgeons of the island nation.* The Cuban people have developed an efficient national health care system, which trains health care professionals, including physicians, from all over the world and provides relief services to countries in need.

We learned about Cuba’s three-tiered health care system, which includes community clinics where primary care and basic health care is provided (tier 1); in-district hospitals that provide general surgery services, acute care, and some specialized surgical care (tier 2); and tertiary and quaternary hospitals in Havana that provide specialized services (tier 3). We found that although surgeons can provide some technologically advanced procedures, they are lacking the supplies and resources to meet the needs of pediatric patients and patients with certain types of cancer. It is worth noting that tertiary outcomes are weak; for example, the mortality rate for Whipple operations is 11 percent.*

We also learned about Cuba’s surgical training system, which is provided at no cost to residents. This system has had some unintentionally negative consequences, including overproduction of physicians, nurses, and other providers, who must then be rented out to low-income countries.*

The Cuban surgeons with whom we met expressed interest in pursuing the following opportunities:*  
• Collaborating with U.S. medical schools and with the ACS in training and research  
• Gaining fair access to technology, pharmaceuticals, and equipment  
• Reducing restrictive regulations that they believe disproportionately disadvantage Cuba and the nation’s health care system

**Israel**
A group of 17 Fellows visited Israel in April 2018. The purpose of the trip was to learn about the development of surgery and the state of surgical services, the challenges and advances in the delivery of surgical and health care services, approaches to civilian and military trauma, and the financing of health care in Israel.†

The Israeli National Health System provides free care to the nation’s population. Despite a large na-
tional defense, Israel has no designated military hospitals.†

We learned about graduate medical education in Israel, including the 30 resident training programs, most of which are affiliated with hospitals rather than universities, distributed throughout the country. Training is for six years, including six months of mandatory research, with examinations at the midpoint and upon completion. Many graduates seek fellowship training in the U.S. but find these difficult to obtain. Some in-country fellowships for trauma and colorectal specialization are well established, whereas fellowships in breast, metabolic (bariatric), and endocrine surgery are in development.†

Because of ongoing conflicts with neighboring countries and territories, Israel hospitals are well prepared for mass casualty events. The hospitals we visited also were equipped to provide advanced surgical care.†

All in all, our visits to several medical centers served to demonstrate that although the people of Israel must constantly be prepared for warfare, they do not let this situation weaken their creative spirit or their technological progress.†

Kosovo

In June 2019, 16 ACS delegates visited Kosovo, which became an independent country in 2008 after its separation from Serbia. Since then, the republic has focused largely on building economic and government stability rather than the mixed public-private health care system, which is underfinanced, with the lowest per capita expenditure in Europe. Kosovars were very welcoming and displayed a real hunger for learning about the College’s resources.

Kosovo has primary care centers in each of its 38 municipalities, seven secondary hospitals, and one tertiary care hospital in the capital city of Pristina. Future plans include the following:

We have learned a lot through these visits. As we become more experienced, we anticipate that the role the ACS can play in global health care will become more clearly defined.

• Updating old hospital infrastructures
• Introducing electronic health records
• Establishing a health insurance fund
• Improving cancer care, which most Kosovars obtain outside the country or in private facilities

Patients may receive care at public institutions for a nominal fee, but the wait times are long; for example, it can take up to two years for a cardiac stent. Workforce needs are engineered centrally, with hospitals submitting requests for specialists and allocations made by the Ministry of Health. The only medical school is in Pristina and graduates 150 physicians per class. Postgraduate training occurs outside of Kosovo, mostly in Germany, Turkey, and Switzerland. Many surgeons choose to remain in those countries after they complete their training, creating a “brain drain.”

The Ministry of Health has expressed interest in collaborating with the U.S. on education, training, and quality improvement. The ACS delegates offered to share several resources with our colleagues, including Advanced Trauma Life Support® training and the Red Book, Optimal Resources for Surgical Quality and Safety.

Morocco

Invitations for the visit to the Kingdom of Morocco, March 15–22, 2020, are being sent to ACS leaders, including the Board of Regents. The focus of this trip will be on the North African country’s efforts to expand its health care system.

The World Health Organization (WHO) in 2008 cited access to care through the public health care system as one of the greatest challenges facing Moroccans. Although the country has a universal health care system, it suffers from a lack of public facilities. In response, a number of privately funded health care centers have sprung up across the nation, providing services to patients who can afford to pay out of pocket or to purchase supplemental coverage.

We will meet with government representatives, hospital administrators, and health care professionals to discuss the following issues:

• Public health priorities
• The role of the WHO and other nongovernmental organizations in ensuring access to care
• Development of surgery and state of surgical services
• Approach to trauma and crisis response
• Quality and value in the delivery of health care
• Cancer care, centers of excellence, and population

Ongoing mission

We have learned a lot through these visits. As we become more experienced, we anticipate that the role the ACS can play in global health care will become more clearly defined. This program is still evolving, and both the surgeon authors of this column have found these experiences enriching professionally and personally. Ms. Davis and her colleagues at World Learning, www.worldlearning.org, would be willing to consider arranging other opportunities for interested Fellows of the College. We would encourage you to join us on this journey and to offer suggestions regarding other countries that we should consider visiting.

If you have comments or suggestions about this or other issues, please send them to Dr. Hoyt at lookingforward@facs.org.

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Practicing primary palliative care: A call to action

by Michael Sigman, MD, and Pringl Miller, MD, FACS
The history of surgery and the moral imperative to palliate pain and suffering are intimately intertwined. Despite the evidence that concurrent palliative care is clinically beneficial and of high value for patients with life-limiting illness and at the end of life (EOL), contemporary surgical literature and educational initiatives for surgeons and surgical trainees demonstrate a concerning lag in incorporating primary or specialty palliative care into standard surgical practice when all operative interventions have failed or been withheld.

This article describes surgery’s traditional reluctance to provide palliative care as a precursor to transitioning to comfort-focused care at the EOL. It addresses the barriers to educational opportunities for surgical trainees and surgeons that would enable this level of care, given the aging and infirm patient population who would benefit from it. It also serves as a call to action to train more surgeons and other clinicians in palliative care and shared decision making.

An unmet need
Underuse of palliative care for patients with life-limiting illness and barriers to the provision of quality EOL care are hardly limited to the surgical profession. A recent survey of health care providers revealed that 34 percent of participants either disagreed or were neutral when asked whether they feel well prepared to provide palliative and EOL care, and 30 percent of the respondents reported that they felt ill prepared to determine when to refer patients to palliative care and hospice. More than half of the respondents said they did not believe that team members delivered clear and accurate information to patients and families, and 82 percent agreed that training in palliative and EOL care should be mandatory.1

Betani and colleagues surveyed 102 surgeons and medical physicians who treat patients with advanced cancer and symptomatic surgical conditions.2 They found that surgeons reported fewer hours of palliative care training—a median of 10 hours—compared with medical oncologists, who had a median of 30 hours, and medical intensivists, who had a median of 50 hours. Betani and colleagues also reported that 25 percent of surgeons had no palliative care training and that those surgeons recommended major operative interventions more frequently than those who had undergone 40 hours or more of palliative care training. The report stated, “These findings highlight the need for greater efforts system-wide in palliative care education among surgeons, including incorporation of a structured palliative care training curriculum in graduate and continuing surgical education.”2 As the U.S. population ages, health expenditures skyrocket, and outcomes plateau, we must incorporate the basic tenets of primary palliative care into our practices and when training the next generation of surgeons.

To date, the most studied surgical patients with unmet palliative care needs have advanced malignancies, need emergency general surgery, or suffer from traumatic injuries. In 2017, Gani and colleagues found that inpatient palliative care services were used 8.5 percent of the time during an initial admission for cancer. They concluded that patients admitted with gastrointestinal or thoracic malignancies undergoing surgery had 79 percent lower odds of receiving a palliative care consultation than patients who did not undergo a surgical procedure during their inpatient admission.3 Temel and colleagues and El-Jawahri and colleagues both

HIGHLIGHTS
- Describes surgical patient populations with unmet palliative care needs, specifically those with advanced malignancies, nontraumatic surgical emergencies, and traumatic injuries
- Identifies palliative care as an emerging medical and surgical subspecialty that functions best in the context of an interdisciplinary team that addresses all eight domains of palliative care
- Outlines the validity and impending necessity of training future generations of clinicians to provide primary palliative care
As the U.S. population ages, health expenditures skyrocket, and outcomes plateau, we must incorporate the basic tenets of practicing primary palliative care into our practices and when training the next generation of surgeons.

found in their prospective randomized controlled trials that patients coping with life-limiting illness from either nonsmall cell lung cancer or hematologic malignancies undergoing hematopoietic stem cell transplantation had improved in quality of life (QOL), mood and depression, and post-traumatic stress disorder when offered palliative care concurrent with standard oncologic management.4,5 Moroney and Lefkowits concluded that high-quality data from medical oncology should inform our practice as surgical oncologists with respect to palliative care integration, and surgeons should adopt American Society of Clinical Oncology (ASCO) recommendations for routine palliative care integration from the advanced cancer time of diagnosis.6

Upstream palliative care intervention also was found to reduce less aggressive care at the EOL at the same time as conferring a longer survival benefit.4 And although insufficient data are available to support early palliative care for patients with operable malignancies, multicenter randomized control trials are in progress to determine its impact.7,8 Lilley and colleagues concluded that surgical patients would likely benefit from early palliative care delivered alongside surgical treatment to promote goal-concordant decision making and to improve patients’ physical, emotional, social, and spiritual well-being and QOL.9 The therapeutic benefits of technical advances, such as image-guided interventions and laparoscopic and robotic approaches to surgery, have expanded opportunities for surgical palliation, as well as resection for curative intent.

Professional guidelines
In 2017, ASCO published updated palliative care practice guidelines that call for integrating palliative care into standard oncologic management when a patient is diagnosed with advanced cancer, highlighting the clinical benefit of concurrent oncologic and palliative care.10 The National Comprehensive Cancer Network (NCCN) practice guidelines—a recognized peer-reviewed standard for clinical policy in cancer care—specify that the goal of palliative care is to anticipate, prevent, and reduce suffering and to improve QOL throughout the oncologic care continuum. Based on these data, surgeons should consider integrating upstream concurrent palliative care into standard surgical oncologic management.11

The trauma and acute care surgery literature identifies this patient population as similarly burdened with suffering and at high risk for unmet palliative care needs.12 An estimated 25 percent of patients hospitalized for trauma are older than age 65.13 Cooper and colleagues found that 16 percent of patients ages 65 and older who underwent emergency laparotomy died during their admission, and 30 percent died within six months after discharge.14 Therefore, it is possible that one-third of this study population was eligible for hospice enrollment and may have chosen that care option had it been discussed during their hospital admission or postoperative course. Improved communication during the decision-making process—including efforts to routinely address advance care planning by surgeons with patients and/or their surrogates—are necessary to ensure that patients receive the care that they want and to avoid nonbeneficial treatment.15 A recent study by Lavanchy and colleagues reviewed roughly 150 octogenarians undergoing emergency abdominal operations and noted that one-third of early mortality was attributable to withdrawal of care. They conclude that interdisciplinary decision making with patient and family involvement may avoid ethically questionable interventions in octogenarians.16

Lilley and colleagues recently conducted a review of Medicare claims data for patients older than 65 years of age who were admitted with traumatic injury over a five-year period. They found that only 2 percent of these patients who died within six months after discharge received inpatient palliative care.17 These data suggest that palliative care may be underused in trauma care and, therefore, a potential means of greatly improving patient-concordant outcomes while at the same time reducing unwanted care and the associated costs.

The American College of Surgeons (ACS) Trauma Quality Improvement Program (TQIP®)
Palliative Care Best Practices Guidelines recognize that palliative care should be delivered in parallel with life-sustaining trauma care throughout the care continuum from injury through recovery. The TQIP guidelines state, “Core trauma palliative care can and should be provided by trauma center teams even if palliative care consultation is not available,” and “optimal care requires trauma physicians and nurses to have basic competencies in primary palliative care, pain and symptom management, and end-of-life care.”

What is palliative care?
Palliative care is an emerging medical and surgical subspecialty focused on improving QOL for patients and their families facing life-limiting illness. Palliative care services are unique and strengthened by an interdisciplinary team that addresses eight domains of care, such as structure and process; physical, psychological/psychiatric, social, spiritual/religious/existential, and cultural care at the EOL; and ethical/legal aspects of care that may be affecting patients and their families during life-limiting illness. Palliative care providers facilitate patient-centered communication between all the stakeholders involved in a patient’s case, enhance patient-family unit understanding of illness and prognosis, and strive to improve patient and caregiver QOL through an informed consent and shared decision-making process that seeks to arrive at a comprehensive patient-concordant care plan. The arduous path traveled while receiving health care for life-limiting illness requires that providers frequently engage in goal-oriented discussions to define and redefine what patient-concordant care is for each individual across the care continuum.

The distinction between palliative and hospice care often gets blurred because both involve an interdisciplinary team approach to care for patients with life-limiting illnesses. Therefore, one can think of hospice as palliative care during the last six months of life, whereas palliative care has no prognostic correlate. Additionally, primary palliative care refers to interventions that all clinicians should perform when caring for patients with life-limiting illness, such as basic symptom management, goals of care, and code status discussions. Specialty palliative care refers to interventions that a dedicated interdisciplinary team would offer for more complex goals of care discussions, symptom management, and transitions of care to hospice.

In 2005, the ACS Statement on Principles of Palliative Care expanded on an earlier statement to include a broad range of surgical patients and clarified the misconception that palliative care is synonymous with EOL care. Today, the patient population most thought to benefit from concurrent palliative care includes all patients with a life-limiting illness, regardless of life expectancy. National Palliative Care Registry data suggest that 1 to 1.8 million patients admitted to U.S. hospitals annually could benefit from palliative care but are not receiving it. Taking all patients regardless of clinical setting into consideration, the Center to Advance Palliative Care suggests that approximately 6 million people in the U.S. could benefit from palliative care. It is worth mentioning that Congress initiated the Medicare hospice benefit in 1982, which became permanent in 1986, for patients with a terminal diagnosis, defined as a prognosis of six months or less. Today, physicians working in hospice certify that patients enrolled have a six-month or less prognosis if their terminal condition runs its natural course, and most hospice patients have transitioned their goals of care from disease-directed to comfort-focused.

In 1998, 10 years before the first American Board of Surgery (ABS)-sponsored Hospice and Palliative Medicine board exam—an effort championed by the late Olga M. Jonasson, MD, FACS—the ACS gave voice to the value of palliative care for surgical patients, making palliation and EOL care a College priority. All 10 principles outlined in the 1998 ACS Statement of Principles of Palliative Care have been preserved but modified to reflect contemporary language. The following five principles are worth highlighting in this article:
The ACS represents more than 80,000 clinicians worldwide and has been a driving force for improving the care of surgical patients since 1913. In the early days of the ACS, Fellows pledged “to place the welfare of my patients above all else.”

- Honor the right of the competent patient or surrogate to choose among treatments, including those that may or may not prolong life
- Identify the primary goals of care from the patient’s perspective, and address how the surgeon’s care can achieve the patient’s objectives
- Strive to alleviate pain and other burdensome physical and nonphysical symptoms
- Provide access to therapeutic support, encompassing the spectrum from life-prolonging treatments through hospice care, when they can realistically be expected to improve the QOL as perceived by the patient
- Recognize the physician’s responsibility to discourage treatments that are unlikely to achieve the patient’s goals, and encourage patients and families to consider hospice care when the prognosis for survival is likely to be less than a half-year

The ACS represents more than 80,000 clinicians worldwide and has been a driving force for improving the care of surgical patients since 1913. In the early days of the ACS, Fellows pledged “to place the welfare of my patients above all else.” In 2016, the ACS Fellowship Pledge was amended to state, “I pledge to place the welfare and rights of my patients above all else.” This new pledge acknowledges a patient’s right to treatment that may or may not prolong life as described in the 1990 Patient Self-Determination Act, which requires institutions to honor health care decision-making rights by recognizing and respecting patient advance directives at the time of hospital admission.

Another initiative that highlights the importance of honoring patient rights and encourages the practice of patient-centered care is the fourth edition of The National Consensus Project Clinical Practice Guidelines for Quality Palliative Care, published in 2018. These evidence-based guidelines were designed to promote consistent, accessible, comprehensive, optimal palliative care after research demonstrated high value for

REFERENCES

continued on next page
patients with serious illness served by palliative care teams across care settings. The National Consensus Project Clinical Practice Guidelines for Quality Palliative Care define serious illness as “a health condition that carries a high risk of mortality and either negatively impacts a person’s daily function or QOL or excessively strains their caregiver.”

The Institute of Medicine (now known as the National Academy of Medicine) published a consensus report in 2014, Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life, which indicates that improving the quality and availability of medical and social services for patients and their families not only enhances QOL up and until EOL, but also contributes to a more sustainable health care system.

Training residents to care for patients with serious life-limiting illness

Surgical culture values palliative and compassionate EOL care, but also places barriers to its provision in training and practice. In addition to systems issues, such as limited resources and miscommunication across medical specialties and among other health care professionals, surgeon knowledge and training has been cited as the largest barrier. Several aspects unique to surgical training and practice likely represent barriers toward increased use of integrating palliative care into standard surgical management, such as surgeon attitudes, exposure, lack of training, and difficulty with prognostication. Surgical intervention is more likely to be invasive than medical or interventional care. Therefore, the selection of candidates for surgery potentially poses a conflict of interest when a patient with life-limiting illness and a limited life expectancy might benefit from a palliative procedure to improve QOL without extending life. In addition, surgical practice and decision making is traditionally hierarchical, with ultimate responsibility for surgical outcomes resting on the shoulders of the attending surgeon. Personal responsibility and ownership of surgical outcomes are inherent to surgical practice.
practice and culture, such that adverse events or deaths may be perceived as personal failures even when death is anticipated. In the context of metrics that track surgical morbidity and mortality as indicators of health care quality, providing palliative surgery may be an unfortunate conflict of interest. A Current Procedural Terminology code modifier that would categorize interventions as palliative in terminal patients might overcome this underlying tension of morbidity and mortality statistics for proceduralists in the privileged position to perform palliative interventions for patients at the EOL. Punitive metrics may reinforce the surgeon’s sense of personal failure and may discourage prioritization of a palliative approach to care. 31,32

As surgeons working with learners, our responsibility in caring for our patients includes modeling patient-concordant surgical care for the next generation of clinicians. In this regard, Klaristenfeld and colleagues found that “most surgical programs have no formal curriculum to teach palliative care.” 33 Communication skills, like technical skills, should be considered invaluable to surgical practice. Bakke and colleagues reported that despite caring for patients near the EOL, surgeons report low confidence in their ability to facilitate EOL conversations, a discrepancy that exists despite competency requirements and professional medical society recommendations. 34

Larkin and colleagues demonstrated significant improvement in empathetic communication for first-year residents. The authors concluded that a unique and comprehensive human factors curriculum is effective in building communication competency for junior-level residents. 35 In 2014, Falcone and colleagues asserted that communication skills-based training is needed across all residency levels. 36

The Surgical Council on Resident Education (SCORE)—a not-for-profit consortium composed of the ABS, ACS, Accreditation Council for Graduate Medical Education (ACGME), and other professional organizations—created a 2017–2018 curriculum that includes a section addressing interpersonal and communication skills, along with other relevant medical ethical issues that present in clinical practice. 37 Although this

 REFERENCES, CONTINUED

national curricular intervention is timely, it remains unclear to what degree each program will incorporate protected time for learners during surgical residency. And relevant to this issue, the SCORE curriculum still characterizes palliative care as an ethical issue in clinical surgery at the EOL. 38

Similarly, at a time when our nation is facing an opioid-prescribing crisis, our role in responsible pain management warrants educational advances and constant review. Last year, the Journal of Surgical Education published a report by Chui and colleagues that indicated that 8.5 percent of a surveyed cohort of all level residents reported receiving no formal best practice training in pain management, and 6 percent said they received no training in opioid prescribing. 39

With learner performance on the ABS in-training exam being a priority for most program directors, it is unknown how much dedicated time will be spent teaching primary palliative care skills. Literature looking at specific educational interventions, such as an ICU-based palliative and EOL care curriculum, 40 case-based palliative care workshop, 41 or surgical palliative care immersion training, 42 consistently suggests that a little time spent during surgical training pays dividends to increase knowledge, change attitudes, and gain confidence in palliative and EOL care for learners. One can only postulate that such educational initiatives for learners will translate to more patient-informed care and satisfaction.

To date, the most comprehensive and foundational teaching tool for primary palliative care skills is the 2009 ACS Surgical Palliative Care: A Resident’s Guide. 24

Putting the dearth of palliative care physicians and surgeon specialists into perspective, as of January 2016, nearly 6,400 active hospice and palliative medicine (HPM) physicians and surgeons were reported by the American Medical Association. On average across the U.S., there were 15.7 HPM physicians per 100,000 people aged 65 years and older. 43

Using those statistics, that is one HPM physician/surgeon for every 6,250 people versus one cardiologist for every 71 people and one medical oncologist for every 141 people. As of the 2018 hospice and

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palliative medicine certification exam administered by the American Board of Internal Medicine (ABIM) and sponsored by the ABS, 79 surgeons have become board certified in HPM.44 A total of 17 surgeons since 2012 also are HPM fellowship trained. According to the ABS website, only a minority of surgeons have sat for the HPM board exam since 2012, when fellowship training became a requirement.45 This tiny subset of hybrid surgeons is not anticipated to flourish now that a one-year, time-based fellowship is required to sit for the HPM board exam, but efforts are under way to support the development of competency-based fellowship training programs, which are a more viable option to accommodate HPM training simultaneously with clinical practice, research, and other professional endeavors.46 This and other part-time options for fellowship training would be particularly beneficial for surgeons interested in remaining engaged with their surgical practices.47

Unfortunately, the number of surgeons who will complete time-based fellowship training in hospice and palliative medicine is unlikely to equal or exceed the number of surgeons grandfathered in who will retire in the next decade. Furthermore, the growing health care demands of the aged population are expected to outstrip the total number of palliative care specialists across the country.48

To optimally and responsibly care for our surgical patients, it is incumbent upon us as surgeons, mentors, teachers, and leaders to integrate primary palliative care skills into our daily intention in practice, and consult palliative medicine specialists when indicated—either directly when available or, if necessary, by alternative means, such as the emerging use of telecommunication.49 This article is a call to action for surgeons to persist—in keeping with our history, innovative tradition, and ethical duty as patient advocates—in obtaining primary palliative care skills and ensuring that we do what is right for our patients. ♦

REFERENCES, CONTINUED

Rural areas encompass approximately 95 percent of the nation’s landmass and have historically been defined as containing fewer than 50,000 inhabitants. Unfortunately, trauma care is generally less accessible for those living in rural areas than for their more urban counterparts; 30 percent of Americans in rural areas live more than 30 miles from an American College of Surgeons (ACS)-verified trauma center, and only 24 percent of rural residents live within 10 miles of a trauma center, compared with 71 percent of individuals who live in more urban areas. This situation is potentially problematic, as injured patients initially triaged to nontrauma centers have been shown to experience up to a 30 percent higher mortality rate in the first 48 hours after injury, and patients in rural areas are twice as likely to die of traumatic injuries than their more urban counterparts. In addition, more than 50 percent of motor vehicle crash (MVC)-related fatalities occur in rural areas, despite the fact that only about 20 percent of the U.S. population lives there.
These findings are not unique to MVC-related injuries, as mortality rates are higher in rural areas for falls, burns/electrocutions, accidental firearm injuries, and suicide attempts. The underlying mechanism is multifactorial and likely includes remote distance from first responders (or lack of trained personnel/response units), limited trauma volume or experience at rural centers, and the need for multiple patient transfers to reach definitive care. One study of an emergency medical services (EMS) system found that increased distance from the injury scene, time on scene, and increased EMS response times were associated with increased mortality in a rural area of Alabama. In a 2018 study from Maryland, which has a robust statewide trauma system, the authors found that patients experienced an 8 percent increased likelihood of death for each five-mile increase in distance from a trauma center. This finding was independent of prehospital time, suggesting that mortality is affected by factors other than distance to the receiving facility and may be related to lack of specialized trauma care. The odds of death increased by almost 50 percent when the nearest trauma center was a Level III facility.

Rural trauma centers face a number of other challenges, including variability in practices, tertiary care referral and transport logistics, and rural staffing crises. In one study of patients transferred to a Level I trauma center from more rural areas, 35 percent had head computed tomography (CT) scans despite the absence of neurosurgical capabilities at the rural facility, 3 percent had aortic arch angiography despite lack of cardiac surgery services, and 5 percent had abdominal CT scans despite documented hypotension. All of these issues have the potential to delay transport and negatively affect patient outcome. A 2013 study by Moore and colleagues showed that up to 63 percent of patients transferred to a trauma center required additional imaging, and 28 percent required duplicate imaging. Other reports have shown an association between pretransfer imaging and delays in transfer of up to 90 minutes, as well as increased costs without concomitant improvements in outcome. Staffing also can be challenging, with one study of rural hospitals of 100 beds or less highlighting inconsistencies with emergency department (ED) staffing models and trauma training among covering providers.

**Experience matters**

Trauma centers save lives. A 2006 meta-analysis concluded that the implementation of trauma systems has led to a 15 percent reduction in trauma patient mortality. That same year, a report in the *New England Journal of Medicine* compared trauma patient mortality between trauma centers and nontrauma centers, and found that the risk of in-hospital, 90-day, and one-year mortality was lower in trauma centers; these improved outcomes were most pronounced in patients with more severe injuries. An increase in the number of trauma admissions per year has been correlated with decreased odds of death in severely injured patients in shock and in a coma. Using data from the National Trauma Data Bank, Brown and colleagues showed that each 1 percent increase in trauma volume was associated with 73 percent increased odds of improved standardized mortality ratio (that is, ratio of observed to expected deaths) over time for patients with an injury severity score (ISS) greater than 15. Centers that experienced decreasing volume over time had worse outcomes, suggesting that even experienced trauma centers are affected by decreasing volumes.

**Bridging the gap**

How can we begin to bridge the gap between rural facilities and trauma centers to improve the care of injured patients? A relatively easy place to start is through education. As Richard K. Simons, MD, said in his address to the 2017 Trauma Association of Canada, “Some authors have reported that some of these mortalities are occurring in-hospital and that injury death rates were threefold higher in regions with limited trauma center access. This would suggest a potential to improve outcomes in rural hospitals through improved education and resource commitment.”
Dr. Simons further observed that many rural and remote communities are served by modest health facilities staffed by general practitioners, with little beyond ATLS® (Advanced Trauma Life Support®) capabilities. He noted that survival will now depend on carefully finessed resuscitation practices and timely transfer to a trauma center and that educational needs exceed the principles of ATLS.4 These statements suggest the need for more tailored trauma education that focuses on the specific needs of the rural or resource-limited facility.

The RTTDC

The Rural Trauma Team Development Course (RTTDC) was developed by the ad hoc Rural Trauma Committee of the ACS Committee on Trauma (COT). From 2003 to 2015, 821 RTTDCs were offered in 37 states. The course, which also has been presented in 12 other countries, operates under the core principles of reducing the authority gradient among providers who care for trauma patients and providing quality care despite geographic, demographic, training, experience, and limited-resource challenges.19 Overall, the course content is structured similarly to ATLS (that is, primary and secondary survey) but places more emphasis on teamwork/team roles, inter- and intra-facility closed-loop communication, and the logistics of efficient patient transfer.

The idea that most rural EDs can construct a team of three providers, albeit different from that of a Level I center, is emphasized. In addition, rapid stabilization, avoidance of unnecessary imaging, and the decision to transfer patients to a higher level of care within 15 minutes of identifying an injury that exceeds local capabilities, are stressed.19 In this context, the RTTDC is applicable not only to rural hospitals, but to any facility with limited resources or experience in the care of severely injured patients. For example, the Level I trauma center at the University of Pennsylvania, Philadelphia, once received an urban hospital gunshot wound patient who ultimately died of exsanguination a short time after arrival following a 50-minute delay in transfer.

The RTTDC and its lectures, communication videos, and skills stations are structured around the objectives listed in the sidebar on this page. The course is multidisciplinary and applicable across a range of disciplines. Physicians, advanced practice providers (nurse practitioners and physician assistants), nurses, prehospital providers, respiratory therapists, radiology technicians, nursing assistants, and administrative clerks all are encouraged to take and instruct the course. Courses are typically taught over a single day and are conducted on site at the rural or nontrauma center to optimize understanding of local resources (assuming that facilities can accommodate). The RTTDC is considered an outreach function of the Level I or II trauma center, and the rural center should not bear the cost. Most importantly, the course offers significant flexibility and can be tailored to each institution’s needs.

Evidence-supported RTTDC effectiveness

A growing body of literature supports the effectiveness of the RTTDC, especially the course’s impact on processes of care. A 2011 study of 18 Level III and IV trauma centers in West Virginia showed that centers with staff who underwent RTTDC training had a statistically significant 19-minute decrease in decision to transfer times compared with centers where staff had not undergone RTTDC training.20 Centers with RTTDC-trained personnel who also had received

<table>
<thead>
<tr>
<th>RTTDC OBJECTIVES</th>
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<tbody>
<tr>
<td>• Organize a rural trauma team with defined roles</td>
</tr>
<tr>
<td>• Prepare the facility for the care of injured patients</td>
</tr>
<tr>
<td>• Identify local resources and limitations</td>
</tr>
<tr>
<td>• Assess and resuscitate trauma patients</td>
</tr>
<tr>
<td>• Initiate early transfer</td>
</tr>
<tr>
<td>• Establish a PI process</td>
</tr>
<tr>
<td>• Encourage effective communication</td>
</tr>
<tr>
<td>• Define relationships between facilities</td>
</tr>
</tbody>
</table>
specialized communication training decreased decision to transfer times by 37 minutes.

In addition, time from decision to transfer until arrival of the transport team significantly decreased after RTTDC training. In a 2016 pre- and postanalysis comparing six centers where RTTDC training took place with control facilities, Dennis and colleagues found that RTTDC training was associated with a 61-minute decrease in referring facility length of stay (LOS) and a 41-minute decrease in time to initial transfer call.21 No statistically significant difference in pretransfer CT scanning was detected, although there was a trend toward less CT imaging in the RTTDC group (59 percent versus 48 percent). Mortality rates were equal. That same year, another study showed that RTTDC training was associated with a 38-minute decrease in overall transfer times but led to no statistically significant improvements in mortality.7 Referring facility CT imaging was found to delay transfer in both the pre- and post-RTTDC training groups. In a study of rural trauma nurses, the RTTDC was well perceived and associated with improvements in fund of knowledge.22

University of Pennsylvania experience with RTTDC

The Level I trauma center at the University of Pennsylvania facilitated its first RTTDC in April 2018 at an affiliated, nontrauma hospital located more than 30 miles from our campus. Because of the positive reception, we facilitated two additional courses, most recently in April. In total, we have had 46 participants—most of them were registered nurses (see Figure 1, this page). Because of the unique staffing model of the rural hospital at night, where prehospital providers from local EMS personnel often stay to assist with resuscitations, it was important to have these individuals participate in the course as well. Most of the instructors were physicians and advanced practice providers (see Figure 2, page 26). With funding from our division, we were able to cover the $40 textbook fee for each student, allowing us to offer the course free of charge (a course expectation). The course does require a significant time commitment from instructors, who do not receive compensation.

We refer to the RTTDC as tailored ATLS, because the course can be taught to the specific needs of the rural hospital. Before each course, we identified recent performance improvement (PI) issues that we could specifically address during the course without singling out or blaming any individual. For example, we found a minor issue with chest tube placement, a task that has been associated with increased complications when performed at nontrauma centers.23 We were able to address this issue during the lecture and skills stations related to breathing. We also found that taking time to tour the ED to get a feel for trauma resuscitation logistics (staffing, location of equipment, and so on) was beneficial in identifying areas for improvement. In addition, we added a Bleeding Control course to the “circulation” lecture for supplementary course content and certification. Finally, feedback from course participants helped to facilitate discussions related to trauma care and transfer logistics. For example, one participant expressed frustration related to an isolated incident involving a transfer to our facility, an issue that we were able to address quickly with our transfer center. The flexibility of the RTTDC curriculum allows for these important additions to course content and provides a
venue to mitigate process concerns. Ideally, rural centers should leave each RTTDC with a to-do list of items that could be implemented to improve processes of care.

In addition to provider education, the RTTDC helps to strengthen relationships between the rural hospitals and trauma centers, offers Continuing Medical Education (CME) credits, and provides ample research opportunities. We have found participation in the course gratifying for students and instructors alike, and it is constructive for the trauma team to be able to see what nontrauma center health care professionals experience routinely. Although, thus far, we have only had experience with our affiliated institution, the course is applicable to any and all acute care facilities interested in participating.

Course satisfaction
Course participants have expressed satisfaction with this experience. Of the 46 participants, 41 (89 percent) completed postcourse evaluations. Using a five-point Likert scale (1 = poor/strongly disagree; 5 = excellent/strongly agree), participants reported high scores in all domains (Table 1, this page). These findings are consistent with a previous study of trauma providers from nine rural hospitals, where the RTTDC was positively perceived and found to improve the fund of knowledge.22

Quantitative evaluation of course effectiveness
As a pilot study, we sought to evaluate the effects of a single RTTDC on patients transferred to our center from our rural affiliate. After the University of
Pennsylvania institutional review board accepted this study as a quality improvement project, we compared baseline and injury-specific characteristics of patients one year before and one year after our first course in April 2018 using descriptive statistics, chi-square/Fisher’s exact test, and Mann-Whitney U test where appropriate. In total, 161 patients were transferred over the two-year period—78 (48 percent) between April 1, 2017, and March 31, 2018 (the precourse group), and 83 (52 percent) between April 4, 2018, and March 28, 2019 (the postcourse group). Overall, most patients (85 percent) were men, had sustained blunt trauma (82 percent), with a median age of 69 years old, and a median ISS of nine. The overall rural hospital ED LOS (as a marker of early transfer) was 258 [184–359] minutes.

When comparing pre- and postcourse groups, no differences were found in baseline characteristics, rural hospital ED LOS, rate of pretransfer CT imaging at the rural facility, trauma center admission vital signs (as a surrogate for adequate rural hospital resuscitation), or disposition from our trauma center ED. No differences were detected in pretransfer blood product use or rate of intubation at the rural facility. We did find a statistically significant difference in the rate of rural facility chest tube placement after specifically addressing this procedure at the first course (0 percent precourse versus 8 percent postcourse, \( p = 0.007 \)), although we did not compare rates of chest injury or indications for chest tube placement between groups (see Table 2, this page). When looking only at patients with ISS greater than 15 (25 in the precourse group versus 19 in the postcourse group), we did not find a difference in rural hospital ED LOS or trauma center admission vital signs when comparing the pre- and postcourse groups.

<table>
<thead>
<tr>
<th>Variables</th>
<th>Pre-RTTDC (n = 78)</th>
<th>Post-RTTDC (n = 83)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>66 [44–83]</td>
<td>70 [55–82]</td>
<td>0.234</td>
</tr>
<tr>
<td>Gender (male)</td>
<td>41 (53%)</td>
<td>44 (53%)</td>
<td>0.955</td>
</tr>
<tr>
<td>Mechanism (blunt)</td>
<td>62 (79%)</td>
<td>70 (84%)</td>
<td>0.312</td>
</tr>
<tr>
<td>ISS</td>
<td>10 [5–16]</td>
<td>9 [5–14]</td>
<td>0.612</td>
</tr>
<tr>
<td>Alive at TC discharge</td>
<td>77 (99%)</td>
<td>82 (99%)</td>
<td>1.000</td>
</tr>
<tr>
<td>Total transfer time (minutes)</td>
<td>294 [204–396]</td>
<td>313 [234–448]</td>
<td>0.206</td>
</tr>
<tr>
<td>RH ED length of stay (minutes)</td>
<td>253 [170–358]</td>
<td>265 [193–365]</td>
<td>0.444</td>
</tr>
<tr>
<td>TC admission SBP</td>
<td>138 [122–147]</td>
<td>137 [122–154]</td>
<td>0.850</td>
</tr>
<tr>
<td>TC admission HR</td>
<td>82 [69–97]</td>
<td>80 [74–92]</td>
<td>0.711</td>
</tr>
<tr>
<td>Disposition from TC ED</td>
<td></td>
<td></td>
<td>0.274</td>
</tr>
<tr>
<td>ICU</td>
<td>42 (54%)</td>
<td>38 (46%)</td>
<td></td>
</tr>
<tr>
<td>Floor</td>
<td>28 (36%)</td>
<td>32 (39%)</td>
<td></td>
</tr>
<tr>
<td>Operating room</td>
<td>1 (1%)</td>
<td>6 (7%)</td>
<td></td>
</tr>
<tr>
<td>Home</td>
<td>7 (9%)</td>
<td>7 (8%)</td>
<td></td>
</tr>
<tr>
<td>RH CT imaging</td>
<td>64 (82%)</td>
<td>75 (90%)</td>
<td>0.125</td>
</tr>
<tr>
<td>RH blood product administration</td>
<td>4 (5%)</td>
<td>6 (7%)</td>
<td>0.747</td>
</tr>
<tr>
<td>RH chest tube placement</td>
<td>0 (0%)</td>
<td>8 (10%)</td>
<td>0.007</td>
</tr>
<tr>
<td>RH endotracheal intubation</td>
<td>1 (1%)</td>
<td>3 (4%)</td>
<td>0.621</td>
</tr>
</tbody>
</table>

Data for nonparametric continuous variables expressed as median [interquartile range]; categorical values expressed as n (%). Abbreviations: ISS—injury severity score; TC—trauma center; RH—rural hospital; SBP—systolic blood pressure; HR—heart rate; ED—emergency department; CT—computed tomography.
## Selected Participant Commentary from Three RTTDCs

<table>
<thead>
<tr>
<th>Change in Practice</th>
<th>Anticipated Barriers</th>
<th>General Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>• “Start transport process immediately”</td>
<td>• “Staffing”</td>
<td>• “Truly excellent course”</td>
</tr>
<tr>
<td>• “No need to get all trauma imaging prior to transfer”</td>
<td>• “May be difficult to get all doctors to initiate transfer before having a diagnosis”</td>
<td>• “We do not know trauma acronyms, did not know half of them used until figured out”</td>
</tr>
<tr>
<td>• “Help initiate early transfer”</td>
<td>• “Lack of trauma-specific trained team”</td>
<td>• “Good to know the attitude of trauma surgeons is receptive”</td>
</tr>
<tr>
<td>• “Use knowledge of trauma system to help patients”</td>
<td>• “We have no abdominal binder”</td>
<td>• “There was a huge amount of team building in the room”</td>
</tr>
<tr>
<td>• “Rethink priorities—keep emphasis on ABCDE”</td>
<td>• “May be hesitant to give blood without a known source of bleeding”</td>
<td>• “I thought this was one of the best symposiums attended in a while”</td>
</tr>
<tr>
<td>• “[Help doctors] decrease time [to] transfer decision”</td>
<td>• “Usually [providers] want imaging and all results prior to transfer”</td>
<td></td>
</tr>
</tbody>
</table>
Whereas this was a pilot study, we did not control for confounders by comparing our findings with a control group of similar patients transferred from centers that did not participate in RTTDC training. We suspect that it will be challenging to show improvements in resuscitation and outcomes from our rural facility, given that patients are generally not seriously injured. As we prospectively collect more data after the completion of three courses at the same institution, we hope to at least show significant improvements in processes of care.

Qualitative evaluation of course effectiveness

Although challenging to show quantitatively, we believe this course has led to important improvements in the care of trauma patients at our rural affiliate. At our first course, for example, we quickly determined that the facility did not stock pelvic binders. The facility was able to stock binders within a week, and we were able to facilitate an in-service focusing on device application. In addition, we identified the need for an in-service on lower-extremity traction splint placement and facilitated inclusion of this competency in a registered nurse orientation checklist. Feedback from course participants suggests that the RTTDC has led to important changes in clinical practice, improved relationships with our team, a desire to spread newly acquired knowledge to other providers, and identification of important barriers to change (see sidebar, page 28). We anticipate that these changes will translate into improved processes of care and patient-reported outcomes.

Future opportunities: Your help is needed

Aside from rural provider education, the RTTDC model may have other important applications moving forward. As mentioned previously, the course can be used not only in rural or critical access hospitals, but in any facility that lacks the appropriate resources or expertise to deal with seriously injured patients.

REFERENCES


continued on next page
including international health care centers. Future research could focus on the effects of RTTDC on other important processes of care (aside from transfer time), costs, process improvement (PI) metrics, and patient outcomes, including mortality. Undoubtedly, the role of the RTTDC will continue to evolve as models for rural trauma care change over time.

In order for these changes to occur, physician participation will need to increase. One study of providers from 11 community and critical access hospitals who were offered free RTTDC courses with CME credits over a two-year period showed that only 18 of 234 (7.7 percent) participants were physicians, and none were surgeons. Although participants—mostly nurses—reported that the course would change their practice, they also cited low attendance by ED physicians and surgeons as a course deficiency. The authors of the study concluded that low physician attendance could be related to schedule challenges and that novel strategies to increase participation are needed. Distributing course materials in areas where rural physicians practice and speaking directly with rural ED medical directors prior to course implementation are strategies we have used to improve physician attendance. We believe that physicians who do not routinely practice at trauma centers would find value in the course material.

Physician participation also could help to solidify relationships between the referring center and the trauma center staff, as well as help to identify potential barriers to the resuscitation or transfer processes at the referring facility. Additionally, trauma surgeons at larger centers are just as likely to learn something from their more rural counterparts.

To learn more about the RTTDC, go to facs.org/rttdc. For more information about instructing or hosting an RTTDC course, contact the ACS Trauma Programs office at 312-202-5160 or at rttdc@facs.org.

REFERENCES, CONTINUED
The most common cause of preventable death following traumatic injury is uncontrolled bleeding. The American College of Surgeons (ACS) Stop the Bleed® (STB) course is designed to teach the nonmedical lay public the essentials of bleeding control. The course uses a simple ABC approach that anyone can apply. The goal of the Stop the Bleed program is to turn bystanders into immediate first responders. This article summarizes the history and goals of the program, and it explains how the North and South Texas Chapters of the ACS worked together to get legislation passed to ensure that Texas middle school and high school students and teachers would have access to lifesaving bleeding control kits.

The beginnings
Following the tragic mass shooting at Sandy Hook Elementary School, Newtown, CT, December 14, 2012, Lenworth M. Jacobs, Jr., MD, MPH, FACS, shepherded a small group of multidisciplinary professionals to meet to find a solution to this public health problem. This group was drawn from multiple federal agencies and civilian organizations. They came together with the goal of developing...
The core premise of the Stop the Bleed initiative is that public education and access to some simple equipment will enable individuals and teams of laypeople to act in the event of any traumatic occurrence that produces uncontrolled bleeding.

Chapters work to bring the program to Texas

From the beginning of the Stop the Bleed program, surgeons in Texas recognized the importance of bringing it to the state. The North and South Texas Chapters of the ACS made it an advocacy priority to enact the ACS model legislation for Stop the Bleed training and bleeding control kits in public schools in Texas. In 2016, at the Texas Chapter Lobby Day, supported by a grant from the ACS, a group of Texas surgeons prioritized our legislative agenda for the upcoming 2017 legislative session (the Texas legislature meets every other year for 140 days). Although other issues important to surgeons and their patients, such as scope of practice and Maintenance of Certification (MOC) legislation, remained high priorities, none united the group as much as a desire to require education about bleeding control in the schools in our state. During the 2017 session, we brought Stop the Bleed kits to our legislators, mentioning the need for the program, but placing emphasis on lobbying for more difficult topics. Compared with many of our legislative asks, the Stop the Bleed program was an easy sell. Teaching the proper use of tourniquets and hemostatic gauze was a lot more compelling than complaining about the inadequate compensation health care professionals receive from state insurance programs.

At the 2018 Texas ACS Lobby Day last fall, we determined that emphasizing Stop the Bleed legislation would be one of the chapters’ foremost priorities in the upcoming 2019 Texas legislative session. The Texas Regional Advisory Councils, which had actively promulgated STB courses in their regions, also recognized that Stop the Bleed training was a critical and necessary skill for the lay public. These grassroots efforts merged into a concerted effort to support STB education, training, and equipment for Texas schools.

With a defined agenda, the teams went to work. The teams were grateful for the vision and leadership of Rep. Barbara Gervin-Hawkins (D-Bexar County) who filed a Stop the Bleed bill, H.B. 496,
December 10, 2018, prior to the opening of the legislative session. Representative Gervin-Hawkins and her staff worked with Jordan Ghawi, MPA, LP (co-author of this article), from the Southwest Texas Regional Advisory Council (STRAC) to draft additional language in the bill. In consultation with Ricardo D. Martinez, MD, FACS (co-author of this article), companion bill S.B. 2087 was filed by Sen. Juan “Chuy” Hinojosa (D-20) in the Senate. After 79 actions, nine votes, seven amendments, and multiple testimonies, H.B. 496 worked its way through both chambers and Gov. Greg Abbott (R) signed it into law June 15, 2019.

H.B. 496 requires all Texas public and charter school personnel to participate in Stop the Bleed training and to offer training to students in grades seven and higher, and mandates that schools install bleeding control kits. How was this achieved? Through advocacy supported by the ACS, with the help of Christopher L. Johnson, State Affairs Associate, ACS Division of Advocacy & Health Policy, the North and South Texas Chapters of the ACS and STRAC, led by the co-authors of this article, came together to rally in support of the bill as it passed through the complex and challenging process of becoming a law. ACS Fellows testified in support of the respective bills in committee hearings in both chambers. Robert O. Carpenter, MD, and Mr. Ghawi waited for eight hours to provide testimony before the House Public Education Committee on April 16, and Elizabeth Scherer, MD, MPH, FACS, testified in the Senate Education Committee on May 16, both in support of H.B. 496. J. Patrick Walker, MD, FACS, testified in support of S.B. 2087 in the Senate Education Committee on April 30.

Dr. Carpenter said, “I’ve had an interest in political advocacy for years. Attending the 2018 ACS Leadership & Advocacy Summit in Washington, DC, provided me with basic political tools, as well as the confidence to know that I could, in fact, make a difference, so I sought out opportunities to get more involved here at home. A day spent with my colleagues from around Texas pressing our agenda allowed me to see how much work was needed if non-providers were going to understand the importance of acting on these issues. As the new Advocacy Chair for the South Texas Chapter of the ACS, I knew that H.B. 496 was of paramount interest to me as an educator, a surgeon, and as the father of two school-aged boys. When the call came out for members willing to testify before the House Public Education Committee, I jumped at the chance, canceled clinic, shifted my patients, and made the drive to Austin. The wait for our opportunity to testify was more than worth it. I truly believe we helped change the trajectory of this piece of legislation by directly addressing misconceptions the committee had about the bill’s intent and details of the training, as well as the required contents of the kits. The ACS made a difference for the children and teachers of Texas. I am so lucky to have been a part of it. In fact, I have started working with local private schools in central Texas to develop their own Stop the Bleed policies in line with this new public school standard.”

In moving testimony, Mr. Ghawi, a former firefighter/paramedic and present director of strategic initiatives for the STRAC–Trauma, urged Texas lawmakers to pass this bill, sharing that his 24-year-old sister was killed in the 2012 Aurora Theater mass shooting in Colorado.

After the hearings, the Texas House of Representatives passed the legislation, and though the bill sponsor amended it with non-ACS supported additions, such as inclusions of chest seals and other equipment in the bleeding control kit, it became the vehicle for the final bill. The Senate passed an ACS-supported amended bill. The differing bills then were sent to a conference committee to work out the differences between the House and Senate versions. Both chambers approved the reconciled version of H.B. 496 Sunday, May 26, just two days before Sine Die—the official adjournment of the Texas Legislature. What a race it was to get the bill passed as the legislature was closing.
It is vitally important that surgeons be involved with legislative efforts. Passage of this law did not start with one visit to the legislator’s office; it began with multiple visits at home and in the capitol with legislators and legislative staff before the session even started, which fostered relationships that proved integral to gaining support for the bill.

**Tips for others**

The final passage and enactment of the law to require Stop the Bleed training and bleeding control kits in schools was the culmination of a multiyear strategy of education, outreach, and grassroots advocacy by the ACS Texas chapters. As noted previously, this effort began when the North and South Texas Chapters of the ACS met with Texas legislators during their Chapter Lobby Day in 2017, providing Stop the Bleed demonstrations in the Capitol Office Building and delivering bleeding control kits to targeted legislative offices.

The chapters took the next step to advance a bill by hosting a Lunch and Learn on Stop the Bleed training for state legislative staff in September 2018, as part of that year’s Lobby Day program. In Texas, it is common practice for advocacy groups to host Lunch and Learn events for legislative staff to educate them on public policy issues and planned legislation for the coming session. From that event, Senator Hinojosa, whose staff person attended the event, agreed to sponsor the ACS model Stop the Bleed bill, introduced as S.B. 2087.

It is vitally important that surgeons be involved with legislative efforts. Passage of this law did not start with one visit to the legislator’s office; it began with multiple visits with legislators and legislative staff at home and in the capitol before the session even started, which fostered relationships that proved integral to gaining support for the bill. It also involved building partnerships with other like-minded health care groups involved in the Texas trauma and emergency health care system, who would form a broad-based collaborative of surgeons, physicians, paramedics, and nurses.

This strategy can be replicated across the states. It begins with engaging in the advocacy process and participating in activities. Introduce yourself to your elected representative, support fundraisers, write letters, visit the legislative staff, and become a trusted expert on health care issues. All of these activities pave the way for successful passage of a bill—often a bill that does not even exist on a topic that you might not know about at the time you are forging a relationship. It is important to know your representative before the session starts and to be committed to building partnerships and consensus with other aligned health care organizations and professionals.

The efforts that began three years ago with Stop the Bleed also enabled us to talk to our legislators about scope of practice issues (stopping chiropractors from infringing on the practice of orthopaedic surgeons, stopping physical therapists from diagnosing orthopaedic injuries, stopping optometrists from practicing periorbital surgery, and so on) and the anti-MOC legislation that would have prevented local hospital medical staffs from even considering if a physician participated in MOC when credentialing a surgeon for hospital privileges. All of these issues failed to gain enough traction to get through the legislature this past session, but we can now begin planning for the next legislative session in 2021, building upon our relationships and successes from the 2019 legislative session.

The last slide in the ACS Stop the Bleed Course PowerPoint reads, “The only thing more tragic than a death...is a death that could have been prevented.” This message resonates with us. We believe no one should bleed to death from extremity or junctional hemorrhage. We hope efforts such as the one described in this article serve to empower and encourage surgeons, emergency physicians, paramedics, and nurses across the nation to engage with their local state legislators and legislatures to make the goals of the Stop the Bleed movement a reality.

**Acknowledgment**

This state legislative advocacy initiative was supported by the national ACS office with funding from the ACS Chapter Lobby Day Grant Program and staff support from the ACS State Affairs team, particularly Mr. Johnson.
As a reflection of considerable public attention to patient experiences with receiving large surprise medical bills over the last few years, state legislatures have been considering and passing legislation to address the issue. As of January 2019, the Commonwealth Fund noted in an online report that nine states (California, Connecticut, Florida, Illinois, Maryland, New Hampshire, New Jersey, New York, and Oregon) had passed comprehensive surprise billing legislation, and 17 (Arizona, Colorado, Delaware, Indiana, Iowa, Maine, Massachusetts, Minnesota, Mississippi, Missouri, New Mexico, North Carolina, Pennsylvania, Rhode Island, Texas, Vermont, and West Virginia) had passed limited surprise billing legislation.*

When state legislatures convened earlier this year, 28 states considered surprise billing legislation, but only four successfully passed legislation.

Who made the cut?

Colorado, Nevada, Texas, and Washington State either enhanced existing laws or enacted new surprise billing laws in 2019. The following is a brief overview of the main components of each state’s unanticipated billing statutes.

Colorado (H.B. 19-1174)

Health care providers or facilities are not permitted to balance bill; however, in the case of nonemergency covered services, a balance bill may be sent when a covered person voluntarily uses an out-of-network provider. If a covered person receives covered services at an in-network facility from an out-of-network health care professional, the insurer will pay the out-of-network provider the greater of 110 percent of the insurer’s median in-network rate of reimbursement for that service in the same geographic area or the 60th percentile of the in-network rate of reimbursement for the same service in the same geographic area for the prior year, based on commercial claims data from the all-payer health claims database. For emergency services received at an out-of-network facility from an out-of-network health care professional, the insurer will reimburse the out-of-network provider 105 percent of the insurer’s median in-network rate for that service provided in a similar facility or setting in the same geographic area, or the median in-network rate for the same service provided in a similar facility or setting in the same geographic area for the prior year, based on claims data from the all-payer health claims database.

Providers who do not believe the reimbursement is acceptable may request arbitration. The arbitrator will consider final offers from both parties and will decide on one or the other. Arbitrator fees and expenses will be paid by the party whose offer was not accepted.

**Nevada (A.B. 469)**
Balance billing is not permitted for emergency services, and payment is based on when the out-of-network provider may have been in-network—that is, within 12 months or 24 months of the provision of the emergency service, and what the in-network rate may have been under the contract. It also takes into account whether the provider or the insurer canceled the contract with or without cause. Patients are responsible only for the in-network copayment, coinsurance, or deductible. Binding arbitration is available for providers to dispute the payment received, and arbitrator fees will be paid by the losing party.

**Texas**
The legislation replaces the state’s mediation process for physicians and insurance disputes with binding arbitration. Balance billing is not permitted; however, an exemption is provided for nonemergency care when the patient knowingly chooses an out-of-network provider(s) and is given required disclosures that include amounts for which the patient will be responsible. Outside of the exemption, patients are responsible for the applicable copayment, coinsurance, and/or deductible. An arbitration system is created to settle disputes over payment, and arbitrators have a wide-ranging list of criteria they may consider in reaching a decision. These factors include but are not limited to the 80th percentile of all billed charges for the service performed by a health care provider in the same or similar specialty and provided in the same geozip—a geographic area usually defined by the first three digits of U.S. zip codes—as reported in a benchmarking database, as well as the 50th percentile of rates for the service or supply paid to participating providers in the same or similar specialty and provided in the same geozip area as reported in a benchmarking database. The arbitrator’s expenses are evenly split between the two parties.

**Washington (H.B. 1065)**
Balance billing is prohibited for emergency services and nonemergency services provided by an out-of-network provider at an in-network hospital or ambulatory surgery center. Insurers must pay providers and facilities for out-of-network care at a commercially reasonable amount based on payments for the same or similar services provided in a similar geographic area, and patients are responsible for in-network cost-sharing amounts only. Providers and facilities may dispute payment through an arbitration process, and arbitrators may consider criteria, such as complexity of the case; evidence submitted by both parties; and the data set compiled by the Washington all-payor claims database, which includes claims for median in-network amounts, median out-of-network allowed amounts, and median billed charges for the same or similar services in a geographic area. Arbitration costs are evenly split among the two parties, although they are responsible for their respective legal fees.

**Bills awaiting passage**
Two other states, Michigan and Pennsylvania, have active surprise billing legislation, as their legislatures meet all year. Bills under consideration in these states at press time are as follows.

**Michigan (H.B. 4459 and H.B. 4460)**
For emergency or nonemergency covered services provided by a nonparticipating health care professional at a participating health facility, the nonparticipating provider would be expected to accept as payment in
full 125 percent of the amount that Medicare would reimburse in that Medicare fee locality. Balance billing would be prohibited, except in nonemergency situations in which the patient provides written consent to receive services from the nonparticipating provider at least 24 hours in advance, and the patient is given a written estimate of the cost of the care to be provided.

Pennsylvania (S.B. 822)
Balance billing would not be permitted for the following: a covered emergency service provided to an insured patient by an out-of-network provider; a covered service provided to an insured patient by an out-of-network provider at an in-network facility; or a covered service provided to an insured patient by an out-of-network provider, in conjunction with a health care service for which the insured patient presented for care to an in-network provider. Balance billing would be permitted for a health care service rendered by an out-of-network provider when an in-network provider is available and the insured patient has elected to receive the service from an out-of-network provider instead of from an in-network provider. Patients are held harmless and are responsible for no more than the cost-sharing amounts that would have been due if the health care service had been rendered by an in-network provider. In instances where billing disputes arise between providers and insurers, a formal dispute resolution process is instituted, with the arbitrator authorized to consider a number of criteria, including the following:

- Level of training, education, and experience of the provider
- The provider’s usual charge for comparable health care services, both in and out of network
- The insurer’s usual payment for comparable services, both in and out of network
- Payment standards in the service area, such as Medicare payment or a median index
- Circumstances and complexity of the case
- Payments made in prior surprise bill disputes between the provider and the insurer

Federal efforts continue
In addition to state legislative activity related to surprise billing, Congress has taken up the surprise billing issue. Multiple congressional committees have held hearings on bills introduced by numerous members of Congress (as reported in various American College of Surgeons [ACS] publications, including the “Dateline DC” in the online Bulletin and the Advocacy page of the ACS website). The College has been very engaged on this issue, regularly meeting with committee staff and elected officials, and convening a coalition of specialty societies to further grassroots advocacy efforts. To view ACS policy statements, comment letters, and other documents on this issue, visit the ACS website at facs.org/advocacy/federal/billing.

Future state legislative activity
Even if the federal government enacts some type of surprise billing legislation in 2019, state legislatures may still move forward with their own surprise billing legislation or with legislation to harmonize their laws with federal statute. Surgeons and ACS chapters should be vigilant as to what their state legislatures may be doing to address surprise billing and engage in grassroots advocacy with their state legislators if bills are introduced. Collaboration with state specialty societies and state medical societies also is key in presenting a unified voice at the state capitol, particularly for an issue as complex as surprise billing.
The American College of Surgeons (ACS) established the multidisciplinary Commission on Cancer (CoC) in 1922 as part of its ongoing commitment to excellence in quality of surgical care. The CoC has sought to fulfill its goal of ensuring the delivery of comprehensive, high-quality cancer care by setting standards, conducting compliance surveys, collecting standardized data from its accredited programs to better measure quality, using data to monitor treatment patterns and outcomes to enhance clinical surveillance activities, and developing effective educational interventions to improve care delivery and outcomes.

Today, the CoC works in tandem with other ACS Cancer Programs—the American Joint Committee on Cancer, Clinical Research Program, National Accreditation Program for Breast Centers, National Accreditation Program for Rectal Cancer, and National Cancer Database—to provide tools, resources, and data that enable cancer programs to deliver comprehensive, high-quality, multidisciplinary, evidence-based, patient-centered care. The CoC remains a consortium of professional organizations, convened by the

HIGHLIGHTS
- Provides background information on the CoC's longstanding commitment to improving cancer patient care
- Outlines federal legislation that the CoC supports
- Describes the CoC’s advocacy efforts at the state level

The CoC:
Ensuring quality cancer care and a commitment to advocacy for cancer research and prevention

by Amelia Suermann and Christopher Johnson, MPP
The CoC remains a consortium of professional organizations, convened by the ACS, dedicated to improving the survival and quality of life for cancer patients through standard-setting, prevention, research, education, and ensuring comprehensive quality care.

ACS, dedicated to improving the survival and quality of life for cancer patients through standard-setting, prevention, research, education, and ensuring comprehensive quality care. The CoC has more than 100 members—surgeons and affiliate health care professionals who represent the ACS and 58 other national organizations. Together, these individuals direct and coordinate the activities of the CoC through various committees.

Established in 2013, the CoC Advocacy Committee is responsible for identifying, evaluating, and recommending positions on legislative and regulatory issues that come before the state and federal government and have the potential to affect the needs or interests of CoC-accredited cancer programs and cancer patients. Priorities focus on issues that are related to the mission of the CoC or its standards for accreditation. The ACS CoC Advocacy Committee develops its list of priority areas on an annual basis and meets regularly throughout the year to review legislation, plan advocacy activities, and discuss ongoing developments.

**ACS CoC advocacy at the federal level**

The ACS CoC is dedicated to improving the survival and quality of life for cancer patients through advocacy on Capitol Hill for legislative solutions that support cancer prevention and research. The ACS CoC encourages members of Congress to maintain a bipartisan commitment to cancer legislation, with the overall goal of improving cancer care. Specific pieces of legislation that the CoC supports are as follows.

**Palliative Care and Hospice Education and Training Act**
The ACS CoC asserts that educating patients and providers on the benefits of palliative care has the potential to significantly improve the quality of life for patients and their families who are experiencing times of serious and complex chronic conditions. However, not all palliative care programs have the interdisciplinary teams necessary to provide comprehensive, high-quality care (see related story, page 13).

The ACS CoC supports the Palliative Care and Hospice Education and Training Act (PCHETA), H.R. 647/S. 2080, introduced by Reps. Eliot Engel (D-NY), Tom Reed (R-NY), Yvette Clarke (D-NY), Buddy Carter (R-GA), Frank Pallone (D-NJ), and Greg Walden (R-OR), and Sens. Tammy Baldwin (D-WI), and Shelley Moore Capito (R-WV). This legislation would improve the training of health professionals in palliative care by creating palliative care and hospice education centers to provide short-term intensive courses focused on palliative care; establishing trainee-ships for individuals preparing for advanced degrees in nursing; and providing education to social workers and physician assistants who focus their studies in palliative care. Additionally, PCHETA would expand palliative care research to strengthen clinical practice and improve care delivery for patients with serious or life-threatening illnesses.

**Removing Barriers to Colorectal Cancer Screening Act**
According to the National Cancer Institute (NCI), colorectal cancer is the second leading cause of cancer-related death in the U.S. This statistic is especially troubling because colorectal cancer is largely preventable if patients have access to effective screening methods. At present, Medicare waives coinsurance and deductibles for preventative colonoscopies; however, when a polyp is discovered and removed, the procedure is reclassified as therapeutic for the purposes of Medicare billing, and patients are therefore required to pay coinsurance charges. Not only is this cost-sharing obligation confusing to patients, it also results in the unintended consequence of creating a financial barrier to the most effective method of colorectal cancer prevention.

The ACS CoC is committed to cancer prevention and urges swift passage of the Removing Barriers to Colorectal Cancer Screening Act, H.R. 1570/S. 66, introduced by Reps. Donald M. Payne (D-NJ), Rodney Davis (R-IL), Donald McEachin (D-VA), and David McKinley (R-WV), and Sens. Sherrod Brown (D-OH), Roger Wicker (R-MS), Ben Cardin (D-MD), and Susan
Collins (D-ME). This bipartisan legislation—which has more than 280 cosponsors in the House and 50 in the Senate—would help to ensure that the threat of unanticipated costs does not deter patients from undergoing the preventative screening by waiving Medicare’s cost-sharing requirement for preventative colonoscopies, even if a polyp or tissue is removed. By removing this financial barrier, Congress would help increase screening rates and reduce the incidence of colorectal cancer.

Cancer Appropriations requests
The ACS CoC has been a strong advocate in the fight to secure additional cancer research and prevention funding. Past congressional support for federally funded cancer research has been the foundation for progress made in the battle against this disease. The ACS CoC strongly supports the goal of maintaining and enhancing funding of these programs in order to build upon the momentum gained throughout the last few years.

The House of Representatives passed a “minibus” appropriations package June 19 to fund government programs, including increased funding for the National Institutes of Health (NIH), NCI, and Centers for Disease Control and Prevention (CDC). To continue the progress that has led to medical breakthroughs for treatment and therapies for millions of cancer patients, the ACS CoC urges the U.S. Senate to pass an appropriations bill that shows a commitment to cancer research funding as follows:

- Increase NIH funding by $2.5 billion, for a total of $41.6 billion, including $6.5 billion for the NCI
- Provide at least $555 million for the CDC’s Cancer Prevention and Control programs, including $70 million for the National Program of Cancer Registries
- Increase NIH funding by $2.5 billion, for a total of $41.6 billion, including $6.5 billion for the NCI
- Provide at least $555 million for the CDC’s Cancer Prevention and Control programs, including $70 million for the National Program of Cancer Registries

Breast Cancer Research Stamp Reauthorization Act
The ACS CoC supports the Breast Cancer Research Stamp Reauthorization Act of 2019, H.R. 2689/S. 1438, which would reauthorize the Breast Cancer Research Stamp for an additional eight years. Since its release in 1998, more than 1 billion of these stamps have been sold in the U.S., raising more than $87.8 million for cutting-edge breast cancer research.

Legislative successes
The Childhood Cancer Survivorship, Treatment, Access, and Research Act, P.L. 115-180, was signed into law in 2018 after years of advocacy. The ACS CoC and the cancer community at large played a critical role in achieving this important legislation, which will help to advance pediatric cancer research and child-focused cancer treatments, while also improving childhood cancer surveillance and providing resources for survivors of childhood cancer.

Cancer legislation at the state level
The ACS tracked more than 1,800 bills in the state legislatures in 2019, of which just 226 were cancer-related public health policy bills, with particular attention given to the issues of raising the legal age for purchasing tobacco to 21 years old (“tobacco 21”), tanning bed restrictions, student use of sunscreen in public schools, and access to breast tomosynthesis three-dimensional (3-D) mammography.

Tobacco 21 laws made significant advancements in 2019, passing in 12 states: Arkansas, Connecticut, Delaware, Illinois, Maryland, New York, Ohio, Texas, Utah, Vermont, Virginia, and Washington State, tripling the total number of states to 18. California, Hawaii, Maine, Massachusetts, New Jersey, and Oregon had passed this legislation previously. The laws in Maryland and Texas, however, exempt members of the U.S. military 18 years or older, while Arkansas and Utah will phase in the age restrictions over the next three years. Louisiana, New Mexico, and South Carolina introduced legislation that failed to pass. The Louisiana ACS CoC and Louisiana Chapter of the ACS supported their state’s legislation.

The ACS CoC has long supported restricting access to tanning beds by minors younger than 18 years of age.
The ACS CoC Advocacy Committee will host an educational briefing on Capitol Hill in the spring of 2020 to further educate Congress about cancer issues and ACS Cancer Programs.

age. Bills containing this restriction passed in Maine and Maryland, whereas Tennessee enacted a law that allows minors between the ages of 14 and 18 years old to use tanning bed with parental permission. With the addition of Maine and Maryland, a total of 19 states and the District of Columbia have enacted the full ACS CoC supported restrictions: California, Delaware, Hawaii, Illinois, Kansas, Louisiana, Massachusetts, Minnesota, Nevada, New Hampshire, New York, North Carolina, Oregon, Rhode Island, Texas, Vermont, and Washington. At press time, a bill in New Jersey, A. 5409, was pending in the State Assembly. Legislation in Arizona, Indiana, Missouri, Montana, and Nebraska failed to pass.

Another skin protection issue that the ACS CoC supports calls for clarifying regulations regarding student possession and use of sunscreen products at school and school-sponsored events. These bills, which ensure that children and teens can protect themselves from harmful ultraviolet exposure outdoors, advanced in Arkansas, Connecticut, Illinois, Maine, Minnesota, and Nevada, with the Department of Education in Nebraska issuing rules clarifying state regulations for student use of sunscreen products. These states join Alabama, Arizona, California, Colorado, Florida, Indiana, Louisiana, Maryland, Michigan, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Texas, Utah, and Washington. Legislation is still pending in Massachusetts S. 284, S. 261, H. 545; New Jersey S. 1803; Rhode Island S.B. 116; and the District of Columbia. Legislation failed to pass in Virginia. The ACS CoC is a member of the SUNucate coalition, joining others in supporting passage of the legislation.

At the request of the New Hampshire ACS CoC and Chapter of the ACS, the College sent a letter to the New Hampshire Senate in support of a bill to correct the legislative intent of the state’s law on insurance coverage for breast tomosynthesis 3-D mammography. Insurance companies had found a workaround to deny coverage for the screening for patients, necessitating passage of the new law. Other bills to expand coverage for 3D mammography were introduced but did not pass in Hawaii, Iowa, and Maine. Arkansas, Colorado, Connecticut, Illinois, Kansas, Louisiana, Maryland, Missouri, New Hampshire, New Jersey, New York, Oklahoma, Pennsylvania, Texas, Vermont, and Washington have laws requiring insurance coverage. Massachusetts, Minnesota, and Rhode Island each have active legislation pending.

2020 and beyond

The CoC already has begun planning its advocacy priorities in 2020. The ACS CoC Advocacy Committee will host an educational briefing on Capitol Hill in the spring of 2020 to further educate Congress about cancer issues and ACS Cancer Programs. Additionally, members of the Advocacy Committee will meet with members and staff to advocate directly for cancer research funding and other federal legislative priorities.

New this year, CoC State Chairs will have additional assistance to further engage and advance the CoC’s state legislative advocacy priorities. A new state advocacy tool kit was presented to ACS CoC State Chairs at Clinical Congress, highlighting activities and resources to work with the ACS State Affairs staff and CoC partner organizations, including the American Cancer Society. Because states often influence how the federal government tackles a problem, the active involvement of State Chairs in advocacy will help to achieve meaningful progress for cancer patients and the adoption of policies that lead to better research, prevention, and outcomes.

For information on other cancer-specific state legislation, contact Christopher Johnson, State Affairs Associate, at cjohnson@facs.org. For questions or additional information about the ACS CoC’s federal legislative priorities, contact Amelia Suermann, ACS Congressional Lobbyist, at asuermann@facs.org.
RAS-ACS Symposium essays: Shift work surgery: Loss of continuity or sensible balance of responsibility?

Editor’s note: Each year, the Advocacy and Issues Committee of the Resident and Associate Society of the American College of Surgeons (RAS-ACS) hosts a symposium at Clinical Congress, which focuses on a current and controversial topic in surgery that affects residents and surgical education. The topic of the 2019 discussion was Shift Work Surgery: Loss of Continuity or Sensible Balance of Responsibility?

Surgical residents are offered the opportunity to submit an essay on the symposium subject. The first-place winners this year were Lili Sadri, MD, a postgraduate year (PGY)-3 in general surgery, Abington Memorial-Jefferson Health, PA, and Jessica Rea, MD, PGY-5, University of California San Francisco East Bay. The essay contest winners were invited to present their papers at the RAS-ACS Symposium at Clinical Congress 2019 in San Francisco, CA, along with moderator Barbara Lee Bass, MD, FACS, FRCSEng(Hon), FRCSI(Hon), FCOSECSA(Hon), and panelists Kenneth Mattox, MD, FACS, and Sharmila Dissanaike, MD, FACS, FCCM.

Following are the second-place essays on the topic.
Pro: Shift work surgery: Loss of continuity or sensible balance of responsibility?

by Suy sen Hung Fong, MD, and Subhasis Misra, MD, MS, FACS

General surgery is a tough and demanding profession that attracts particular individuals with an “unwritten but understood code of rules, norms, and expectations.” Training in a surgical residency is a rigorous and long process that requires substantial commitment, dedication, and determination; however, the required hard work, long work hours, and the need to deal with their patients’ life and death situations create personal sacrifices that may lead to burnout and other negative repercussions on individual well-being.¹

Effect of work-hour restrictions
The July 2003 implementation of the Accreditation Council for Graduate Medical Education’s resident work-hour restrictions led to general surgery training reforms designed to reduce the adverse physical and mental health effects on residents and to reduce medical error resulting from sleep deprivation.²⁻⁵ Several studies have analyzed the different aspects of how work-hour limitations have affected American Board of Surgery In-Training Examination (ABSITE) performance, resident quality of life, burnout, quality of patient care, patient morbidity and mortality, continuity of care, and time spent in the operating room.²⁻⁷ These studies have found that ABSITE performance, resident quality of life, and burnout have significantly improved, and a less significant improvement or no change was revealed in quality of patient care, morbidity and mortality, and operative experience. However, researchers did find a decrease in continuity and coordination of care, raising concerns that residents were developing a shift work mentality, leading to a decrease in residents’ responsibility—a deviation from the patient-focused culture in the surgical profession.²
Despite all the concerns that have emerged with regard to the duty-hour limits and their effect on surgical resident competency and readiness for independent practice, no studies have shown any worsening of quality patient care. In fact, this shift work model could correlate with higher prevalence of newly board-certified surgeons choosing to join surgical groups instead of going into independent practice, which could lead to a more robust surgical workforce. U.S. surgeons in group practices are less likely to experience work-home conflicts. A cross-sectional study found that work-home conflicts is associated with burnout, symptoms of depression, problematic alcohol abuse, and career dissatisfaction and is more prevalent among surgeons who had fewer years in practice, longer work hours per week, and more frequent overnight calls. Some other independent factors associated with work-home conflicts were gender and having children, with women surgeons and surgeon parents (regardless of gender) at greater risk.

As a benefit of the shift work model, junior surgeons will be joining senior surgeons to decrease their weekly clinical work hours and subsequently reduce their work-home conflicts and maintain work-life balance. A systemic review of surgeon burnout found that nine out of 10 studies reported increased risk with the number of hours worked, and seven out of 10 studies reported an increased risk of work-life imbalances.

Applications in acute care surgery and hospitalist programs

Two successful surgical disciplines have successfully implemented the shift work model. One is acute care surgery, which is most commonly staffed by trauma surgeons in academic settings in response to the decreasing interest in emergency call coverage among general surgeons, who are becoming increasingly more specialized. An acute care surgery model that started at Loma University Medical Center, Loma Linda, CA, in 2010 combined trauma and emergency general surgery into a 12-hour, in-house service, which improved patient outcomes. In 2012, the institution performed a retrospective study comparing the acute care surgical model with the traditional surgical care model. This study showed that the acute care model resulted in lower costs and improved quality of care for patients who underwent appendectomies and cholecystectomies. Similarly, a Level I trauma center in Texas reported struggling with yearly increases in workload in trauma, critical care, and emergency general surgery call until a redesigned model was introduced that comprised a team of six surgeons and a 12-hour shift for 14 out of 28 days. The results were two weekends off per month; less disruption of circadian rhythm; protected time for research, education, and administrative work; and improved efficiency at the hospital by the cohesive team of surgeons. This new, redesigned 12-hour shift has been referred to as “surgeon- and patient-friendly.”

Surgical hospitalists—surgeons with “nearly exclusive inpatient practice”—also follow the shift work model. This profession came about to address the shortage of surgeons in hospitals and the burden of emergency department (ED) call for general surgeons. The University of California San Francisco (UCSF) introduced this program in July 2005, and some results of its prospective study on patient outcome showed shorter ED length of stay and improved timeliness of care. Another significant outcome was in hospital revenue, with a 24-fold increase in the first year of the program, resulting from a 190 percent increase in requested consults from ED and inpatient wards. One of UCSF’s surgical hospitalists reports that this model is a “far cry” from anything he would have dreamed when he started surgery years ago and that “it is the wave of the future.”

In conclusion, it is important to remember that surgeons are human beings with their own personal lives who, at the same time, care for their patients. But
the increase in health care demand makes it challenging to find a balance. As more general surgeons become more specialized, the shift work model will play a major role in addressing the shortage of general surgeons who take ED calls. The benefits of the shift work model, in comparison with the traditional culture of surgery, seem to outweigh the lack of continuity of patient care in surgical practice. Moreover, as the trend of physician shortages continues, the future leaders in the field of surgery foresee a potential new adaptation with a new practice model to better balance health care challenges, patient care, and physician well-being. For now, shift work surgery works best and should be viewed as a sensible balance of responsibility. ♦

REFERENCES


Con: Shift work surgery: Loss of continuity or sensible balance of responsibility?

by Venkat M. Ramakrishnan, MD, PhD

The decision to support resident duty-hour restrictions and transition to shift work have been significant topics of debate in modern medicine. In surgery, the debate has taken on particular significance, as the field has characteristically embodied long hours as well as physical and mental strain in the pursuit of technical excellence. While shift work and duty-hour restrictions make sense in certain environments, they should not be blindly applied to all medical specialties—especially surgery. Surgery adds a unique dimension to patient care in that surgical care takes place over a continuum and provides unique opportunities for trainees to learn and practice acute perioperative medicine. Here, I aim to provide evidence generally supporting the maintenance of longer hours instead of shift work surgery, with the immediate caveats that first, not all surgery programs are similarly structured, and second, not all programs receive the same case volumes.

Interference with resident education
A surgical trainee’s responsibilities and education do not simply end at the conclusion of a case. The immediate postoperative period is one of high activity and interest for surgeons and trainees; this period often shapes a patient’s long-term outcome and sets the tone for the relationship between health care professionals and their patients. Many complications (such as myocardial infarction and chest pain, hypotension, arrhythmia, respiratory anomalies, and bleeding) often present themselves within the first 48 hours after an operation.¹,² From a training standpoint, it is imperative that budding surgeons familiarize themselves with the presentation and
management of such outcomes, as this experience can directly affect pre- and intraoperative maneuvers in future cases.

With shift work, this critical period of care time is interrupted, thereby affecting learning and synthesis. The emotional pendulum has swung back and forth on the issue, but numerous quality and safety articles have suggested that longer hours do not diminish patient safety or education.\(^3\)\(^-\)\(^5\)

In fact, the opposite may be true. Early data had suggested that case volume per resident remained unchanged or even increased in a shift work environment;\(^6\) however, the latest data from Europe actually demonstrate reductions by as much as 13 percent for traumatic cases and up to 32 percent for elective procedures.\(^7\) Moreover, in one setting, surgeon performance on in-service exams actually decreased after regulations were put in place, although more studies are needed to validate this finding.\(^8\)

**Personal tolls**

Surgical residencies are notorious for physical and mental strain, and sleep deprivation is a prevalent consequence. Yet, while shift work sought to provide residents with a predictable schedule and more personal time for recovery—both of which are favorable—the manner in which shifts are scheduled is directly dependent on the preferences of the scheduler. Anecdotally, many programs establish shifts based on seniority, with senior residents receiving a more predictable schedule and juniors being scheduled to fill in any remaining gaps in coverage.

Therefore, the end result for many trainees is often a shift schedule that arbitrarily peppers nights suboptimally. For residents transitioning from a period of day shifts to nights, the seemingly random insertion of nights without factoring in an adequate adjustment time ends up propagating insomnia, circadian misalignment, and melatonin suppression, which, in turn, promotes an abnormal routine, nutritional problems, and exposes residents to the very issues that shift work sought to mitigate in the first place.\(^9\)\(^-\)\(^11\) Some of the most tangible shortcomings of the shift system also rear their heads at night, including workload imbalance, a decrease in resources, and emotional isolation.

**Effects on colleagues and patients**

Shift work also calls attention to a general increase in midlevel support, as well as continued shortcomings with communication. Many surgical departments around the country have employed physician assistants (PAs), most of whom actively manage floor patients and many of whom assist to a significant degree in the operating room. Because PAs reduce resident workload and facilitate an increase in overall surgical volume, they fill a crucial role in modern health care delivery and ultimately allow residents to pursue an educational agenda with greater freedom and focus.\(^12\) To have residents adopt the shift work schedule that midlevels use would certainly hamper such benefits.

With respect to communication, the quality of a given patient’s course becomes significantly more dependent on a higher quality handoff between residents. While recent efforts have sought to improve and standardize this process, handoffs are still variable, carry a degree of subjectivity, and are prone to errors and omissions that can complicate patient care.\(^13\)\(^-\)\(^15\) With a shift-based system, the number of such handoffs proportionately increases and can set the stage for error propagation.

The aim of this article is not to malign shift work, but rather to emphasize that it has been used broadly without consideration of the ancillary factors that
promote or encumber seamless care. It is a system of practice that actually makes a lot of sense in fields naturally espousing little to no long-term critical care—particularly emergency medicine, radiology, and physical medicine, to name a few. However, in fields that often have complex patients necessitating inpatient care for periods of time—internal medicine and surgery most classically—the value of a shift system becomes increasingly questionable.

The aim of this article is not to malign shift work, but rather to emphasize that it has been used broadly without consideration of the ancillary factors that promote or encumber seamless care.

**REFERENCES**

ACS responds to frequently asked questions about CPT coding

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

It is often challenging to assign a correct Current Procedural Terminology (CPT)* code to unusual procedures and services. This column responds to several frequently asked questions posed to the American College of Surgeons’ Coding Hotline.

What codes are reported for laparoscopic takedown and repair of an ileosigmoid fistula, ileocolic resection, creation of loop ileostomy, and intraoperative sigmoidoscopy?

This procedure would be reported with codes 44205, Laparoscopy, surgical; colectomy, partial, with removal of terminal ileum with ileocolostomy, and 44187, Laparoscopy, surgical; ileostomy or jejunostomy, non-tube. It would be incorrect to report the intraoperative sigmoidoscopy, which may be performed to check the anastomosis.

During the approach of a sigmoidectomy procedure, the surgeon encounters an abdominal abscess. He “unroofs” the abscess and continues to complete the sigmoidectomy. Can he report 49020, Drainage of peritoneal abscess or localized peritonitis, exclusive of appendiceal abscess, open, for the unroofing procedure?

Code 49020 specifies drainage of an abscess. If the surgeon only opened (unroofed) the abscess, code 49020 should not be separately reported in addition to the sigmoidectomy procedure code. If the unroofing work was significant, modifier 22, Increased procedure services, may be appended to the sigmoidectomy procedure code. Documentation must support the substantial additional work and the reason for it (that is, increased intensity, time, technical difficulty of procedure, severity of patient’s condition, and physical and mental effort required).

The surgeon used a falciform ligament flap to reinforce the pancreatic jejunal anastomosis when performing a Whipple procedure. How would the flap be reported?

There is no code to report this procedure, and it would be difficult to find a code to crosswalk a value to if an unlisted code were reported. The best option would be to append modifier 22 to the primary procedure and document the additional work and time compared with the typical time for a Whipple procedure (for example, 25 percent more operative time). Documentation must support the substantial additional work and the reason for the additional work (that is, increased intensity, time, technical difficulty of procedure, severity of patient’s condition, and physical and mental effort required).

How do you report a sigmoid resection, left descending colostomy, and repair of an inguinal hernia?

Report both code 44143, Colectomy, partial; with end colostomy and closure of distal ileostomy, and code 44306, Herniorrhaphy, through a midline incision.
A patient with an elevated prostate-specific antigen undergoing prostate biopsy had a rectal stricture treated by anal dilation before an ultrasound probe and needle to perform the biopsy were inserted. Is it appropriate to report CPT codes for both the dilation of the rectal stricture and the prostate biopsy?

No, only report code 55700, Biopsy, prostate; needle or punch, single or multiple, any approach. Code 55700 includes dilation of the anus, and therefore, it would be inappropriate to report code 45905, Dilation of anal sphincter (separate procedure) under anesthesia other than local or code 45910, Dilation of rectal stricture (separate procedure) under anesthesia other than local. Codes 45905 and 45910 are both designated as a “separate procedure,” which means the procedure is carried out as an integral component of the total procedure. To report a code with a “separate procedure” designation, the procedure must be considered unrelated to or distinct from other procedures performed at the same time.

How do I report laparoscopic repair of an internal hernia in the small intestine?

The correct code to report is 44238, Unlisted laparoscopy procedure, intestine (except rectum), although some payors may accept or require reporting 44799, Unlisted procedure, small intestine, or code 49659, Unlisted laparoscopy procedure, hernioplasty, herniorrhaphy, herniotomy. When reporting an unlisted code to describe a procedure, it is necessary to submit supporting documentation with the claim to provide an adequate description of the nature, extent, and need for the procedure, as well as the time, effort, and equipment necessary to provide the service.

The surgeon performed a laparoscopic repair of a strangulated ventral hernia and a laparoscopic repair of an inguinal hernia on the same day. Can the surgeon bill for both procedures?

Yes, both procedures can be reported with codes 49653, Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); incarcerated or strangulated, and 49650, Laparoscopy, surgical; repair initial inguinal hernia. Because this code pair does not have a National Correct Coding Initiative edit, modifier 51, Multiple procedures, would be appended to the lower-valued code as follows: 49653, 49650-51.

ACS Fellows can call the Coding Hotline for answers to questions related to CPT; Healthcare Common Procedure Coding System; International Classification of Diseases, 10th Revision Clinical Modification codes; and global fee periods. To contact a coding specialist, call 800-ACS-7911 (800-227-7911), 8:00 am to 5:00 pm Central time, Monday through Friday, excluding holidays and weekends. ♦
New protocol leads to improved trauma decannulation rate

by Michael S. Farrell, MD, MS; Tom Gillin, RRT; John Emberger, RRT; Richard Caplan, PhD; Michael S. Johns, DO; Mark Cipolle, MD, PhD; and Kevin M. Bradley, MD, FACS, FCCM

Editor’s note: The authors published a similar article in the July 2019 issue of Critical Care Explorations. This column is published with the permission of Wolters Kluwer Health, Inc. and Copyright Clearance Center, New York, NY.

Tracheostomy is one of the most commonly performed procedures in critical care. Multiple studies and guidelines address the timing and techniques for placement of a tracheostomy. Prolonged tracheostomy placement is associated with certain risks, including tracheal stenosis, bleeding, site infection, dehiscence, and others. Despite these risks, very limited data and no official guidelines are available to assist with decannulation. Other institutions have attempted to address this need with mixed results by developing tracheostomy teams and bundle packages. The trauma team at Christiana Care Health System, Newark, DE, sought to develop a reliable protocol that can work in a variety of settings and maintain patient safety.

The local problem
Christiana Hospital is a large community hospital within a health system that serves patients in northern Delaware. It has approximately 1,000 beds and is an American College of Surgeons (ACS) Level I trauma center, and a Joint Commission-accredited stroke center. It serves approximately 4,000 trauma patient annually.

Because the decision to decannulate a patient must be considered on a case-by-case basis, it can be difficult to compare decannulation rates at various institutions. Rather than compare Christiana Hospital with national guidelines, we identified our local problem through a series of individual patient encounters. Specifically, we noticed that some patients were being decannulated just prior to discharge, and the trauma team agreed that it could have been completed earlier. Furthermore, we identified instances when discharge planning was limited due to tracheostomies that may no longer have been required.

Putting the quality improvement (QI) activity in place
The decannulation initiative was driven primarily through collaboration between the trauma department and the respiratory therapy department. Initial
planning developed after the recognition of the opportunity for improvement. A task force was created in the summer of 2015 with the goal of developing a protocol, which was finalized in March 2016. There were six primary participants in the group, including two surgical intensivists, one pulmonary intensivist, two respiratory therapists, and one speech therapist.

The protocol was developed to incorporate the daily routines of team members and to allow for clinical judgment based on the skills and knowledge of team members. Patient safety, because of the potential for an airway emergency, was of primary concern. For added safety, a provider order was required to initiate the protocol and before decannulation. Because no standard guideline for decannulation is available, the protocol was developed based on consensus among trauma and respiratory therapy health care professionals. After an agreed upon protocol was created, an order option for the protocol was added to the order set used for tracheostomy. All team members were educated on the topic in small groups at regularly scheduled meetings. Protected time and financial incentives were not offered for this project. We obtained team support through early engagement.

**Implementation of the QI activity**
The team developed a tracheostomy decannulation protocol (see Figure 1, this...
The decannulation initiative was driven primarily through collaboration between the trauma department and the respiratory therapy department. Initial planning developed after the recognition of the opportunity for improvement.

The population of interest consisted of trauma patients with new tracheostomies. Under the protocol, critical care providers and respiratory therapists identified patients as appropriate for the protocol based on clinical judgment. Additional inclusion criteria included:

- Patients who were not ventilator dependent
- Patients without planned procedures requiring an advanced airway
- Patients with an intact airway and with a cough reflex
- Maintaining adequate oxygenation with FiO2 (fixation of inspired oxygen) <40 percent demonstrated by pulse oximetry or blood gas
- Addressing sleep apnea, if applicable

The protocol was initiated in March 2016. The respiratory therapy department was primarily responsible for education. The surgical intensivists, residents, physician assistants, nurse practitioners, respiratory therapists, and speech therapists, all received education on the steps of the protocol and the selection criteria.

The respiratory therapists primarily were responsible for patient identification. The order for initiation or final decannulation could be placed by the surgical intensivists, residents, physician assistants, or nurse practitioners. Respiratory therapists proceeded through the protocol on daily rounding. Speech therapy would assist with speaking valves, if needed. Intensive care unit (ICU) nurses were informed of the protocol, but it did not affect their daily role.

The initial protocol development consisted of one to two representatives from each involved department. Specifically, the director or associate director for the departments of trauma, pulmonology, respiratory therapy, and speech therapy department were involved.

No additional costs were involved beyond the normal hospital operations to implement and maintain this program. This protocol empowered individuals to progress patient care within their skill set and within agreed upon standards.

Results

We conducted a full assessment approximately 18 months after initiation. Propensity matching was used to account for patient age, gender, injury severity score, and duration on a ventilator. We assessed for decannulation rates, time to decannulation after a patient was liberated from the ventilator, and time to discharge after ventilator liberation. Patients treated with the protocol were compared with patients not treated per the protocol. To be considered for the analyses, all patients had to meet the inclusion criteria outlined previously.

A total of 134 patients received care subsequent to the initiation of the protocol; 62 (46 percent) of these patients received treatment that complied with the protocol. In this assessment, patients treated by the protocol were 50 percent more likely to be decannulated (odds ratio [OR] 9.2 [4.0, 21.4], p<0.001). If they were decannulated, it was 1.1 days sooner (p = 0.54). There was no difference in the time to discharge (p = 0.96).

Initiation of the protocol led to a cultural change that affected patient care. By comparing the 134 patients treated since the protocol was made available to 118 patients treated before the protocol was available, we saw similar results. Even if a patient was not treated by the protocol, patients were more likely to be decannulated after the protocol was available (OR 2.1 [1.5, 3], p<0.001). Patients treated since the protocol was implemented were decannulated 5.2 days sooner (p = 0.07) and were discharged 7.3 days sooner (p = 0.04).

One patient did require a reintubation. This patient was treated within the protocol.

Nationally, the standard of
The key factor that made our decannulation protocol successful was the decision to empower the respiratory therapists to advance patient care within a structured system.

Lessons learned
The key factor that made our decannulation protocol successful was the decision to empower the respiratory therapists to advance patient care within a structured system. We did not require additional funding or staff because it incorporated established daily routines.

We had early buy-in from a multidisciplinary standpoint, which was likely secondary to involving members from each department and incorporating their concerns for both patient safety and ease of use. In addition, widespread, in-person education on the protocol and the steps required by each team member allowed for easy adoption. All of these factors were dependent on a strong and trusting relationship between the trauma providers and the respiratory therapists. At our institution, this relationship was well established, but increased communication on patient updates and outcomes could help during the transition period.

For additional details on our methods and results, read our article in Critical Care Explorations, available at https://journals.lww.com/ccejournal/Fulltext/2019/07000/Improving_Tracheostomy_Decannulation_Rate_in1.aspx.

REFERENCES
Over the last few years, the topics of harassment, bullying, and discrimination have come to the forefront of discussion in medicine and society at large. Surgical culture, in particular, has been guilty of perpetuating behaviors that are punitive and promote inequality, negative work environments, and job dissatisfaction. More importantly, such behaviors negatively affect patient care and outcomes. Fortunately, the surgical community’s commitment to combating the patterns of injustice endemic to our culture has recently gathered increasing momentum.

A worldwide issue
Surgical societies around the world are paying increased attention to their role in setting and upholding standards of conduct expected of their active and resident members. A watershed moment occurred in 2015 after Gabrielle McMullin, MCH, FRCSEng, FRACS, vascular surgeon director, South Sydney Vascular Centre, Australia, described a pervasive culture of sexism within the profession of surgery in her country. Professor McMullin claimed that sexual harassment of trainees was widespread and that the system offered little protection for the victims and impunity for the perpetrators.

An independent expert advisory group was commissioned by the Royal Australasian College of Surgeons (RACS), the official body that represents surgeons in Australia and New Zealand, to evaluate the extent of the problem. A national survey conducted as part of the investigation revealed that half of all trainees reported having experienced bullying, discrimination, or harassment, with women and international medical graduates most at risk. Later that year, Prof. David Watters, FRACS, FRCSEd, OBE, then-president of the RACS, issued a formal apology for the destructive behaviors that had become pervasive.

Training on implicit bias will be a crucial measure in preparing physicians to combat these problems in their own daily work environment.
As trainees, we have both the responsibility and opportunity to promote a more positive, respectful, and equitable learning environment to benefit our own education, our daily working environment and that of our colleagues, and most importantly, the care of our patients.

in the RACS training system and launched Operate with Respect to address some of these issues. Mandatory courses for RACS fellows and trainees challenge common biases and assumptions in surgical culture, and provide practical skills and strategies to respond appropriately to unacceptable behavior.

ACS issues statement
Recognizing the international relevance and importance of this topic, the ACS Women in Surgery Committee, with input from the ACS Committee on Diversity, recently developed an updated Statement on Harassment, Bullying, and Discrimination. The ACS Board of Regents approved the statement at its June 7−8 meeting in Chicago, IL. As the Resident and Associate Society of the ACS liaisons to these committees, the authors had the opportunity to contribute to draft and revise this important policy.

Although blatant examples of bullying and harassment can still be found in surgical training, the ubiquitous agreement on the significance of this topic has led to escalating efforts to eliminate the most egregious examples of this behavior. It is unacceptable for attending surgeons to throw instruments at residents in the operating room, for example, and residency programs cannot expect that women residents delay pregnancy. Though not yet consistently acted upon, it is generally accepted that the residency program must have zero tolerance for discrimination based on gender, race, or religion.

In the hierarchical world of surgery, however, some individuals find the everyday indiscretions trainees experience much easier to forgive or overlook. Examples include inappropriate comments, differential treatment of team members, pressure to work longer hours, or punishment for failure to meet unrealistic expectations. The profound imbalance of power between faculty, trainees, and students allows for continuation of negative, yet frequently accepted, behaviors. Implicit—and sometimes explicit—bias at all levels of physician and patient interaction remains a significant contributing factor.

What can you do?
As trainees, we have both the responsibility and opportunity to promote a more positive, respectful, and equitable learning environment to benefit our own education, our daily working environment and that of our colleagues and, most importantly, the care of our patients. As a result of generational and educational differences, today’s trainees are acutely aware of the value of workplace diversity, the importance of inclusion, and the challenge of managing implicit bias—our own and that of others.

It is essential that cultural change is embraced and modeled from the very top. The ACS’ issuance of a disruptive behavior-related statement is a testament to the overall commitment of our leaders and our wider community to end bullying, harassment, and discrimination in surgery. For true change to be realized, however, such commitments must extend beyond high-level discussions and statements into our workplaces and our daily working lives. Education of trainees and trainers, nonpunitive reporting structures, and an enforced policy of zero tolerance within institutions and departments will encourage changes in attitude, culture, and behavior. Training in implicit bias will be a crucial measure in
Education of trainees and trainers, nonpunitive reporting structures, and an enforced policy of zero tolerance within institutions and departments will encourage changes in attitude, culture, and behavior.

preparing physicians to combat these problems in their own daily work environment.

Bystanders are complicit in enabling bullying, harassment, and discrimination in the workplace, and this passivity has been especially problematic in surgery. Most students and residents can readily recall circumstances in which we have witnessed examples of bullying, harassment, or discrimination, even if we ourselves have not been the target.

As trainees, it can be challenging to call out what is wrong or stand up for what is right in the moment within the evident hierarchy of surgical culture. This behavior must change, and it is incumbent on leadership at all levels to promote a culture where it is safe to speak up. It may be difficult or uncomfortable at times, but trainees must find a way to articulate when conduct is outside the standard they expect. It can be especially important to demonstrate these attitudes and behaviors in front of junior team members, who often look to senior trainees to set the tone. The standard we walk past is the standard we accept. For too long as a profession, we have silently witnessed and walked past behavior we know is wrong.

We hope that the College’s statement will inspire you to model and maintain a new standard of professionalism at work—to lead by example at your institution or participate in national efforts to promote a standard of inclusion and equity in surgery. As future leaders in surgery, residents and fellows can contribute in our own way to fostering fair, respectful, and inclusive training and working environments, and ensuring our surgical culture reflects the best—not the worst—aspects of our profession.

REFERENCES


Could axillary reverse mapping be useful in reducing surgical comorbidities?

by V. Suzanne Klimberg, MD, PhD, FACS; Charles Balch, MD, FACS, FASCO; and Judy C. Boughey, MD, FACS

As many as 170 million people worldwide and 3 to 5 million people in the U.S. suffer from secondary lymphedema.1 Many varied procedures have been developed to try to cure lymphedema without tremendous success. Thus, preventing the development of lymphedema is the key to reducing this disease. The techniques of axillary lymph node dissection (ALND) and even of sentinel lymph node (SLN) surgery have yet to be standardized, likely compromising both accuracy of staging and risk of lymphedema. Operative Standards for Cancer Surgery Volumes I and II have introduced surgical standards for these procedures, some of which are being adopted as Commission on Cancer quality measures in 2020.2,3

A recent pooled analysis of 6,711 breast cancer patients who underwent SLN surgery found the incidence of lymphedema to be 6.3 percent, with a range of 0 to 23 percent. A similar analysis of 5,354 patients undergoing ALND found a pooled incidence of 28 percent, with a range of 11 to 57 percent.4 This wide variation in lymphedema rates with the same surgical procedure is related to patient factors, treatment factors, and technical factors associated with how the axillary surgery was performed. Surgeons have good reason to deescalate surgery in order to decrease postoperative complications. Problematic in the deescalation of surgery is that it often is replaced with escalation of radiation to the undissected axilla, which may result in axillary fibrosis and more lymphedema over time.5

SLN surgery and ALND do not distinguish the lymphatics of the breast from the lymphatics draining the upper extremities (UE), and the possibility of mapping the drainage from the UE into the axilla has only recently been published.6-8 Transection of the major UE lymphatics, which can be up to 6mm in diameter, during axillary lymphadenectomy in patients without significant collaterals is most likely the root cause of lymphedema, which is arguably the most widely published complication of both SLN surgery and of ALND. Some might say the risk from SLN surgery is already reasonably low (0 to 13 percent). However, most patients who undergo SLN surgery have negative nodes and then lymphedema occurs in node-negative patients. We should strive to lower the risk of axillary surgery toward zero.

Adding ARM to the armamentarium

Axillary reverse mapping (ARM) may be one tool that can help further refine the technique of axillary staging, whether performing SLN surgery and/or ALND. ARM uses split mapping of the breast and the UE to distinguish lymphatics draining the breast from those draining the UE and preserve them.

In a single-institution prospective phase II trial, 642 patients underwent 685 ARM procedures with SLN surgery and/or ALND.7 Objective lymphedema rates by volume displacement for SLN surgery and ALND were 0.8 percent and 6.5 percent, respectively, with 26-month median follow-up. Blue lymphatics were identified during SLN surgery in 29.2 percent of patients—indicating they were in harm’s way during the dissection to remove the SLNs—and in 71.8 percent of ALND procedures. Metastases
were seen in the blue node in 4.5 percent of the cases and only in patients with advanced N3 disease. In the subset of patients in the phase II trial, in which an identified blue lymphatic was transected, the overall lymphedema rate was 18.7 percent (9/48) when the lymphatic was not reanastomosed/reapproximated, and 0 percent (0/33) when the lymphatic was reanastomosed/reapproximated (p = 0.009) over an average follow-up of 14 months (range 3 to 54 months).

Similarly, Yue and colleagues performed a randomized study in 265 patients undergoing ALND, randomizing patients to ARM versus ALND only. In the control group, 33 percent developed lymphedema, whereas only 6 percent of the patients with UE lymphatic mapping developed lymphedema at 20-month follow-up. In this trial, no reapproximation of lymphatics was performed.

To further evaluate the role of axillary reverse mapping in patients undergoing axillary surgery for breast cancer, the Alliance for Clinical Trials in Oncology has launched a prospective trial to address this question.

**Study design of A221702**

For Alliance A221702: Axillary Reverse Mapping: A Prospective Trial to Study Rates of Lymphedema and Regional Recurrence after Sentinel Lymph Node Biopsy and Sentinel Lymph Node Biopsy Followed by Axillary Lymph Node Dissection with and without ARM, patients with T1-T3, N0-3, M0 disease are eligible for participation if they are undergoing a mastectomy with any axillary surgery (see Figure 1, this page) or if they are having breast conservation therapy with an ALND (see Figure 2, page 60). National Comprehensive Cancer Network guidelines recommend an ALND in any patient treated with mastectomy for a node-positive axilla excluding micro-metastases. Patients undergoing breast conservation surgery and not meeting Alliance Z0011 criteria also are eligible for the trial.

**Study objectives**

The primary objective of the A221702 study is to determine the occurrence of postoperative lymphedema by conical geometric volume measures in clinical T1–3, N0–3, M0 breast cancer patients undergoing axillary surgery and randomized to Group I (no ARM) versus Group II (ARM). Secondary objectives will compare the study groups’ lymphedema symptom intensity and distress as measured by the lymphedema symptom...
The study will evaluate the technical success of performance of ARM procedure, identification of ARM lymphatics and the ability to spare or reapproximate ARM lymphatics, and will compare the rate of regional recurrence between patients randomized to undergo ARM versus patients who are not.

Surgical training

Like the National Surgical Adjuvant Breast and Bowel Project (also known as NSABP)-32 and many surgical trials, the ARM procedure will require training but is easy to learn and apply. Surgeons can watch a YouTube video—available at https://youtu.be/v_Ln11PFvVg—and perform and submit two training cases. Thus, any practicing surgeon could apply this technique to their present practice of lymphadenectomy with minimal training and cost, with a potentially huge benefit of preventing or mitigating lymphedema in our patients.

Successful completion of the proposed study will likely help standardize technical aspects of axillary surgery and launch a new area in the primary prevention of lymphedema. Future studies may use the knowledge gained to determine who is at risk for lymphedema and guide therapeutic surgical interventions for secondary lymphedema.

Any questions related to the A221702 clinical trial should be directed to Suzanne Klimberg, MD, PhD, FACS, at Klimberg1954@gmail.com.

REFERENCES

Matilda A. Evans, MD, was the first African-American woman surgeon licensed to practice medicine in South Carolina. A true renaissance woman, she was not only a surgeon, obstetrician, and gynecologist for more than three decades, but she also founded and ran two hospitals, and was an educator, humanitarian, public health advocate, and author.

Family background and education
The eldest of three children, Dr. Evans was born in 1872 to Anderson and Harriet Evans in Aiken, SC. After her mother died when Matilda was eight years old, her grandmother, Edith Willis Corley—a lay midwife—and her uncle—an herbalist who treated people without access to physicians—became prominent influences in her life and exposed her to the world of service in health care. Matilda decided at a young age to become a physician, despite having never met a woman in that role. As a child, she played doctor just as other children played house, made “medicines” from leaves, and “pills” from clay.

At age 13, she was offered a place in the nearby Schofield Portrait of Dr. Evans in the official program of the Bishops’ Council of the African Methodist Episcopal Church (courtesy of the R. Carroll Papers, South Caroliniana Library, University of South Carolina, Columbia, SC)
Normal and Industrial School founded by Martha Schofield, a prominent Quaker and abolitionist. Matilda was a brilliant student and quickly rose to the top of her class. Ms. Schofield encouraged Matilda to pursue a medical career and helped her obtain a scholarship to attend Oberlin College, OH. She then taught for several years before entering the Woman’s Medical College of Pennsylvania, Philadelphia, and graduating in 1897.

Surgical leader, educator, and mentor

After graduation, Dr. Evans opened her practice in Columbia, SC. Because no medical facilities during that time would allow an African-American physician to admit and treat patients, she started a hospital and nursing school in her home. Dr. Evans built a large clientele of wealthy white women who sought her services for medical problems they wanted to keep confidential. These patients paid her sufficiently, which enabled her to treat poor black women and children for free.

In 1901, she established the Taylor Lane Hospital and Training School for Nurses, Columbia. When the hospital ran into financial trouble, Dr. Evans gave up her home and moved into the hospital. She asked all of her staff to work without pay for 90 days and started farming the land around the hospital to pay the bills. Later, after a fire...
destroyed Taylor Lane Hospital, Dr. Evans founded the St. Luke’s Hospital and Training School for Nurses. Dr. Evans closed St. Luke’s in 1918 when she began service in the U.S. Medical Service Corps during World War I. She supported other women who wanted to pursue medical careers, and some of the letters that she wrote on behalf of other women are preserved in the Drexel University College of Medicine Legacy Center Archives & Special Collections, Philadelphia (see Figure 1, this page).

Public health advocate
Dr. Evans was a strong advocate for community medical education and for improved health care for black children. She conducted physical exams of black children within Columbia’s public school system and found many children with undiagnosed diseases and ailments. As a result of her work, routine health examinations of children in Columbia’s public schools were implemented, and these exams eventually became part of a permanent health care program. In 1931, she founded the Columbia Clinic Association, the city’s first free clinic for black children. On the day the clinic opened, more than 700 people came in for evaluations and for services such as vaccinations.

Dr. Evans later founded the Negro Health Association of South Carolina, which provided health education to minority families throughout the state. She served as president of the Palmetto State Medical Society in 1922 and as regional vice-president of the National Medical Association.

An author and editor, she wrote about the life and work of Martha Schofield and also founded and ran The Negro Health Journal of South Carolina. Dr. Evans never married; she adopted and raised seven children and served as a foster parent for more than two dozen others. She died in 1935 at the age of 63 after a short illness, leaving a remarkable legacy of service to her patients, students, and community despite the daunting obstacles of a segregated society and limited resources.

BIBLIOGRAPHY
JAMA Surgery “Viewpoint” misrepresents Joint Commission’s role in the opioid epidemic

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

A “Viewpoint” published in JAMA Surgery in August 2019 perpetuated the falsehood that pressure from The Joint Commission in part led to the opioid epidemic.

As I see it, the author makes two major contentions related to The Joint Commission in “When a vital sign leads a country astray—the opioid epidemic.” The first asserts that The Joint Commission pain standards that went into effect in 2001 resulted in a significant increase in opioid prescriptions, and the second is that The Joint Commission created the concept of “pain as a fifth vital sign.” Both assertions are incorrect.

Did The Joint Commission 2001 pain standards cause a substantial increase in the prescription of opioid medication?

Total opioid prescriptions had been increasing in the U.S. for at least 10 years before The Joint Commission’s pain standards went into effect in 2001 (see Figure 1, page 65). According to data gathered by the National Institute on Drug Abuse, the number of opioid prescriptions dispensed by U.S. pharmacies between 1991 and 1997 (well before the pain standards were released) increased from 76 million to 97 million. Moreover, no incremental increase or change occurred in the rate of increase after the standards were released in 2001. To claim otherwise simply ignores these facts.

The increase in opioid prescribing actually dates back to the 1980s—perhaps in response to the health care industry’s past failure to adequately assess and treat pain. In 1990, then-president of the American Pain Society Mitchell Max, MD, penned an editorial in the Annals of Internal Medicine that spoke to the lack of improvement in those areas. In his editorial, Dr. Max offered the following recommendations:

• Make pain “visible”
• Provide tools to the care team for better analgesic treatment
• Keep patients in the communication loop with their care team
• Hold physicians accountable for inadequate pain control

In response to the outcry over the widespread undertreatment of pain, The
Joint Commission established standards for pain assessment and treatment in 2001. The 2001 standards required that hospitals and other health care facilities establish policies regarding pain assessment and treatment and that they educate their health care professionals to ensure compliance. The standards did not, however, require the use of drugs to manage a patient’s pain. If a pain drug was appropriate, the 2001 standards did not specify which drug should have been prescribed.

Thus, the authors are illogical in their conclusion that placing the responsibility for pain management on health care facilities is wrong or somehow contributed to today’s epidemic. It is analogous to suggesting that our emphasis on the management of sepsis with antibiotics has led to the development of bacterial resistance.

In accordance with its mission to continuously improve health care for the public, The Joint Commission revised its pain standards in 2016—with the revisions going into effect in 2018 across all of The Joint Commission’s accreditation programs. The process involved rigorous research, evaluation, and review, ultimately leading to new and revised pain assessment and management standards.

Among the new requirements were the following:

- Identify a leader or leadership team to be responsible for pain management and safe opioid prescription
- Engage patients to participate in the development of their treatment plans, while setting realistic expectations and measurable goals
- Improve access to drug monitoring tools and databases for care teams, as well as the availability of nonpharmacological therapy
- Educate patients on the addictive nature of opioids and how to
As surgeons, we must do our part by working with our patients, setting the right expectations, managing anxiety and fear, and using all the modalities available today to provide the most efficient and safe treatment to manage pain.

Did The Joint Commission create the concept of the “fifth vital sign?”

The “Viewpoint” published in JAMA Surgery also misrepresents The Joint Commission regarding the “fifth vital sign,” a concept that the American Pain Society developed and that gained the attention of the U.S. Department of Veterans Affairs (VA).

While The Joint Commission included the VA’s initiative in its “Examples of Implementation”—which was released in 2001 along with the pain standards—it was removed from the “Examples of Implementation” in 2002 when concerns about the fifth vital sign were raised.

The outlook moving forward

Good news is on the horizon. The Centers for Disease Control and Prevention states that drug overdose remains the leading cause of unintentional injury-associated death in the U.S.—with 24.2 percent of fatal drug overdoses in 2017 involving prescription opioids. However, the number of opioids prescriptions being dispensed has declined since 2013.2,4

In the meantime, The Joint Commission will continue to do its part to address the opioid epidemic by striving to inspire the more than 22,000 health care institutions it accredits and certifies, as well as all health care professionals who work in those facilities, to provide the safest, highest-quality care to patients.

As surgeons, we must do our part by working with our patients, setting the right expectations, managing anxiety and fear, and using all the modalities available today to provide the most efficient and safe treatment to manage pain.

REFERENCES


Disclaimer

The thoughts and opinions expressed in this column are solely those of Dr. Pellegrini and do not necessarily reflect those of The Joint Commission or the American College of Surgeons.
Editor’s note: The Bulletin team thanks Dr. Fantus for his dedication to writing these lively and informative columns every month for the last 17 years. He has been a pleasure to work with, and we wish him good health and happiness in the future.

This month’s column marks the 200th consecutive monthly appearance of National Trauma Data Bank® (NTDB®) data points. I am thankful to have been able to contribute to the Bulletin and promote the NTDB over the years.

The fourth Thursday of this month is Thanksgiving. Thanksgiving is an annual North American holiday with religious observations to give thanks for the harvest and for health. In the U.S., the holiday lands on the fourth Thursday of November, whereas in Canada it is on the second Monday in October.*

In November 1621, Massachusetts Gov. William Bradford invited the Native American allies of the Plymouth colonists to help celebrate the first successful corn harvest. Members of the Wampanoag tribe brought food to share and participated in a three-day celebration. It is unclear whether turkey was part of this feast. The members of the Wampanoag tribe brought deer and local seafood, which would have included mussels, lobster, and bass, along with the season’s first harvest of corn and pumpkin.†

Today, approximately 46 million turkeys are cooked each Thanksgiving. Another 50 million pumpkin pies are consumed—along with all the other fixings—and that may be responsible for a meal that can total more than 3,000 calories, including 229 grams of fat, even before participants go back for seconds.‡

To examine the occurrence of injuries sustained during the 24 hours of Thanksgiving Day 2017, NTDB research admission year 2017 medical records were searched using an injury incident date of Thanksgiving Day, November 23. A total of 5,441 records were found, 4,533 of which contained a discharge status, including 2,997 patients discharged to home, 587 to acute care/rehab, 757 to skilled nursing facilities, and 36 to law enforcement; 156 died (see Figure 1, page 68). Of these patients, 60 percent were men, were on average 50.7 years of age, and had an average hospital length of stay of five days, an intensive care unit length of stay of 4.8 days, an average injury severity score of 9.3, and were on the ventilator for an average of 5.6 days. The top three mechanisms of injury accounting for more than 80 percent of all cases were fall (50.7 percent), motor vehicle-related (24.2 percent), and struck by/against (7.1 percent) (see Figure 2, page 68). Of those tested for alcohol, more than 27 percent (629 out of 2,299) tested positive.

American College of Surgeons (ACS) Committee on Trauma (COT) NTDB Subcommittee meeting that he chaired. We then went on to collaborate on the first 47 monthly columns.

I would like to thank the staff of the ACS COT, who have assisted with the data collection over these past 17 years, as well as the great editorial team of the Bulletin. I also would like to thank all of my co-authors, including my two sons, who have joined the Resident Member ranks of the ACS. Lastly, I would like to thank my wife, who proofread all of these columns before I sent them to the Bulletin editorial team. I wish you a happy holiday season.

If you are interested in obtaining Trauma Quality Programs (TQP) data for your own analysis, or your trauma center is interested in participating in the TQP, you can e-mail us at traumaquality@facs.org or find more information at facs.org/quality-programs/trauma/tqp.

Acknowledgment
Statistical support for this column was provided by Ryan Murphy, Data Analyst, NTDB.
Valerie W. Rusch, MD, FACS, an esteemed thoracic surgeon from New York, NY, was installed as the 2019–2020 President of the American College of Surgeons (ACS) at the Clinical Congress 2019 Convocation, October 27 in San Francisco, CA. The First and Second Vice-Presidents also were installed at this event.

Dr. Rusch is vice-chair, clinical research, department of surgery; Miner Family Chair in Intrathoracic Cancers; attending surgeon, thoracic service, department of surgery, Memorial Sloan-Kettering Cancer Center, New York, NY; and professor of surgery, Weill Cornell Medical College, New York.


As a young faculty member at the University of Washington, Seattle, she served as Field Liaison Fellow to the CoC for the Seattle Veterans Affairs and University Hospitals and as a Councilor of the ACS Washington State Chapter. For more than 15 years, Dr. Rusch has been closely involved in the American Joint Committee on Cancer (AJCC) and has served as Chair of the Lung and Esophagus Task Force for the 6th and 7th editions of the AJCC Cancer Staging Manual, and as Chair, Thoracic Expert Panel for the recently published 8th edition of the AJCC Cancer Staging Manual, personally authoring several of the thoracic chapters for those manuals. In addition to speaking at various ACS Postgraduate Courses and Clinical Congress Scientific Sessions, Dr. Rusch delivered the John H. Gibbon, Jr., Lecture at Clinical Congress 2014.

Dr. Rusch specializes in the diagnosis and treatment of patients with cancers of the lung, airways (trachea, bronchi), esophagus, mediastinum, chest wall, and pleura (malignant pleural mesothelioma). She was among the first women in the U.S. to be board certified in thoracic surgery.

For more than 30 years, she has emphasized a multidisciplinary approach to treating patients with thoracic malignancy. Her research has focused on the molecular behaviors of asbestos cancers and the genetic tendencies of lung cancer as a means to identify certain cancers in the earlier stages.

Dr. Rusch has been a leader in national and international clinical trials for the treatment of thoracic malignancies and played a pivotal role in establishing the ACS Oncology
An ACS Fellow since 1986 and the 2018 recipient of the ACS Distinguished Service Award, Dr. Rusch has been a leader in national and international clinical trials for the treatment of thoracic malignancies and played a pivotal role in establishing the ACS Oncology Group—now known as the ACS Clinical Research Program.

Among her many honors, in 2007, Dr. Rusch received the Thoracic Surgery Foundation for Research and Education Socrates Award, and in 2012, the Association of Women Surgeons awarded her The Nina Starr Braunwald Award for lifetime contributions to the advancement of women in surgery. She received the Henry Harkins Award from the Washington State Chapter, as well as the Outstanding Teacher Award, department of surgery, and the Willet F. Whitmore Award for Clinical Excellence, Memorial Sloan Kettering Cancer Center. The Mesothelioma Applied Research Foundation has honored Dr. Rusch with the Pioneer Award for clinical research in malignant mesothelioma.

She has held 25 visiting professorships and lectureships and given more than 300 major lectures on thoracic cancers at medical conferences around the world. Her curriculum vitae boasts more than 400 peer-reviewed publications.

In addition to the ACS, Dr. Rusch has been a leader of other surgical organizations. She served as chair of the American Board of Thoracic Surgery, chair of the Lung and Esophagus Task Force of the AJCC, and chair of the Mesothelioma Subcommittee of the International Association for the Study of Lung Cancer Staging Committee. She is a member of the American Association for Cancer Research, Association for Thoracic Surgery, American College of Chest Physicians, American Radium Society, American Surgical Association, American Thoracic Society, Association for Academic Surgery, Society of Surgical Oncology, and Society of Thoracic Surgeons. She is an honorary member of the European Society of Thoracic Surgeons and the Society for Cardiothoracic Surgery in Great Britain and Ireland.

Dr. Rusch is fluent in both French and English, having graduated from the Lycée Français de New York. She graduated with honors from Vassar College, Poughkeepsie, NY, with a degree in biochemistry and Alpha Omega Alpha with her medical degree from the Columbia University College of Physicians and Surgeons, New York, and completed surgical residency training in general surgery and thoracic surgery at the University of Washington, followed by a fellowship at the University of Texas MD Anderson Cancer Center, Houston.

**First Vice-President**

The First Vice-President is John A. Weigelt, MD, DVM, FACS, who recently retired as the Milton and Lidy Lunda/Charles Aprahamian Professor of Trauma Surgery; professor and chief, division of trauma and critical care; and associate dean for quality, Medical College of Wisconsin (MCW), Milwaukee. Dr. Weigelt is a general surgeon with an emphasis on trauma, critical care, and acute care surgery. Dr. Weigelt is now on the faculty of Sanford Health System and the University of South Dakota, Sioux Falls.

A Fellow since 1982 and the recipient of the 2015 ACS Distinguished Service Award, Dr. Weigelt has been a leader of ACS trauma programs. He has been a member of the ACS Committee on Trauma (COT) since 1992, serving as COT Chair (1994–1998) and...
Dr. Weigelt has been active in state-level ACS activities, serving as Chair, North Texas Chapter COT, and Council Member, North Texas Chapter (both 1983–1989). He has also been a member of the Minnesota and Wisconsin chapters.

He joined the faculty of the MCW in 1999 and served on MCW’s Residency Education and Evaluation Committee, Executive Committee, and Peer Review Committee and is past-chair of the MCW’s Society of Teaching Scholars.

At Froedtert Hospital, Milwaukee, he chaired the trauma committee (1999–2017) and the joint quality committee (2004–2015). He served as the first medical director of quality at Froedtert (2005–2015). Earlier faculty appointments include positions at University of Texas (UT), Dallas; Parkland Memorial Hospital, Dallas; Dallas Veterans Medical Center; Presbyterian Hospital, Dallas; St. Paul Medical Center, MN; Zale-Lipsky University Hospital, Dallas; University of Minnesota, St. Paul; Regions Hospital, St. Paul; Gillette Children’s Hospital, St. Paul; North Memorial Medical Center, Minneapolis, MN; Fairview University Medical Center, Minneapolis; Regina Medical Center, Hastings, MN; and Osceola Medical Center, WI. While at UT Southwestern Medical Center, Dallas, his clinical activities were acknowledged by the Weigelt-Wallace Award in 1991, which recognizes clinical excellence and dedication to patient care. In 2012, he was awarded the Thomas L. Smallwood Award for Patient Care Excellence by the board of directors of Froedtert Hospital.

As professor at the University of Minnesota (1992–1999), he was twice awarded the Wagensteen Award for Excellence in Teaching (1993, 1999). In 2002, he was awarded the Association for Surgical Education Outstanding Teacher Award. And since joining MCW, he has twice been awarded the Teacher of the Year Award (2004, 2010). In 2013, he was honored by being elected one of the Giants of General Surgery by UT Southwestern and Parkland Foundation.

In addition to the ACS, Dr. Weigelt is or has been a member of many other honorary and professional
A Fellow since 1982 and the recipient of the 2015 ACS Distinguished Service Award, Dr. Weigelt has been a leader of ACS trauma programs and also has been involved in many of the College’s educational programs.

Dr. Weigelt is a graduate of Michigan State University, Lansing, where he also earned his doctor of veterinary medicine degree. He received the Distinguished Alumni Award from Michigan State University in 1993 and in 2017 the MSU Veterinary School awarded him its Distinguished Alumni Award. He completed his medical degree at MCW and his internship and residency at UT Southwestern. He received his master’s in hospital administration from the University of Wisconsin-Madison.

Second Vice-President
The Second Vice-President is F. Dean Griffen, MD, FACS. Dr. Griffen is clinical professor of surgery at Ochsner Louisiana State University Health Sciences Center-Shreveport (LSUHSC-S). Having served in several different capacities over the last 12 years (including acting chair of the department of surgery), he is now an active member of the Ochsner LSU department of surgery, division of general surgery.

For 35 years, Dr. Griffen was in private practice at the Highland Clinic, Shreveport,
A Fellow of the College since 1975 and the 2009 recipient of the Distinguished Service Award, Dr. Griffen has been recognized for his groundbreaking work on the ACS Closed Claims Study, which offered insights into ways to improve surgical care and reduce liability through professional behavior.

where he and his partners developed and introduced the double-stapling technique for low rectal reconstruction.

A Fellow of the College since 1975 and the 2009 recipient of the Distinguished Service Award, Dr. Griffen has served the organization in the following capacities: member, Health Policy Steering Committee (2007–2010); Vice-Chair, Comprehensive Communications Committee (2006–2011); Liaison, Program Committee (2003–2006); and Chair, Committee on Patient Safety and Quality Improvement (2002–2006). He was a member of the Board of Governors (1993–1999), serving as Vice-Chair of the Governors’ Nominating Committee (1998–1999) and Chair of the Governors’ Committee on Physician Competency (1997–1999). He is Past-President of the Louisiana Chapter of the ACS (1992–1993) and a former member of the Louisiana Credentials Committee (2000–2005).

Dr. Griffen has been recognized for his groundbreaking work on the ACS Closed Claims Study, which offered insights into ways to improve surgical care and reduce liability through professional behavior. He led numerous seminars, Postgraduate Courses, and mock trials at Clinical Congress on the issues of liability and professionalism. In addition to Dr. Griffen’s involvement with the College, he has been a leader of numerous surgical and medical associations. He is a past-president of the Southern Society of Clinical Surgeons, Surgical Association of Louisiana, John C. McDonald Surgical Society, Louisiana State Medical Society (LSMS), and Shreveport Medical Society. Dr. Griffen also has chaired the Louisiana Patients’ Compensation Fund Oversight Board and served as vice-president of Southern Surgical Association. He was elected to the LSMS Hall of Fame in 2016. Recently, Dr. Griffen was appointed to the Louisiana Medical Disclosure Panel and serves at the discretion of Louisiana’s governor.

Dr. Griffen is a graduate of Louisiana State University Medical School, New Orleans, and trained in general surgery at LSUHSC-S. Following two years as a Lieutenant Commander in the U.S. Navy, he practiced general, thoracic, and vascular surgery in Shreveport at the Highland Clinic before joining the core faculty at LSUHSC-S in 2007. Dr. Griffen is the recipient of the 2010 as well as the 2011 Clarence Webb Clinical Instructor of the Year Award at LSUHSC-S and received the Allen Copping Award for best clinical educator in 2011. ♦
Patricia J. Numann, MD, FACS, receives ACS Lifetime Achievement Award

Patricia J. Numann, MD, FACS, Past-President of the American College of Surgeons (ACS) and a general surgeon from Syracuse, NY, received the ACS Lifetime Achievement Award at the Clinical Congress 2019 Convocation, October 27 in San Francisco, CA. Dr. Numann is the Lloyd S. Rogers Professor of Surgery Emeritus, State University of New York (SUNY) Upstate Medical University, Syracuse; SUNY Upstate Distinguished Service Professor, and SUNY Upstate Distinguished Teaching Professor Emeritus.

Dr. Numann is the fourth surgeon to be accorded the ACS Lifetime Achievement Award. Previous recipients are as follows: C. Rollins Hanlon, MD, FACS, Past-Director of the ACS; George F. Sheldon, MD, FACS, ACS Past-President; and Thomas R. Russell, MD, FACS, Past-Executive Director of the ACS.

Dr. Numann became a Fellow of the College in 1974 and has actively contributed to the work of the ACS for many years. She has attended every Clinical Congress since 1969. Most recently, she served on the ACS Foundation Board of Directors (2011–2018), starting as an ex officio member during her College presidency. Among her other leadership positions in the ACS, she served as ACS Second Vice-President (1999–2000) and as Director, ACS Fundamentals of Surgery Curriculum (FSC), and led the ACS FSC Steering Committee. She continues to serve as ACS FSC Co-Chair and on the ACS Entering Resident Readiness Assessment Committee.

Previously, Dr. Numann was a member of the Board of Regents Communications Committee (1999–2000), Advisory Council for General Surgery (1999–2002), Graduate Medical Education Committee (1992–1994), and member (1992–1994) and Chair (1994–1995) of the Nominating Committee of Fellows and Committee on Surgical Education in Medical Schools (1986–1996). She joined the ACS Surgical Education and Self-Assessment Program (SESAP®) Committee in 1976 for SESAP 3 and served as Co-Chair (1983–1999) through eight successful releases—SESAP™ 3 through SESAP™ 10. In 2006, the ACS recognized Dr. Numann for her invaluable service contributions by naming her the recipient of its Distinguished Service Award, the College’s highest honor. In 2018, she was selected as an inaugural Fellow of the ACS Academy of Master Surgeon Educators.

In addition to the ACS, Dr. Numann has been an active leader and member of several other national surgical and medical organizations. In 1987, she was elected to the American Medical Association Council on Scientific Affairs. She was the first woman to serve as chair of the esteemed American Board of Surgery (1994–2002) and was vice-president of the American Association of Endocrine Surgeons (1992). Dr. Numann was one of the founding members and president of the Association for Surgical Education (1985–1986) and founded the Association of Women Surgeons (AWS) in 1982 and later served as its president (1986–1987).

Throughout her remarkable career, Dr. Numann has received numerous honors and awards at the local, state, and national level, including the New York State Woman of Distinction in Medicine Award (1994); the AWS Nina Starr Braunwald Award (1998); and the Susan G. Komen Breast Cancer Foundation Distinguished Service Award (2001). The Carol M. Baldwin Breast Cancer Research Fund of Central New York named her Humanitarian of the Year in 2003. Dr. Numann was...
inducted into the International Women Physicians’ Hall of Fame and named a “Local Legend” to the National Library of Medicine’s “Changing Faces of Medicine” exhibit (2004). In 2011, she was awarded the Davis Prize of the International Society of Surgery/Société Internationale de Chirurgie—its highest honor. She received the American Medical Women’s Association Elizabeth Blackwell Award and the Lila M. Wallis Women’s Health Award.

Throughout her surgical career, Dr. Numann’s clinical and scientific interests have focused on breast disease and thyroid and parathyroid disease, a commitment reflected in the establishment of the Breast & Endocrine Surgery Center at SUNY Upstate in 1986. Moreover, she received grants and served as principal investigator or co-investigator of several studies researching various aspects of breast and endocrine disease. When
Throughout her surgical career, Dr. Numann’s clinical and scientific interests have focused on breast disease and thyroid and parathyroid disease, a commitment reflected in the establishment of the Breast & Endocrine Surgery Center at SUNY Upstate in 1986.

Dr. Numann authored or co-authored several chapters in surgical textbooks, as well as numerous journal articles and abstracts, many of which focus on breast and parathyroid disease. She has served on the editorial boards of several prestigious medical and surgical journals including the Journal of Surgical Research, Journal of the American College of Surgeons, and World Journal of Surgery.

Dr. Numann resides in Syracuse, where she continues to devote herself to many teaching and community service organizations, including the boards of the Everson Museum of Art, The Community Health Foundation of Western and Central New York, and Vera House. She chairs the Carol M. Baldwin Breast Cancer Research Funds grant committee and remains an active advocate for women surgeons. She is regularly invited to national and international meetings to speak about topics related to career success and development for women surgeons. She supports Women in Surgery Africa by attending their annual meetings at the College of Surgeons of Eastern, Central, and Southern Africa (COSECSA), participating in the COSECSA fellowship exams and mentoring women surgeons in Africa. She is an honorary fellow of the Royal College of Surgeons of Glasgow, Academy of Medicine and Surgery of Malaysia, Association of Surgeons of India, Royal College of Surgeons of Edinburgh, and Royal College of Surgeons of Thailand.

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Retired U.S. Army Colonel Norman M. Rich, MD, FACS, DMCC, MC, received the first American College of Surgeons Distinguished Military Lifetime Achievement Award as part of the Clinical Congress 2019 Convocation, October 27 in San Francisco, CA. This award recognizes Dr. Rich’s “outstanding contributions to surgery during military service and as a pioneer of modern vascular surgery.” According to the award citation, his “expertise has brought vascular injury management into a new age, particularly with arteriovenous injuries to the extremity that spared many soldiers from limb amputation or death.” Military and civilian patients have benefitted from the Vietnam Vascular Registry he created in 1966, which contains data on more than 10,000 reported cases treated by surgeons involved in vascular trauma during wars or conflicts.

Dr. Rich has trained literally an army of top-quality military and civilian surgeons. It is for all these reasons, along with his many years of active duty military service in the U.S. Army Medical Corps, that the College’s Honors Committee recognized him with this honor.

Born in Ray, AZ, January 13, 1934, Dr. Rich attended the University of Arizona, Tucson, before transferring to Stanford University, CA, where he earned a bachelor of arts degree in 1956 and a medical degree in 1960. He completed a rotating internship at the U.S. Army Tripler General Hospital (now known as Tripler Army Medical Center) in Honolulu, HI, and a general surgery residency at Letterman General Hospital (now Letterman Army Hospital), San Francisco, CA. He was assigned to the Second Surgical Hospital as chief of surgery, first at Fort Bragg, NC, in 1965 and later in An Khe in the Republic of Vietnam (1965–1966). As a young, newly trained surgeon and the chief of surgery, 2nd Mobile Army Surgical Hospital unit during the Vietnam War, Dr. Rich refined vascular surgical techniques, particularly for arteriovenous injuries to the extremity, emphasizing the importance of venous and arterial system repairs. His expertise and newly espoused techniques helped save scores of soldiers from limb amputation or death, and has led him to be known as the surgeon who heralded a new age in vascular injury management, with particular focus on venous reconstruction.
as the surgeon who heralded a new age in vascular injury management, with particular focus on venous reconstruction.

He was the first vascular surgery fellow at Walter Reed General Hospital (1966–1967), Washington, DC, and assumed the position of chief of vascular surgery and director of the vascular fellowship program in 1967, a post he held until 1978.

His initial academic appointment was as associate professor, George Washington University, Washington, DC (1973–1978). He was appointed professor of surgery at the Uniformed Services University of the Health Sciences (USUHS) School of Medicine in 1976, and became the first chairman of the department of surgery in 1977. At the time of his retirement from active duty in 1980, he made a second commitment to serve as chairman. He served as chief, division of vascular surgery (1977–1999), and director of the Vietnam Vascular Registry. He was the academic advisor to the department of surgery, and co-directed the vascular fellowship program at Walter Reed Army Medical Center from 1978 onward, and became emeritus in 1993. He was appointed professor of military medicine in 1983.

He became the Leonard Heaton and David Packard Professor in 1999—a post named for two USUHS founders. He stepped down as the founding chairman of surgery in October 13, 2002, after more than 25 years of service, and USUHS announced the establishment of the Norman M. Rich Department of Surgery. When his successor, 1982 USUHS graduate Colonel David Burris, MD, FACS, deployed to Iraq in 2003, Dr. Rich stepped in as acting chairman. With the untimely death of Colonel Burris in August 2010, Dr. Rich continued to serve as interim chair, with Captain Patricia L. McKay, MD, FACS, as deputy chairman. He served as senior advisor to the third Uniformed Services University (USU) chair of surgery, Captain Eric A. Elster, MD, FACS, working with him and David B. Hoyt, MD, FACS, ACS Executive Director, in the early development of the Military Health System Strategic Partnership ACS.

At USUHS (now known as USU), he was named the Outstanding Civilian Educator (1983–1984), and was awarded the Exceptional Service Medal (1989), the Outstanding Service Medal (2000), the USU Medal (2001), and the Carol Johns Medal as the Outstanding Faculty Member (2003). He also is a founder of USU Surgical Associates.

Dr. Rich has earned international recognition and lectured in more than 45 countries. He has published more than 300 manuscripts and has been the author or co-author of five books, including the first edition of Vascular Trauma, written with ACS Past-President Frank C. Spencer, MD, FACS, as well as two subsequent editions of the textbook. He has served on 10 editorial boards of clinical journals, including Cardiovascular Surgery, Journal of Trauma, Journal of Vascular Surgery, Phlebology,
and Surgery. In 2009, he became the international co-editor of the *Polish Journal of Surgery*.

A Fellow of the ACS since 1970, Dr. Rich served on the College’s Board of Governors (1983–1989), Committee on Chapter Relations (1985–1989), Committee on Trauma (1980–1995), International Relations Committee (1976–1986), and Surgical History Group Executive Committee (2017–2018). He became an Instructor for the ACS Advanced Trauma Life Support® course in 1980 and received the 2003 Surgeons’ Award for Service to Safety from the ACS, the American Association for the Surgery of Trauma (AAST), and the National Safety Council. In 2014, he delivered the Excelsior Surgical Society/Edward D. Churchill Lecture at the centennial Clinical Congress and received the First Distinguished Organization Award from the ACS Foundation in 2015 for the Norman M. Rich Department of Surgery’s efforts to establish the USU Surgical Associates’ Military Professor of Surgery Fund at the ACS. He became the first Honorary Member of the revitalized Excelsior Surgical Society at Clinical Congress 2016.


He is a member or honorary member in many international surgical societies, holds honorary degrees from several international universities, and is an Examiner for the Apothecaries of London, U.K. His military awards include the Legion of Merit, the Bronze Star, and the Meritorious Service Award. He received the Médaille D’Honneur from France in 1991. In 1999, he received the J. E. Wallace Sterling Lifetime Alumni Achievement Award from the Stanford Medical Alumni Association. Dr. Rich has received a number of other distinguished honorifics from international and North American surgical societies and is a recipient of the Frank Berry Prize in Federal Health Care. In 2010, the Peripheral Vascular Surgery Society established The Norman M. Rich Lecture in Vascular Trauma.
Honorary Fellowship in the American College of Surgeons was awarded to 12 prominent surgeons from around the world at the October 27 Convocation at Clinical Congress 2019 in San Francisco, CA. The granting of Honorary Fellowships is one of the highlights of Clinical Congress; this year’s recipients were as follows.

Prof. Italo F. Braghetto, MD, MHA, FACS, of Santiago, Chile, specializes in gastric and esophageal surgery, is an academic surgeon who has been a devoted teacher active in building an international surgical network in Latin America, and a supporter of scientific surgical societies. Professor Braghetto has contributed to numerous books, book chapters, and more than 400 scholarly publications on gastric and esophageal surgery. He is a recognized surgical leader in Latin America and is a member of many national and international surgical societies.

Prof. Laurence Chiché, MD, PhD, professor of surgery and director, department of surgery, Bordeaux University, France, is a recognized gastrointestinal surgeon, clinical investigator, educator, and leader. She is an accomplished scholar in the field of transplantation, and her program at Bordeaux is the second largest liver transplantation program in France. Professor Chiché has made formative contributions to solving a variety of clinical problems in hepatobiliary and liver transplantation surgery. She is widely considered nationally and internationally to be a thought leader in this discipline and has served as a research mentor and doctoral thesis advisor to multiple candidates.

Prof. Ian D.S. Civil, MBChB, FACS, FRACS, director of trauma services, Auckland Hospital, New Zealand, is a broadly trained general, vascular, and trauma surgeon. He is clinical director for the Major Trauma National Clinical Network and clinical leader for the Safe Surgery New Zealand Expert Advisory Group for the Health Quality and Safety Commission of New Zealand. He has been a primary force in the development of trauma care in New Zealand and now has assumed leadership in establishing national quality assurance standards in system development. He has been a long-time supporter and active member of the ACS, having also served as a President of the Australia-New Zealand Chapter and Governor at-Large for the chapter.

Prof. John M.P. Hyland, MCh, FACS, FRCS, FRCSI, FRCSEd(Hon), consultant general and colorectal surgeon, St. Vincent’s University Hospital, Dublin, Ireland, is founder of the hospital’s Centre for Colorectal Disease, which provides multidisciplinary care and uses educational and clinical research to improve the clinical management of colorectal patients. Among his many contributions in the field of colorectal cancer treatment, perhaps the most notable occurred in the early 1980s when he developed a clinical database of patients with colorectal cancer and inflammatory bowel disease, which resulted in clinical research publications. He is a lead educator in minimally invasive surgery and preceptor in laparoscopic surgery in the U.K.

Prof. Yoko Kato, MD, PhD, is professor and chair, department of neurosurgery, Fujita Health University Banbuntane Hotokukai Hospital, Aichi, Japan. In 2006, she became the first woman professor of neurosurgery in Japan and, ultimately, chair of the department of neurosurgery and chief of the stroke center at the hospital. She is recognized by her peers as one of the foremost authorities on the surgical management of brain aneurysms and has performed more than 1,800 brain aneurysmal clipping procedures throughout her career. The volume of procedures, using state-of-the-art technology, has attracted many young neurosurgeons to study at her institution each year.

Prof. Marek Krawczyk, MD, PhD, professor and chairman, department of general, transplant, and liver surgery; and president, Medical University of Warsaw, Poland, has been intimately involved in resident training in general surgery and transplant surgery, has mentored 17 doctor of philosophy (PhD) students, and served as an advisor or reviewer for 47 PhD students. Professor Krawczyk was the first Polish surgeon to obtain the European Honorary Certificate as an expert in liver, pancreas,
and hepatobiliary surgery and he personally established the first successful liver transplant program in Poland.

Prof. Antonio M. de Lacy Fortuny, MD, PhD, is head, gastrointestinal surgery service, and chief, minimally invasive surgery department, Hospital Clinic, Barcelona, Spain. One of his most important pioneering contributions was as the investigator and author of the “Barcelona trial,” the world’s first randomized control trial showing the acceptability of laparoscopic colorectal surgery for the cure of colonic carcinoma. He also is known for the development and implementation of natural orifice transluminal surgery, including transoral esophageal anti-reflux surgery, transvaginal sleeve gastrectomy, and transanal total mesorectal excision for rectal cancer.

Prof. Ari Kalevi Leppäniemi, MD, PhD, is professor of surgery, abdominal center, Meilahti Hospital, and chief, division of emergency surgery and surgical critical care, University of Helsinki, Finland. He is an internationally recognized leader in the care of the injured patient, critically ill, emergency general surgical patient, and in the reconstruction of the patient with major abdominal compartment syndrome complications. He has cared for the underserved in Nigeria; served as a field surgeon during the civil wars in Cambodia, Sudan, and Afghanistan; and was a volunteer surgeon in the South Pacific.

Prof. Neil Mortensen, MBChB, MD, MA, FRCSEng, FRCPSGlasg(Hon), FRCSEd(Hon), FRCSI(Hon), is professor of colon and rectal surgery, University of Oxford Medical School, and honorary consultant colorectal surgeon and a fellow of Green Templeton College, U.K. A former ACS Paul Hawley International Guest Scholar, he has published more than 350 original peer-reviewed manuscripts, 30 book chapters, and has edited eight books. Professor Mortensen’s world renown has been recognized in part by the numerous named lectures he has delivered in the U.K., Europe, Australasia, and North America.

Prof. Vijay Narayansingh, MD, FACS, professor emeritus of surgery, University of the West Indies, Kingston, Jamaica, has played a significant role in organizing surgery and establishing a program of surgical education in the West Indies and throughout the Caribbean. He established vascular surgery as a specialized service in Port of Spain and Trinidad and introduced a number of complex surgical procedures to the area. He has published many manuscripts related to vascular and general surgery, most of which are case reports or studies of particular diseases or management strategies important for his region. His contributions have been widely recognized, most notably with the Chaconia Gold Medal—the second highest civilian award given by his government.

Prof. Kerstin Sandelin, MD, PhD, FACS, FRCS, professor of surgery, Karolinska Institutet, Stockholm, Sweden, is a leading expert in endocrine and breast surgery. She chairs the National Quality Breast Cancer Register and is a founding member and past-president of Breast Surgery International, which promotes breast surgery worldwide, particularly in developing countries where the diagnosis, management, and treatment options differ from standard recommendations because of limited resources and cultural and socioeconomic barriers. She works closely with breast cancer support groups and nongovernmental organizations to promote health awareness and early detection of breast cancer.

Prof. Panayotis Soucacos, MD, FACS, professor of orthopaedic surgery, The Panayotis N. Soucacos Orthopedic Research and Education Center, Attikon University Hospital, University of Athens School of Medicine, Greece, is an internationally recognized contributor to orthopaedic surgery. He has published more than 400 scientific articles in the Greek and international literature, contributed to 55 book chapters, and has served as guest editor of 25 special editions of referred journals in the U.S. and internationally, and served on the editorial boards of 15 European and American journals. ♦
Prof. Italo F. Braghetto is a general surgeon specializing in gastric and esophageal surgery. He was born in Santiago, Chile, in 1948 and attended primary and secondary school at Liceo Salesiano Don Bosco in Santiago. He had a great penchant for sports as a child and began playing soccer in his early adolescence and continued to play throughout most of his adult life. His sport of choice these days is soft kayaking and bocce. During his early years, he also was part of a scouting group and was baptized by his scout chiefs as “cunning tiger” for his clever and intuitive approaches to problems and obstacles outside of the norm.

He attended medical school at the Universidad de Chile Medical School, Santiago, and completed his general surgery residency training there in the late 1970s. In residency, he spent a year as a guest scholar studying digestive surgery at the University of Rome, Italy, with Prof. Giuseppe Grassi, MD. He received further training in digestive surgery at the Universidad de Chile from 1980 through 1981 and was appointed coordinator of research. In 1989, he received an American College of Surgeons guest scholarship to visit Creighton University, Omaha, NE; the Mayo Clinic, Rochester, MN; the University of California, San Francisco; and New England Deaconess Hospital in Boston, MA, to learn esophageal surgery techniques.

When he returned to Chile in 1990, he was appointed vice-chair of the digestive surgery unit at the Universidad de Chile Clinical Hospital and was promoted in 1994 to the position of chairman of their unit. He then began pursuing an additional degree in health administration, which he earned in 2000, and was appointed general director of the Universidad de Chile Clinical Hospital, a position he held until 2005. In 2006, he was named medical director of Avansalud Clinic in Santiago and was elected chair of the department of surgery of Universidad de Chile Clinical Hospital. He held that position from 2013 through 2015.

Professor Braghetto’s main contributions are in the field of gastric and esophageal surgery with numerous books, book chapters, and more than 400 publications on related subjects. As an academic surgeon, he has been a devoted teacher and active in building an international surgical network in Latin America and supporting scientific surgical societies. He is recognized as a surgical leader in Latin America and is a member of many national and international surgical societies, including our College, since 1984. He was president of the Chilean Surgical Society and president of the College’s Chilean Chapter in 1989. He has received many awards during his professional life and is an honorary member of several Latin American surgical societies.

His students and mentees are appreciative of his leadership, and one of our Past-Presidents, Carlos Pellegrini, MD, FACS, FRCSI(Hon), FRCSEng(Hon), FRCSEd(Hon), who has known him most of his professional life, states, “I believe his standing among Latin American surgeons and his standing in the world of GI [gastrointestinal] surgery make him an ideal candidate for the Honorary Fellowship.”

Citation for Prof. Italo F. Braghetto, MD, MHA, FACS

by Michael J. Zinner, MD, FACS
Prof. Laurence Chiché is a professor of surgery and director for the department of surgery at Bordeaux University, France. By reputation in the transplant community, she is known as a highly skilled gastrointestinal surgeon, and I personally know one of her trainees, who speaks passionately of her excellence as a surgeon, clinical investigator, educator, and leader. She clearly has become a highly respected leader in academic surgery in France. She also is an accomplished scholar in the field of transplantation, and her program at Bordeaux is the second largest liver transplantation program in France.

Professor Chiché has had a most distinguished career pathway, graduating medical school from the University Paris V–CHU Meckler-Enfants Maladies before completing her general and abdominal surgical training at the Hopitaux de Paris. Her medical training was coupled with a research fellowship studying the use of baboon hepatic xenografts as a bridge for fulminant hepatic failure. She received her medical degree in 1990 and completed her formative clinical training at the Hôpital Paul-Brousse, Paris, under the mentorship of Prof. Henri Bismuth, MD, FACS(Hon), who also is an Honorary Fellow of our College. It was there that she forged her expertise in hepatobiliary and liver transplantation surgery, which led to her 1993 appointment as assistant professor of surgery at the University Hospital of Caen, France. In 2003, now recognized as a highly productive scholar and clinician, she was promoted to professor of digestive surgery and named head of their digestive surgery department’s hepatobiliary surgery and liver transplantation unit. She was promoted again in 2010 to chief of their department of digestive surgery before being recruited in 2012 by Bordeaux University to fill the role of chief of the liver transplantation program. In 2017, Professor Chiché was named director of the University Hospital of Bordeaux. In that role, she holds responsibility for the academic advancement of the faculty, clinical programs in the department of surgery, training of surgical residents and fellows, and administrative oversight of the hospital’s surgical operations.

By invitation, Professor Chiché has made formative contributions to practice, setting national consensus groups in France on a wide variety of clinical problems in hepatobiliary and liver transplantation surgery. She is widely considered nationally and internationally to be a thought leader in this discipline and has served as a research mentor and doctoral thesis advisor to multiple candidates. She was one of three French academic surgeons selected for the traveling exchange program of the American Surgical Association, a highly competitive opportunity, and serves as an important and inspiring role model for women in surgery in Europe. ♦

Citation for Prof. Laurence Chiché, MD, PhD

by Barbara Lee Bass, MD, FACS, FRCS(Hon), FRCSI(Hon), FCOSECSA(Hon)
Prof. Ian D.S. Civil is a broadly trained general, vascular, and trauma surgeon, and director of trauma services at Auckland Hospital, New Zealand. In addition, he is clinical director for the Major Trauma National Clinical Network, and clinical leader for the Safe Surgery New Zealand Expert Advisory Group for the Health Quality and Safety Commission of New Zealand. Born in Rotorua, New Zealand, Dr. Civil attended King's College in Auckland for both his undergraduate and medical training, with a subsequent masters in surgery from the University of Auckland, and trauma fellowship at the University of Pennsylvania, Philadelphia.

Professor Civil’s career is noteworthy for his decades as the leading clinician in the development of trauma care and trauma systems in New Zealand. In recognition of his outstanding efforts, he has been awarded the Certificate of Merit and the RACS Medal from the Royal Australasian College of Surgeons (RACS). He has served as an Officer, Commander, and Knight of Grace in the Order of Saint John, and awarded a Gordon Trinca Medal and Henry Windsor Medal from the RACS. He has served as President of the RACS, only the seventh New Zealander to serve in this role. In honor of his contributions, he has been bestowed as a Companion of the New Zealand Order of Merit, the highest civilian award short of knighthood.

He has been a primary force in the development of trauma care in New Zealand, and now has assumed leadership in establishing national quality assurance standards in system development. He served with distinction in the military medical ranks of the New Zealand Army during the Gulf War. He has been a long-time supporter and active member of the American College of Surgeons, having also served as President of the Australia-New Zealand Chapter, and Governor for the chapter.

It is indeed a pleasure to introduce Prof. Ian Civil as a well-deserved Honorary Member for his career of outstanding clinical care and commitment.
Prof. John M.P. Hyland is consultant general/colorectal surgeon, St. Vincent’s University Hospital, Dublin, Ireland. He is the founder of the Centre for Colorectal Disease at St. Vincent’s University Hospital, including multidisciplinary care encompassing patient care, and educational and clinical research—with the ultimate aim to improve clinical management of patients. Professor Hyland has previously held the office of President of the Royal College of Surgeons in Ireland, the Association of Coloproctology of Great Britain and Ireland, the Irish Society of Gastroenterology, and the Irish Surgical Travellers.

Professor Hyland graduated from University College Dublin Medical School and continued his postgraduate studies at St. Vincent’s University Hospital and the University of Liverpool, U.K., and obtained his Fellowship from The John Hopkins Hospital, Baltimore, MD. He remains a consultant surgeon at Saint Vincent’s University Hospital Dublin to this day.

Professor Hyland is recognized both nationally and internationally in the field of advanced laparoscopic colorectal surgery. Among his many contributions in the field of colorectal cancer treatment is his development of a clinical database in the early 1980s of patients with colorectal cancer and inflammatory bowel disease, resulting in clinical research publications: a most impressive feat. He is a lead educator in minimally invasive surgery and preceptor in laparoscopic surgery in the U.K.

Professor Hyland has the distinction of holding multiple national and international chairmanships and committee appointments. He was appointed by the Minister of Health of Ireland as Regional Director of Cancer Services in 1996 to develop a higher level of multidisciplinary team management in cancer services.

Citation for Prof. John M.P. Hyland, MCh, FRCS, FRCSI, FACS, FRCSEd(Hon)

by John R. T. Monson, MD, FACS, FRCSIre(Hon), FRCSEng(Hon), FRCSEd(Hon), FRCSGlasg(Hon), FASCRS
Prof. Yoko Kato is professor and chair of the department of neurosurgery of Fujita Health University Banbuntane Hotokukai Hospital in Aichi, Japan. She received her medical degree from the Aichi Medical University in 1978. After finishing residency in the department of neurosurgery at Aichi, she joined the department of neurosurgery at Fujita Health University. Subsequently, in 1981, she served as instructor of neurosurgery at the Suzhou Medical College in China before returning to Fujita Health University’s department of neurosurgery in 1983 as an assistant instructor. She was board certified by the Japan Neurological Society in 1985.

In 1986, she went to Australia to pursue research and became a research fellow at the department of neurosurgery, Graz University, Austria. She returned to Fujita Health University’s department of neurosurgery in 1989 as an assistant professor and there expanded her career as a neurosurgeon for the subsequent 11 years. She was promoted to associate professor at Fujita in 2000 and in 2006 became the first female professor of neurosurgery in Japan. Her exemplary performance has continued as she became professor and chair, department of neurosurgery, Fujita Health University Banbuntane Hotokukai Hospital and named as chief of its associated Stroke Center in 2014. Presently, she serves as an affiliate professor at Mainz University in Germany; George Washington University, Washington, DC, in the U.S.; and the Sri Ramachandra Medical College and Research Institute in Chennai, India.

Professor Kato plays a conspicuous role in a number of neurosurgical scholarly activities and has served as assistant secretary of the World Federation of Neurosurgical Societies (WFNS), on the board of the World Federation of Neurosurgical Societies Foundation Committee, as chair of the World Federation of Neurosurgical Societies Women in Neurosurgery Committee, on the advisory board for the Tenth Asian-Australasian Congress of Neurological Surgery, as the Secretary of the WFNS Foundation Committee, and as the chair of the WFNS Education and Training Committee.

In addition, she has been appointed to various
international editorial boards and advisory journal boards. These include associate editor of the journal Neurosurgery; member, Perspectives in Neurological Surgery; the international advisory board for the Pan Arab Journal of Neurosurgery; and the advisory board of Neurosurgical Review (SpringerVerlag). She has held key posts in various academic conferences both nationally and internationally, including as president of the Third Asian Conference of Neurological Surgeons; president, Fourth Asian Women’s Neurosurgical Association Conference; president, Seventh Annual Meeting of the Japan Society of Intraoperative Imaging; president, 16th Annual Meeting of the Japan Society of Neurosurgical Emergency; president, 16th Meeting of the Japanese Association of Brain Hypothermia; assistant secretary, bidding committee, 15th WFNS World Congress; general secretary, 13th WFNS; president, 44th Annual Meeting of The Japanese Society of Neuroradiology; and president, 2016 International Mt. BANDAI Symposium for Neuroscience.

She is recognized by her peers as one of the premier neurosurgeons in the world with regard to the surgical management of brain aneurysms and has performed more than 1,800 brain aneurysmal clipping procedures throughout her career. The volume of procedures, using state-of-the-art technology, has attracted many young neurosurgeons to study at her institution each year. She has published more than 100 peer-reviewed journal articles related to research in brain aneurysms.

In addition, in order to contribute to the development of global neurosurgical treatment, she established the Yoko Kato Foundation. Not only is Professor Kato a notable clinician and teacher who has made an incredible contribution to the neurosurgical field, she also has played an invaluable role as a role model for women in medicine and the life sciences, providing inspiration to innumerable female clinicians and scientists. To this end, she founded the Women’s Neurosurgical Association of Japan in 1990 and the Asian Women’s Neurosurgical Association in 1996. She is recognized as a leader in the field of neurosurgery both in Japan and internationally. She is a diligent physician, a meticulous researcher, and an outstanding leader, who has served as a role model and an inspiration for women in surgery for many decades, demonstrating the ability to revolutionize health systems and to promote a successful career in a male-dominated profession. ♦
**Citation for Prof. Marek Krawczyk, MD, PhD**

by Marek Rudnicki, MD, PhD, DMSc, FACS

**Prof. Marek Krawczyk** is professor and chairman, department of general, transplant, and liver surgery, Medical University of Warsaw, Poland. Professor Krawczyk was born in Poland and received all of his education at the University of Warsaw, earning his medical degree in 1969 from the Medical University of Warsaw. Following medical school, he completed an internship and surgical residency in 1977, also at the Medical University of Warsaw. During his residency, he earned a PhD in medical sciences in 1975 and was afforded additional training opportunities at other European institutions, beginning in 1977 through 1987, to study pancreatic and laparoscopic surgery and liver transplantation. In 1987, he earned a doctor of medical science degree from the Medical University of Warsaw, and he was appointed full professor in their department of surgery. Since 1988, he has been their chief of surgery. Additionally, he has been the president of the Medical University of Warsaw since 2008.

Professor Krawczyk has contributed extensively to peer-reviewed journals, totaling 472 publications. Of those, 162 have been in English in both European and U.S. journals, and he has published in 33 more journals, including the *European Journal of Surgical Oncology*, *Transplantation Proceedings*, *Annals of Transplantation*, and the *Annals of Surgery*, with his primary focus in the area of transplantation and hepatobiliary surgery.

Professor Krawczyk is a member of numerous medical societies in Europe, as well as the Transplantation Society. He also has been intimately involved in resident training in general surgery and transplant surgery, mentored 17 PhD students, and served as an advisor or reviewer for an additional 47 PhD students. He is well respected by both young academic surgical trainees and experienced surgical colleagues. He has received many honors and awards, which include 11 awards from the Minister of Health for clinical/scientific achievements, as well as 20 other awards and honorary distinctions from various organizations. He was named the 2011 “Personality of the Year in Medicine.”

Finally, Professor Krawczyk was the first Polish surgeon to obtain the European Honorary Certificate as an expert in liver, pancreas, and hepatobiliary surgery, and he personally established the first, and very successful, liver transplant program in Poland. ♦
Prof. Antonio M. de Lacy Fortuny is professor of surgery, University of Barcelona School of Medicine, and chief, department of general and digestive surgery, Hospital Clinic of Barcelona, Spain. He completed his undergraduate degree from the University of Barcelona’s School of Medicine in 1980 before starting his surgical training in general surgery at the Hospital Clinic of Barcelona. In 1988, he earned his doctorate in medicine upon completion of his thesis paper, titled “Hemodynamic changes after distal spleno-renal shunt in patients with portal hypertension.”

Shortly thereafter, he left Spain for the U.S. to further his postgraduate training at Emory University, Atlanta, GA; The Cleveland Clinic, OH; and Mt. Sinai Hospital and Cornell University, New York, NY. He returned to Spain and joined the surgical faculty at the University of Barcelona, where he rose quickly through the ranks. In 2003, he was appointed professor of surgery, and in 2007 was named chief of the department of general and digestive surgery for the Institute of Metabolic and Digestive Diseases within the Hospital Clinic of Barcelona.

Most of his medical career has been focused on general laparoscopic, oncologic, and bariatric surgery, as well as the implementation of Natural Orifice Transluminal Surgery (NOTES). Professor Lacy developed the first three-dimensional operating theatre to facilitate minimally invasive surgical procedures through a joint venture with industry. He founded the automatic identification system channel, which, at the time, was an innovative approach to communicate with surgeons worldwide about educational information, surgical techniques, and contemporary advances in surgery.

He has published more than 200 scientific articles and presented his work or served as an invited guest lecturer at countless national and international medical assemblies. He is a member of many European surgical organizations and was inducted into honorary membership in the American Association of Colorectal Surgeons. Professor de Lacy was president of the European Association for Endoscopic Surgery and a founding member and vice-president of the Multidisciplinary International Rectal Cancer Society.

Citation for Prof. Antonio M. de Lacy Fortuny, MD, PhD

by Steven D. Wexner, MD, PhD(Hon), FACS, FRCS(Eng), FRCSEd, FRCSI(Hon), FRCSGlasg(Hon)
Prof. Ari Leppäniemi is professor of surgery, Abdominal Center, Meilahti Hospital, and chief, division of emergency surgery and surgical critical care, University of Helsinki, Finland. He also is an adjunct professor of surgery at the Uniformed Services University of the Health Sciences (USUHS) in Bethesda, MD. Dr. Leppäniemi is an internationally recognized leader in the care of the injured patient, critically ill, emergency general surgical patient, and in the reconstruction of the patient with major abdominal compartment syndrome complications.

Dr. Leppäniemi received his education and training in Finland, from the University of Helsinki, with additional diplomas in surgery, medical care catastrophes, international health care, prehospital care, and emergency surgery. He has been recognized and honored for his surgical efforts in global health throughout his career, including the Red Cross Medal, the Police Cross for Distinguished Service, Surgeon of the Year, Military Achievement Medal, and the Faltin Lecture of the Finnish Surgical Society. He has served in multiple roles in his surgical community, including recent tenure as president of the Finnish Society of Surgery and president, European Society for Trauma and Emergency Surgery.

Dr. Leppäniemi has had a major commitment to global outreach for surgical care in primarily war-torn and natural disaster settings. He has cared for the underserved in Nigeria; been a field surgeon during the civil wars in Cambodia, Sudan, and Afghanistan; and served as a volunteer surgeon in the South Pacific. He directed the Finnish surgical team in support of the severely injured following catastrophes throughout the globe. He also has served as an international consultant to other countries, including Sweden, Hong Kong, and Norway, and has served as a visiting scientist and adjunct professor to the USUHS.

Dr. Leppäniemi is a dedicated clinician, educator, and surgical consultant. He has been a significant contributor to the global development in the care of injury and emergency general surgery. It is indeed a pleasure to introduce him as a well-deserved Honorary Fellow in the American College of Surgeons.
Prof. Neil Mortensen is a colorectal surgeon from Oxford, England. As a medical student he spent a summer in the surgical research labs at the Boston City Hospital, MA, and a term at the department of surgery, University of Minnesota. Professor Mortensen trained in surgery and subsequently colorectal surgery in Birmingham, Bristol, and in London at St. Mark's Hospital. In 1979, he was American College of Surgeons (ACS) Paul Hawley International Guest Scholar. He has published more than 350 original peer-reviewed manuscripts, 30 book chapters, and has edited eight books.

He has been chair of the British Journal of Surgery Society, president of the Ileostomy Association, president of the Association of Coloproctology of Great Britain and Ireland, and president of the Coloproctology Section of the Royal Society of Medicine. Professor Mortensen is now completing his tenure as editor-in-chief of Colorectal Disease. He is an honorary member of numerous national and international societies, including the American Society of Colon and Rectal Surgeons. Professor Mortensen is professor of colon and rectal surgery at the University of Oxford Medical School, where he has been on staff since 1987. He is an honorary consultant colorectal surgeon and a fellow of Green Templeton College.

He met his wife Jane at medical school, and they have three children, one of whom is an interventional radiologist.

Professor Mortensen's world renown has been recognized in part by the numerous named lectures that he has delivered in the U.K., Europe, Australasia, and North America.

Professor Mortensen was elected as a member of the council of the Royal College of Surgeons of England in 2013 and a member of the trustee board in 2016. In 2017, he was appointed as vice-president of the Royal College of Surgeons of England. He has numerous additional functions at the Royal College of Surgeons, including chair of the Journals Committee, editor-in-chief of the Bulletin, and chair of the Research and Quality Committee.

Professor Mortensen is a world renowned academician, skilled educator, articulate orator, and gifted clinician. He exemplifies all of the best attributes that the ACS looks for in its Honorary Fellows.
Citation for
Prof. Vijay Naraynsingh, MD, FACS
by Dilip Vijay Dan, MB BS, FACS

Prof. Vijay Naraynsingh is professor emeritus of surgery, University of the West Indies (UWI), Kingston, Jamaica. He has played a major role in organizing surgery and establishing a program of surgical education in the West Indies and throughout the Caribbean. He graduated from UWI Medical School in 1974 and completed his general surgery training in the U.K., followed by a fellowship in vascular surgery in the U.S. He earned his Fellowship in the Royal College of Surgeons of Edinburgh in 1978 and became a Fellow of the American College of Surgeons in 1987. He also is a Fellow of the International College of Angiology, the International College of Surgeons, the Royal College of Surgeons of England, and the Caribbean College of Surgeons.

Professor Naraynsingh has spent his entire surgical career in the West Indies providing outstanding clinical service, education, and maintaining an active research interest. He rose through the ranks of UWI’s department of surgery to become professor and ultimately chair and deputy dean of the faculty of medicine (clinical).

Despite limited resources, Professor Naraynsingh was remarkably innovative, bringing high-quality, modern surgical care in general and vascular surgery to his region. He established vascular surgery as a specialized service in Port of Spain and Trinidad and introduced a number of complex surgical procedures to the area. He has published many manuscripts related to vascular and general surgery, most of which are case reports or studies of particular diseases or management strategies important for his region. He has received numerous awards for his educational excellence from his region, as well as from India, and organized and became the first president of the Society of Surgeons of Trinidad and Tobago. He has been a leading figure and founding member of the Caribbean College of Surgeons, of which he was president in 2007.

He also has been recognized for his public service, particularly for providing care to disadvantaged children, and his mentoring efforts are an inspiration to youth in the region. His contributions have been widely recognized in his region, most notably with the Chaconia Gold Medal, the second-highest civilian award given by his government. At the most recent meeting of the Caribbean College of Surgeons, I had the opportunity to meet Dr. Naraynsingh and discuss his contributions with him and his colleagues, as well as the leading surgeons from Guyana, Bahamas, Curacao, and Barbados, and each have been extremely effusive in their comments about his enormous contributions to surgery and society in the Caribbean. ☀
Prof. Kerstin Sandelin received her medical training and postgraduate education at Karolinska Institutet in Stockholm, Sweden. Recognized as one of the world’s foremost medical universities, the Karolinska Institutet is the single largest center of medical academic research in Sweden. Since 1901, the Nobel Assembly at Karolinska Institutet has selected the Nobel laureates in Physiology or Medicine.

Professor Sandelin is one of a small number of women professors of surgery at Karolinska University Hospital. Her field of interest is endocrine and breast surgery. She serves as the chair of the National Quality Breast Cancer Register and is a founding member and past-president of Breast Surgery International (BSI). BSI was formed in 1999 as an integrated society within the International Surgical Society (ISS) with the goal of promoting breast surgery worldwide, particularly in developing countries where the diagnosis, management, and treatment options differ from standard recommendations due to lack of resources and cultural and socioeconomic barriers. Her research involves breast MRI (magnetic resonance imaging) in women with breast cancer, patient-related outcome measures, and management of women at high risk of breast cancer and oncoplastic breast surgery. In recognition of her work, she was awarded honorary membership of the ISS in 2015.

Professor Sandelin is widely regarded as an expert in the epidemiology of breast disease. She is the principal investigator on a number of clinical trials and has been sought as a collaborator for several national and international task forces and multicenter studies. She works closely with breast cancer support groups and nongovernmental organizations to promote health awareness and early detection of breast cancer, including the Kicki Waller Breast Cancer Foundation.

Professor Sandelin has published more than 100 papers in peer-reviewed, high-impact journals. She has served as an associate editor of the World Journal of Surgery and is a member of the advisory board for Cancer Society Sweden. In recognition of her stature as a researcher and scholar, Professor Sandelin was elected as scientific secretary to the Swedish Breast Surgeons Society in 1997.

Professor Sandelin is truly living the American College of Surgeons’ mission to inspire quality, high standards, and better outcomes and to mentor, train, and support surgeons from different parts of the world. ♦
Prof. Panayotis Soucacos is professor of orthopaedic surgery, The Panayotis N. Soucacos Orthopaedic Research and Education Center, Attikon University Hospital, University of Athens, Greece, School of Medicine. He obtained his medical degree in 1965 from the National and Kapodistrian University of Athens, where he also completed his orthopaedic residency. He then came to the U.S. in 1971, where he spent five years as a clinical and research fellow in the department of orthopaedic surgery at Duke University, Durham, NC. In 1975, he returned to Greece as an assistant professor of orthopaedic surgery at the University of Athens. He ascended in the academic ranks in Greece from 1980 to 2002 and was named professor and chair of the orthopaedic department of surgery at the University of Ioannina. He returned to the University of Athens in 2002 to assume a similar position as professor and chair of orthopaedic surgery until 2009. From 2012 to 2017, he served as president of the board of trustees at the University of Ioannina.

He is an internationally recognized contributor to the orthopaedic surgery specialty. Academically, he has published more than 400 scientific articles in the Greek and international literature. He edited 11 orthopaedic textbooks and published three history books dealing with European history, mainly old Hellenic maps and the expeditions of Alexander the Great. He also published 55 chapters and served as guest editor of 25 special editions of referred journals in the U.S. and internationally. He served on the editorial boards of 15 European and American journals and has received approximately 40 awards and recognitions and completed 22 visiting professorships in the U.S. and abroad. Professor Soucacos is a member of 28 medical and surgical organizations, including our College, and is an honorary member of the American Academy of Neurological and Orthopaedic Surgeons, the Bulgarian Orthopaedic and Traumatology Association, and the Serbian Society for Orthopaedic Surgery and Traumatology. He also served as president of four Greek surgical organizations.

His extensive and most impressive list of invited national and international presentations, membership on editorial boards, book chapters, visiting professorships, and guest editorships is indicative of his stature in the international orthopaedic and reconstructive surgery community. In summary, he has been a “bridge builder” between Europe and the U.S. in the fields of orthopaedics, hand surgery, and reconstructive microsurgery.
Members in the news

Juan A. Asensio, MD, FACS, FCCM, FRCSEng, chief, division of trauma surgery and surgical critical care, Creighton University School of Medicine, Omaha, NE, recently was selected for two high honors. In November 2018, Dr. Asensio, professor of clinical and translational science at Creighton, and adjunct professor of surgery, Uniformed Services University of the Health Sciences, Bethesda, MD, was elected distinguished member of the Royal National Academy of Medicine, Madrid, Spain. In Spain, the distinction of becoming an academic at the Royal National Academy is considered to be the highest honor bestowed on physicians of all specialties. Prof. Enrique Moreno-Gonzalez, MD, FACS(Hon), introduced Dr. Asensio at the induction ceremony.

In August 2019, Dr. Asensio was awarded the Danis Prize by the International Society of Surgery (ISS)/Le Société Internationale de Chirurgie. The prestigious Danis Prize is awarded to a surgeon who has made seminal contributions to the care of wounded and injured patients. The ISS was founded in 1902, and the prize has been awarded to only 31 surgeons in the society’s history. Dr. Asensio received the Danis Prize at the 48th World Congress of Surgery in Krakow, Poland.

Ronald Robertson, MD, FACS, in May assumed the position of chair, department of surgery, College of Medicine, University of Arkansas for Medical Sciences (UAMS), Little Rock. A UAMS faculty member since 1996, Dr. Robertson has served as chief of the division of trauma, critical care, and acute care surgery since 2013. He became vice-chair for clinical affairs in the department of surgery in 2018. Dr. Robertson was a driving force in the establishment of the Arkansas Trauma System in 2010, and as trauma medical director at UAMS since 2013 he leads the only American College of Surgeons (ACS)-verified Adult Level I trauma center in the state. The center
NEWS

performs in the top 10 percent of Level I trauma centers nationwide.

Dr. Robertson completed a fellowship in trauma, critical care, and burn surgery at UAMS before joining the faculty as an assistant professor. He was promoted to associate professor in 2001 and to professor in 2008. Early leadership posts included director of the burn unit at Arkansas Children’s Hospital, Little Rock, from 1995 to 2005.

Read more about Dr. Robertson at news.uams.edu/2019/04/16/ronald-robertson-m-d-named-chair-of-surgery/.

William G. Cance, MD, FACS, recently was selected as the American Cancer Society’s chief medical and scientific officer. Dr. Cance will lead the integration of the society’s research and cancer control departments, unifying its intramural and extramural research; prevention and early detection; patient and caregiver support and service strategies; global cancer control; and health systems engagement programs. Dr. Cance began his new position October 21 at the American Cancer Society headquarters, Atlanta, GA.

Since 2016, Dr. Cance has served as deputy director and interim director of the University of Arizona (UA) Comprehensive Cancer Center, Tucson. There, he established a culture of collaboration that advanced cancer care and treatment. He also is a professor in the departments of interdisciplinary oncology, pharmacology, and toxicology, and surgery for the UA Colleges of Medicine and Pharmacy, Phoenix, AZ.

Dr. Cance has an active surgical oncology practice and is the principal investigator for a 25-year National Cancer Institute grant focused on focal adhesion kinase, a protein involved in cancer metastasis. He also has been an American Cancer Society grantee, holds eight patents, and has been involved in several entrepreneurial projects to bring his research advancements to market.

Read more about Dr. Cance at pressroom.cancer.org/Cance2019.

Jeffery Upperman, MD, FACS, will succeed John Brock III, MD, FACS, as surgeon-in-chief, Monroe Carell, Jr., Children’s Hospital at Vanderbilt, Nashville, TN, in November.

Dr. Upperman was chosen after an extensive national search and has been director of the trauma program at Children’s Hospital Los Angeles (CHLA), CA, since 2006. He has since achieved national recognition as an expert in trauma, disaster preparedness, and injury prevention. He oversees the CHLA’s ACS Level I pediatric trauma center and serves as tenured professor of surgery at the University of Southern California, Los Angeles.

Dr. Upperman will be Monroe Carell’s second surgeon-in-chief.

Dr. Brock, who served as surgeon-in-chief at the children’s hospital for 17 years, will transition to focus on his role as senior vice-president of pediatric surgical services and will become surgeon-in-chief emeritus. He also will continue his roles as pediatric urologist and Monroe Carell Jr. Professor. Under Dr. Brock’s guidance as surgeon-in-chief, case volumes for all surgical specialties at Children’s Hospital have tripled, transparent patient quality and safety models have been developed, and multiple off-site clinics have been established.

The American College of Surgeons Division of Education welcomes abstract submissions to the following programs:

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- ORAL PRESENTATIONS*
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*Accepted authors are encouraged to submit full manuscripts to JACS

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

The American College of Surgeons (ACS) 2020 Nominating Committee of the Fellows (NCF) and the Nominating Committee of the Board of Governors (NCBG) will be selecting nominees for leadership positions in the College as follows.

Call for nominations for Officers-Elect
The 2020 NCF will select nominees for the three Officers-Elect positions of the ACS: President-Elect, First Vice-President-Elect, and Second Vice-President-Elect. The deadline for submitting nominations is February 21, 2020.

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

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

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

Applications submitted without the requested information will not be considered.

Nominations must be submitted to officerandbnominations@facs.org. If you have any questions, contact Emily Kalata, staff liaison for the Nominating Committee of the Board of Governors, at 312-202-5360 or ekalata@facs.org.

Call for nominations for Board of Regents
The 2020 NCBG will select nominees for four pending vacancies on the Board of Regents to be filled at Clinical Congress 2020. The deadline for submitting nominations is February 21, 2020.

Criteria for consideration
The NCBG will use the following guidelines when considering potential candidates:

- Nominees must be loyal members of the College who have demonstrated outstanding integrity and an unquestioned devotion to the highest principles of surgical practice.
- Nominees must have demonstrated leadership qualities, such as service and active participation on ACS committees or in other areas of the College.
• The ACS encourages consideration of women and underrepresented minorities for all leadership positions.

• Only individuals who are currently and expected to remain in active surgical practice for their entire term may be nominated for election or reelection to the Board of Regents.

The NCBG recognizes the importance of the Board of Regents representing all who practice surgery in both academic and community practice, regardless of practice location or configuration. Nominations are open to surgeons of all specialties, but particular consideration will be given in this nomination cycle to the following specialties:

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

Note that during this nomination cycle, two of the seats are Bylaws-designated Canadian seats and, therefore, only Canadian Fellows will be considered for these vacancies.

All nominations must include the following:

• A letter of nomination
• A personal statement from the candidate detailing their ACS service and interest in the position
• A current CV
• The name of one individual who can serve as a reference

Further details
Entities such as surgical specialty societies, ACS Advisory Councils, ACS Committees, and ACS chapters who wish to provide a letter of nomination must provide at least two nominees, and a description of their selection process, along with the total list of applicants reviewed.

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

Nominations may be submitted to officerandbrnominations@facs.org. If you have any questions, contact Emily Kalata, staff liaison for the Nominating Committee of the Board of Governors, at 312-202-5360 or ekalata@facs.org.

For information only, the current members of the Board of Regents who will be considered for re-election are (all MD, FACS): Gary L. Timmerman and Douglas E. Wood. ♦
The elderly are getting complex surgeries. Often it doesn’t end well.
New York Times, June 7, 2019

“[Dr. Clifford Ko, MD, FACS] and Dr. Ronnie Rosenthal, [MD, FACS,] a surgeon and geriatrician at the Yale University School of Medicine, lead the American College of Surgeons’ Coalition for Quality in Geriatric Surgery.

As older people undergo more operations, the coalition has focused on the results. Perhaps unsurprisingly, older surgical patients often fare worse than younger ones.”

Doctors weigh in on why teen surviving shark attack is more than a miracle
ABC News, June 18, 2019

“Under the leadership of a trauma surgeon, Dr. Lenworth Jacobs, Jr. [, MD, MPH, FACS], and the American College of Surgeons, a massive educational campaign has been undertaken. The focus of ‘Stop the Bleed’ is to train non-medical personnel to stop life-threatening hemorrhage. Integral to the training is early application of tourniquets.

Our trauma center has trained over a thousand citizens in our trauma system, distributing hundreds of tourniquets.”

Hospitals look to cut opioids from surgery and beyond
Modern Healthcare, July 8, 2019

“Dr. John Daly, [MD, FACS,] co-chair of the Patient Education Committee at the American College of Surgeons, said the decision whether or not to prescribe opioids has to be weighed with an understanding of both the benefits and risks for the patient.

‘The benefit of opioids is that they do reduce pain,’ Daly said. ‘If a surgeon is going to utilize opioid-free surgery for some procedures then they would need to adopt other mechanisms for reducing pain, because it’s not the goal to simply eliminate opioids.’”

New standards aim to improve surgery for the oldest patients
Associated Press, July 19, 2019

“The American College of Surgeons launched a program Friday to encourage hospitals around the country to adopt 30 new standards to optimize surgery on patients who are

Editor’s note: Media around the world, including social media, frequently report on American College of Surgeons (ACS) activities. Following are brief excerpts from news stories published from June through September 2019 that mention key ACS programs and initiatives, including research findings that appear in the Journal of the American College of Surgeons. To access the news items in their entirety, visit the online ACS Newsroom www.facs.org/media/acs-in-the-news.
Harvard, American College of Surgeons team up to improve health care quality
BenefitsPRO, July 24, 2019
“The American College of Surgeons and the Harvard Business School’s Institute for Strategy and Competitiveness are launching a program to quantify outcomes and costs of health care to improve both quality and the bottom line.

The new program, to be called THRIVE (Transforming Health Care Results by Investing in Value and Excellence), will be piloted with 10 to 15 hospitals and will focus on measuring the full cycle of care, including surgical, medical, behavioral and social elements, for three surgical conditions.”

The talk seniors need to have with doctors before surgery
Kaiser Health News, August 1, 2019
“Older patients, it turns out, often have different priorities than younger ones. More than longevity, in many cases, they value their ability to live independently and spend quality time with loved ones, according to Dr. Clifford Ko, professor of surgery at UCLA’s David Geffen School of Medicine.

Now new standards meant to improve surgical care for older adults have been endorsed by the American College of Surgeons. All older patients should have the opportunity to discuss their health goals and goals for the procedure, as well as their expectations for their recovery and their quality of life after surgery, according to the standards.”

Tap know-how to prevent firearm deaths
Seattle Times, August 14, 2019
“We know how to do this,” says Dr. Eileen Bulger, [MD, FACS] professor of surgery at the University of Washington School of Medicine and Chief of Trauma at Harborview [Seattle, WA]. “We have to tackle the big picture, the 40,000 people that die every year in the country from firearm violence. We can’t forget them.”

Society has to tackle the problem comprehensively, considering the role of people, equipment and environment, said Bulger, one of 22 co-authors of the American College of Surgeons’ consensus recommendations to reduce firearm injury, death and disability. Enlist gun owners as part of the solution and focus on the ‘vast middle ground’ between ideological extremes.”

A patient’s guide to surgery
U.S. News & World Report, September 11, 2019
“Surgery is classified in several ways, including by its magnitude, location in the body from head to toe and type of condition (such as orthopedic, neurologic or oncologic). Elective surgery can be planned in advance, whereas emergency surgery is needed right away for conditions like acute appendicitis. Complex conditions and procedures may require multiple surgical specialists.

The two basic types of surgery are major and minor, says Dr. John Daly, [MD, FACS] a surgical oncologist at Fox Chase Cancer Center in Philadelphia[,] and co-chair of the patient education committee for the American College of Surgeons.”
Opinion: A public health approach reduced deaths from car crashes. It can do the same for gun violence
Los Angeles Times, September 13, 2019
“In February, more than 45 of the largest medical, legal and injury-prevention organizations in the U.S. came together for an inaugural medical summit on firearm injury prevention. They reached a historic agreement to recognize firearm violence as a public health crisis in the U.S. and supported a comprehensive public health approach to solve it. The summit provided a road map of practical interventions to address the firearm injury crisis.”

You’ve survived cancer. What comes next?
The Wall Street Journal, September 15, 2019
“The health-care industry is facing increasing pressure to adapt to such success. In 2015, the Commission on Cancer, a program of the American College of Surgeons, began requiring that, as a condition of accreditation, hospitals provide patients with a survivorship-care plan.”

Coming next month in JACS and online now
Outcomes of resectability assessment of the Dutch Colorectal Cancer Group Liver Metastases Expert Panel
Joost Huiskens, MD; Karen Bolhuis, MD; Marc R. W. Engelbrecht, MD, PhD; and colleagues in the December issue of the Journal of the American College of Surgeons (JACS) analyzed prospective resectability evaluation of patients with colorectal cancer liver metastases (CRLM) by a panel of radiologists and liver surgeons and found that the high rate of disagreement among experienced liver surgeons reflects the complexity in defining treatment strategies for CRLM and supports the use of a panel rather than a single-surgeon decision.
This article and all other JACS content is available at journalacs.org.
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—David B. Hoyt, MD, FACS, ACS Executive Director

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Apply for Firearm Injury Prevention Clinical Scholar in Residence Fellowship

In partnership with the American Foundation for Firearm Injury Reduction in Medicine, American Association for the Surgery of Trauma, Eastern Association for the Surgery of Trauma, and Western Trauma Association, the American College of Surgeons Committee on Trauma (ACS COT) has announced a fully funded two-year on-site fellowship in firearm injury prevention research, July/August 2020–June 30, 2022. The application deadline is December 15, 2019.

Purpose
The primary goal of the fellowship program is to provide a mentored research experience to support the career development of surgical investigators interested in injury prevention research and health policy. The Firearm Injury Prevention Clinical Scholar will be engaged in ongoing firearm injury prevention research and initiatives within the ACS COT, which includes working with large databases, including the Trauma Quality Improvement Program (TQIP), and validation of best practices. The scholar will work on projects with the Injury Prevention and Control Committee of the ACS COT and also will have the opportunity to engage with ACS efforts in health policy and advocacy. The ACS Trauma Quality program and analytic staff will be available as resources to the clinical scholar, and the scholar will meet regularly with a mentorship team.

As part of the program, the scholar will complete a master of science degree at Northwestern University Feinberg School of Medicine in one of the following disciplines of their choosing: clinical investigation, health services and outcomes research, or health care quality and patient safety. The scholar also will be able to continue their surgical education through Northwestern University’s department of surgery by attending weekly conferences and grand rounds and will have opportunities to practice surgical skills in the training lab or through clinical moonlighting.

Eligibility
This program is open to applicants who have completed a minimum of two years of general surgical residency or have finished surgical residency. The applicant must be an Associate Fellow of the ACS and in good standing with the College. Because the clinical scholars work closely with the ACS staff and need to complete coursework, it is required that the clinical scholar reside in Chicago, IL, for the duration of the fellowship. The scholar will be notified of their appointment by February 3, 2020.

For more information
For more program details, visit the Firearm Injury Prevention Clinical Scholar in Residence Fellowship web page at facs.org/quality-programs/trauma/firearm-ip-clinical-scholar. Contact the ACS COT with any additional question at COT@facs.org.

Apply for Firearm Injury Prevention Clinical Scholar in Residence Fellowship
The American College of Surgeons (ACS) is offering two-year Faculty Research Fellowships to surgeons entering academic careers in surgery or a surgical specialty through the generosity of Fellows, Chapters, and friends of the College. The closing date for receipt of the completed online application and all supporting documents is November 15, 2019.

The fellowship will assist a surgeon in the establishment of their research program under mentorship, with the goal of transitioning to becoming an independent investigator. Applicants should have demonstrated their potential to work as independent investigators. The fellowship award is $40,000 per year for each of two years.

The specific fellowships are as follows:

- **The Franklin H. Martin, MD, FACS, Faculty Research Fellowship of the ACS** honors Franklin H. Martin, MD, FACS, founder of the ACS
- **The C. James Carrico, MD, FACS, Faculty Research Fellowship for the Study of Trauma and Critical Care** honors C. James Carrico, MD, FACS, ACS Past-President, and is designated for research in trauma and critical care.

### General policies
The following criteria are applied in awarding the ACS Faculty Research Fellowships:

- The fellowship is open to Fellows or Associate Fellows of the College who have done the following:
  - Completed the chief residency year or accredited fellowship training within the preceding five years, not including time off for maternity leave, military deployment, or medical leave.
  - Received a full-time faculty appointment in a department of surgery or a surgical specialty at a medical school accredited by the Liaison Committee on Medical Education in the United States or by the Committee for Accreditation of Canadian Medical Schools in Canada. Preference will be given to applicants who directly enter academic surgery following residency or fellowship.

- Recipients may use the award to support their research or academic enrichment in any fashion that the recipient deems maximally supportive of their investigations. The fellowship grant is to support the research of the recipient. Indirect costs are not paid to the recipient or to the recipient’s institution.

- Application for this fellowship may be submitted even if comparable application has been made to organizations such as the National Institutes of Health (NIH) or industry sources. If the recipient is offered a scholarship, fellowship, or research career development award from such an agency or organization, it is the responsibility of the recipient to contact the College’s Scholarships Administrator to request approval of the additional award. The Scholarship Committee reserves the right to review potentially overlapping awards and adjust its award accordingly.

- Applicants who have previously won an award of more than $25,000 from another professional society or NIH are not eligible for this fellowship. Intramural K awards are permitted.

- Supporting letters from the head of the department of surgery (or the surgical specialty) and from the mentor supervising the applicant’s research effort must be submitted. This approval would involve a commitment to continuation of the academic position and of facilities for research. Only in exceptional circumstances will more than
The fellowship will assist a surgeon in the establishment of their research program under mentorship, with the goal of transitioning to becoming an independent investigator. Applicants should have demonstrated their potential to work as independent investigators.

• A minimum of 50 percent of the Fellow’s time must be spent in the research proposed in the application. This percentage may run concurrently with the time requirements of NIH or other accepted funding.

• The Faculty Research Fellows are expected to attend the Clinical Congress of the ACS in 2022 to present a report and receive a certificate at the annual meeting of the Scholarships Committee.

For further information regarding this fellowship, visit the ACS website at facs.org/member-services/scholarships/research/acsfaculty or e-mail to scholarships@facs.org.

SCHOLARSHIPS

The fellowship will assist a surgeon in the establishment of their research program under mentorship, with the goal of transitioning to becoming an independent investigator. Applicants should have demonstrated their potential to work as independent investigators.

• A minimum of 50 percent of the Fellow’s time must be spent in the research proposed in the application. This percentage may run concurrently with the time requirements of NIH or other accepted funding.

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For further information regarding this fellowship, visit the ACS website at facs.org/member-services/scholarships/research/acsfaculty or e-mail to scholarships@facs.org.

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I was honored to be selected as the 2019 American College of Surgeons (ACS) Traveling Fellow to Australia and New Zealand (ANZ). The opportunity to collaborate with and learn from colleagues across the globe affords enhanced perspective and passion for the care of surgical patients, and I believe is at the heart of the traveling fellowship. Representing the ACS was the honor and experience of a lifetime. I hope in the paragraphs that follow you, too, will be inspired by commonalities we share with our global partners and the endless possibilities for driving our field forward as we continue to prioritize forging these relationships.

**Sydney**

Approximately 48 hours after leaving Birmingham, AL, and crossing the international dateline, I arrived in Sydney, Australia, as the 2019 ACS Traveling Fellow to ANZ. I had planned a four-hour journey to climb the Sydney Harbor Bridge to acclimate to Sydney time, and the summit afforded me a 360-degree view of city, including the famous Sydney Opera House and Watson’s Bay. Afterward, I felt prepared for my busy few days at Westmead Hospital.

Over the next several days, I was immersed in all things transplant at Westmead, home to the editorial offices of *Transplantation*, the preeminent international transplant journal. I had planned to focus my visit to Westmead entirely on research and publication processes. My host, Henry Pleass, MD, FRACS, transplant surgeon and consultant, weaved opportunities to observe and discuss the clinical programs within the broader framework of academics. The collective experiences reminded me of the importance of being both a surgeon and scientist, as it is the rare combination of the two that drives the field forward, enhances the lives of our patients, and educates the next generation of transplant surgeons.

The days began with presentations from the registrars (or residents) on difficult cases from ward rounds. One case in particular, presented by the transplant surgery fellow Jinna Yao, MD, clinical associate lecturer, highlighted a recent hyperacute rejection after a blood group incompatible (ABOi) living donor kidney transplant. The ABOi living donor kidney transplant program follows the same desensitization regimen/paradigm as my program at the University of Alabama at Birmingham (UAB), which includes the use of total plasma exchange (TPE) and low-dose intravenous immunoglobulin (IVIg) to remove anti-ABO antibodies before crossing the blood group barrier for transplant. Multiple studies, including those conducted at Westmead, have demonstrated success with this technique over the years.

This particular case did not go as planned, and the kidney was immediately rejected. Listening to the details of the case, observing the pain on the registrar’s face and the frustration of Professor Pleass, I felt a common bond with my colleagues that traversed oceans and nationalities. We have much more in common than we realize. It was gratifying to be able to share a similar case that occurred...
The opportunity to collaborate with and learn from colleagues across the globe affords enhanced perspective and fuels shared vision and passion for the care of surgical patients, and I believe is at the heart of the traveling fellowship.

at UAB. I was able to alert them to the need to check ABO antibody levels in the IVIg before administering the medication, as preparation can vary widely. In other words, similar to my experience at UAB, it is likely that the very antibodies that were the target of removal by TPE were inadvertently returned to the patient during the IVIg infusion. Not only did I have a shared experience, but that experience forged a bond and collaboration that will endure for years to come.

Prof. Richard Haney, MBBS, FACS, FRACS, invited me to lecture at surgical grand rounds, during which I discussed Finding Your Passion: A Career Road Map. I described both my successes and failures with ease and without concern for judgment. Faculty joined the discussion and shared their personal career road maps. I found this session particularly rewarding, as it actively engaged trainers (consultants) and trainees (registrars) in a productive and meaningful way.

After grand rounds, we joined the transplant research conference, where I reunited with friends from The Transplantation Society and the editorial board of Transplantation, including Prof. Philip O’Connell, MBBS, BSc[med], PhD, FRACP, past-president, The Transplantation Society, and Prof. Allison Tong, PhD, co-leader, Centre for Kidney Research. We spent several hours discussing ongoing research projects at both UAB and Westmead and realized that in many ways, our patient populations are similar—rural/remote and often poor—and that we are attempting to overcome these disparities in similar ways by incorporating patient navigators into the care of our patients. We recently published initial results from the UAB Living Donor Navigator Program in Transplantation. Professors O’Connell and Tong read the article with interest, as they recently developed and implemented the Patient NAvigator program for Early Chronic Kidney Disease (PAVE-CKD). Discussing findings and implementation hurdles was invaluable. I left with actionable items to examine in UAB’s navigator program that may lead to improved adaptation and maintenance.

My days ended with extraordinary team dinners from Malaysian cuisine in the Harbor to tremendous seafood at Watson’s Bay.

Auckland
I said goodbye to my colleagues and friends at Westmead Hospital and headed for Auckland, New Zealand. There, my host Prof. Stephen Munn, MBCChB, had arranged a spectacular dinner at Mudbrick Vineyards on Waiheke Island (the “Island of Wine”). The wine was extraordinary,
but the view looking across the harbor at mainland New Zealand was even better.

The next day, I was eager to learn from colleagues about their national policies on living donor compensation, as this is an area of active clinical and research practice for me. The topic is hotly debated in the U.S., with no current resolution. Members of the transplant community who favor providing compensation to living donors feel that it is important that these altruistic individuals be made whole and not suffer a financial loss as a result of the donation, while those individuals opposed cite concerns of coercion and promotion of organ trafficking. However, it is possible to satisfy both parties, as our colleagues in New Zealand have demonstrated. Professor Munn and colleagues from Christchurch, including Dilip Naik, MBChB, FRACS, were instrumental in supporting the passage of the New Zealand Compensation for Live Organ Donors Act 2016, which was intended to remove a financial deterrent to the donation of organs by live donors. In brief, the act gives eligible donors an entitlement to compensation for loss of earnings from employment while they recuperate from surgery and in limited circumstances for loss of income related to the donor evaluation process. Since implementation, the number of living donors has steadily increased without any observed increase in exploitation through organ trafficking. The data are impressive. Armed with data and real-world observation, I felt encouraged and more confident about effecting similar change back home.

**Bangkok**

We finished in Auckland just in time to make our way to Bangkok, Thailand, for the 88th Annual Scientific Congress of the Royal Australasian College of Surgeons (RACS). I was excited to be reunited with my colleagues from Sydney and New Zealand during the transplant section meetings before the start of the conference. I was the guest of Dr. Naik and had been asked to give several talks, ranging from the U.S. allocation system, to simultaneous liver kidney transplantation, to incompatible kidney transplantation.

The section meeting was a success. I was told it was the best turnout in years. I enjoyed the series of lectures and connected with colleagues from Europe, Profs. Peter Friend, MD, and Anthony Warrens, MD, president, British Society of Transplantation. We discussed normothermic perfusion of liver allografts both ex-vivo and regional perfusion. Their results demonstrated increased use of livers from donation after cardiac death (DCD) donors and little to no problems with ischemic cholangiopathy, the most dreaded long-term complication of DCD liver transplants. I thought about all the lives we could save if we expanded our own experience with ex-vivo normothermic perfusion to regional perfusion.

I also was invited to participate in the Developing a Career and Skills in Academic Surgery (DCAS) course, which Dr. Hanney led. It afforded me additional opportunities to interact with trainees and possibly pique their interest in becoming
a transplant surgeon-scientist. We discussed achieving academic balance and developing a career as a surgeon-scientist. It was an honor to be able to interact with the trainees, and I felt like perhaps I was starting to pay forward all the successes I have achieved because of excellent mentorship.

As the ACS Traveling Fellow to ANZ, the meeting was enhanced with the pomp and circumstance of the opening ceremony. It was an honor to present the ACS lecture and be introduced by John Batten, MBBS(Hon), FRACS, FAOrthA, RACS president, and to attend the celebration lunch with Julian Smith, MB, BS, MS, MSurgEd, FACS, FRACS, FFSTRCSEd, FCSANZ, FAICD, Governor of the ANZ Chapter, and Ronald V. Maier, MD, FACS, FRCSEd(Hon), FCSHK(Hon), FCCS(Hon), then-ACS President, at the meeting of the ACS ANZ Chapter. The privilege of meeting giants in surgery and sharing the podium with international experts was humbling and exhilarating.

The fellowship was an opportunity of a lifetime. It was an extraordinary journey from which grew countless friendships and collaborations. It has been my great privilege to be the ACS ANZ Traveling Fellow in 2019.

I felt a common bond with my colleagues that traversed oceans and nationalities. We have much more in common than we realize.

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Calendar of events

Dates and locations subject to change. For more information on College events, visit faces.org/events or faces.org/member-services/chapters/meetings.

**NOVEMBER**

Wisconsin Surgical Society
November 8–9
Kohler, WI
Contact: Terry Estness,
wisurgical@att.net,
wisurgicalsociety.com

Oklahoma Chapter
November 11
Oklahoma City, OK
Contact: Nathalia Granger,
granger@facs.org

ACS Region 17 Meeting
November 14–16
Kuwait City, Kuwait
Contact: E.M. Philips,
mathew_philips@yahoo.com

Keystone Chapter
November 15
West Reading, PA
Contact: Jessica Winger,
jwinger@pamedsoc.org,
kc-acs.org

India Chapter
November 29–30
New Delhi, India
Contact: Prof. Chintamani,
profchintamaniacs@gmail.com

**FEBRUARY**

North Texas Chapter
February 21–22
Dallas, TX
Contact: Carrie Steffen,
carrie@ntexas.org,
ntexas.org

**MARCH**

South Texas Chapter
March 5–7
Houston, TX
Contact: Janna Pecquet,
janna@southtexasacs.org,

Arkansas Chapter
March 14–15
Little Rock, AR
Contact: Linda Gist,
lindac92@comcast.net

Peru Chapter
March 25–27
Lima, Peru
Contact: Dr. Jaime Herrera-Matta,
juanjaimehpe@yahoo.com

**JANUARY 2020**

Southern California Chapter
January 10–12
Santa Barbara, CA
Contact: Tracey Dowden,
socalsurgeons@gmail.com,
socalsurgeons.org

Louisiana Chapter
January 17–19
New Orleans, LA
Contact: Janna Pecquet,
janna@laacs.org,
laacs.org

Utah Chapter
January 23–25
Snowbird, UT
Contact: Nathalia Granger,
granger@facs.org

**FUTURE CLINICAL CONGRESSES**

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2021
October 24–28
Washington, DC

2022
October 16–20
San Diego, CA
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facs.org/webcasts  Olivier Petinaux 866-475-4696  elearning@facs.org
The Rural Trauma Team Development Course (RTTDC), hosted by the Committee on Trauma (COT), emphasizes a team approach to the initial evaluation and resuscitation of the trauma patient at a rural facility.

New in 2019!

- Videos focused on the benefits of running skills scenarios in the emergency department during a RTTDC course
- How tele-education has been utilized to teach RTTDC in rural environments/inaccessible areas
- Tips to engage RTTDC faculty before the course

The newest surgical skills course offered by the COT, Basic Endovascular Skills for Trauma (BEST), is gaining momentum. Six new course sites have formed in the last year across the U.S. This course teaches basic endovascular techniques such as REBOA, or resuscitative endovascular balloon occlusion of the aorta, to trauma and acute care surgeons.

Introducing the Disaster Management and Emergency Preparedness (DMEP) 2nd Edition!

The DMEP course teaches planning methods, preparedness, and medical management of trauma patients in mass casualty disaster situations. Internationally, DMEP is growing, and the newest DMEP program will start in Italy later this year.