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In November 2018, this column introduced readers to the ACS-COSECSA Surgical Training Collaborative, a joint initiative between the American College of Surgeons (ACS), the College of Surgeons of East, Central and Southern Africa (COSECSA), Hawassa University College of Medicine and Health Sciences, and 13 U.S. institutions that have surgical faculty engaged in global health.* In this month’s column, we describe the progress that has been made in pilot testing this program at Hawassa University in Ethiopia.

Background
As previously reported, the ACS Board of Regents approved an ACS global engagement strategy developed in 2017–2018. The Operation Giving Back (OGB) Committee on Global Engagement recommended a pilot project in collaboration with COSECSA to establish a centralized training hub where the quality of surgical training could be improved and the number of trainees could be scaled up.

The goal of this collaborative is to collectively develop a surgical training center of excellence that can better serve the region by providing opportunities to increase the surgical workforce, transfer knowledge and skills, and build the infrastructure for better patient care and research. This collaborative is based on the principles of twinning partnership, where shared goals are collectively developed, long-term institutional commitment is emphasized, responsibility is shared, and mutual benefit is acknowledged. This partnership was supported by policy leaders at the Ethiopian Ministry of Health and Hawassa University leadership.

After a series of exploratory trips, representatives of the ACS, Hawassa University, and the 13 partner institutions met in July 2018 at ACS headquarters in Chicago, IL., to discuss shared goals and to devise a workplan for the coming year. Four pillars of focus emerged: clinical care, quality, research, and education. Several strengths were identified, including the skills and hospitality of Hawassa faculty, willingness to collaborate, and knowledge base. Areas for improvement included operating room (OR) functionality and capacity, equipment/supplies availability and maintenance, and team-based learning to include other specialty areas, such as nursing and anesthesia.

Progress to date
The pilot ran from early January through the end of June 2019. Although the six-month pilot was intended to serve as a needs assessment process, several activities were implemented, including the introduction of morbidity and mortality (M&M) conferences, FAST (focused assessment with sonography in trauma) ultrasound training, intraoperative laparoscopic training, and improvement of basic infection protocols, among others. Details about these and other early achievements of this partnership in the four pillars of the program are as follows.

Clinical care
The Hawassa University department of surgery comprises seven general surgeons, one colorectal surgeon, and one pediatric surgeon. The U.S. faculty are involved in all aspects of clinical care, including providing services in the outpatient clinic, participating in inpatient rounds, as well as scrubbing in on OR care.

The first laparoscopic cholecystectomy at Hawassa was performed after one of the ACS volunteers, Marc De Moya, MD, FACS, Medical College of Wisconsin, Milwaukee, identified a functioning laparoscopic tower in the storage area. This procedure is now available with the help of our U.S. volunteers, and all the general surgeons at Hawassa University are being trained in the simulation lab in the fundamentals of laparoscopy.

Other first-time procedures include low anterior resection, extended neck dissection, and pancreatic resection. Principles of Advanced Trauma Life Support® also have been introduced to improve care for severely injured patients.

Quality
As surgeons, our core value is to promote a culture of quality in our institutions. Through this collaborative, the Hawassa University department of surgery has begun convening weekly M&M conferences. This initiative launched in February 2019 with support and mentoring from Abier Abdelnaby, MD, FACS, a faculty member from the University of Texas Southwestern, Dallas, who also is looking forward to implementing the principles outlined in the ACS Red Book, Optimal Resources for Surgical Quality and Safety.

Understanding that appropriate documentation is a fundamental component of ensuring quality of care, the local surgical faculty is adopting and customizing some of the U.S. operative report formats. The early foundations of quality assurance processes are being laid, as evidenced by the fact that baseline understanding of surgical infection rates and other complications are being documented to systematically address shortcomings.

Research
A research infrastructure is in development, starting with a basic research methodology course and assessment of the available research infrastructure. This initiative is supported by a taskforce led by Mary “Libby” Schroeder, MD, FACS, department of surgery, Rutgers New Jersey Medical School, Newark. The partnership has a collective goal of submitting five major manuscripts and publishing 10 case reports in this academic year. In addition, a trauma database is in development.

Education
The Education Workgroup, led by Edgar Rodas, MD, FACS, Virginia Commonwealth University, Richmond, has developed a detailed plan, which has led to the initiation of the following activities:

• Formation of a biweekly journal club, which launched in September 2019 and is led by the U.S. volunteers
• Biweekly didactic seminars scheduled to match the expertise of on-the-ground U.S. volunteers
• Simulation center standardization and training in Trauma Evaluation and Management, laparoscopy, basic surgical skills, and so on
• FAST ultrasound training for all surgical residents, which has significantly improved the assessment and care of surgical patients
• U.S. volunteer participation in a structured inpatient care and outpatient service
• Acute care surgeon participation in critical care services and education
In addition, we have established a philanthropy workgroup that has been hard at work identifying material support for this partnership. Under the leadership of Richard Caplan, MD, FACS, department of surgery, Houston Methodist, TX, hundreds of pounds of medical equipment have been delivered. The training center is seeking to build meaningful partnerships with industry and other nongovernmental organizations leading efforts to improve global health.

Moving forward
In the course of just one year, the ACS-COSECSA Surgical Training Collaborative has made great strides toward improving the training of surgical residents and the quality of care provided to surgical patients at Hawassa University. As Joseph Sakran, MD, MPA, MPH, FACS, faculty from Johns Hopkins University, Baltimore, MD, said, “With over 20 million Ethiopians receiving care at Hawassa, the ACS, along with other partners, has had the opportunity to begin transforming surgical care in this region. While the collaboration is at its infancy, what’s clear is the importance of the programmatic infrastructure being laid down that will ensure long-term sustainable interventions that will ensure capacity building within the region.”

Adding strong surgical services to any medical facility strengthens the whole system and guarantees sustainability. As the work at Hawassa University continues, plans are under way to establish a surgical training hub in other low-income regions. Our goal is to mitigate the negative health care consequences of living in under-resourced parts of the world for surgical patients and to expose U.S. surgeons and residents to techniques they can apply to improve value-based care at their home institutions. This initiative epitomizes how much good a small group of caring individuals can accomplish when they join forces to achieve a common goal. The ACS-OGB program is looking forward to working with other interested academic global surgery programs to develop additional collaboratives in other parts of the world.

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

Dear sir or madam,

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Have we drifted too far from the fundamentals of surgical training?

The August 2019 issue of the Bulletin focused on wellness and resilience in surgical trainees and introduced the topic of the Resident and Associate Society Symposium at Clinical Congress 2019—the pros and cons of shift work. Because I am one of those older surgeons the authors disparage when they belittle those who talk about “the good old days” of surgical education, you know what I am about to say regarding the August issue. I have been a surgeon for more than 30 years both as an academic surgeon and in clinical practice at two community hospitals with wonderful, talented colleagues.

Without question, surgical training is different than when I trained. As the authors mention, with laparoscopy, robotics, and the requirement of constant supervision, the resident of today, in many programs, is ill-prepared for the real world of active practice. It is not the fault of the residents we are training, but the fault of those of us who are training them. Academia, surgical organizations such as the American College of Surgeons, and others have succumbed to our present-day politically correct environment where criticism, toughness, and total dedication are seen as evil. Instead of experienced and well-trained staff telling the residents what is expected and what it takes to be the best, the residents tell the staff how they want to be taught.

As the authors mention, the Halstedian idea of a residency was just that. You lived at the hospital, waited to get married, and dedicated your life to your patients. The authors correctly note that “burnout,” today’s buzzword, should have been an issue then, but there is no evidence to support this perspective. This is because as surgeons we were talking about life and death issues daily. Morbidity and mortality (M&M) conferences were terrifying experiences because our mentors realized that it was vitally important to try to make us understand that we should remember the mistakes we saw at M&M so another patient might avoid death or a complication. It was meant to make an impression, and it succeeded.
To whom it may concern,

Dear sir or madam,

The authors also talk about shift work and loss of continuity or sensible balance of responsibility. They thankfully point out that the shift work mentality can be seen as a threat to the professional tenets that define the core values of surgery. I only wish that were the case. Shift work is now the norm and what we tell our trainees they should desire for a good “quality of life.”

Most of the liability lawsuits I read as an expert witness revolve around lack of continuity of care or lack of ownership. What used to separate surgeons from all other health care providers was the dedication to the patient no matter what. I compare surgeons with Navy Seals and other special forces soldiers. We need to make it clear that being a surgeon is special and requires a special person with a special drive and dedication. Stop trying to make surgery appeal to everyone and start going after the best. Make it clear it is not for everyone and that your quality of life is not the issue, but the quality of the patient’s life is the only issue. If you don’t see yourself as being able to make this commitment, then don’t sign up for the tour of duty.

Surgery is not easy, and we have tried to recruit young people by telling them it is easy, and they can have it all. We have become a victim of the lowest common denominator in the recruiting and training of surgeons.

I know I would much rather look up from my stretcher in the hospital at a well-trained, sleepy, dedicated surgeon than one who is well rested, poorly trained, and needs a lavender room to deal with the stress of the occupation. It is time for leaders to lead instead of following the trends and politically correct path. I know it won’t happen, but I can dream.

Guy Voeller, MD, FACS
Memphis, TN

With laparoscopy, robotics, and the requirement of constant supervision, the resident of today, in many programs, is ill-prepared for the real world of active practice. It is not the fault of the residents we are training, but the fault of those of us who are training them.
Recapturing the joy of surgery

by Carol E.H. Scott-Conner, MD, PhD, MBA, FACS
Clinicians are beset by numerous stressors, and it seems that we surgeons, because of our active and direct involvement in patient care, are stuck in the “pain point” between our patients and the system. For our own well-being, we need to recapture the joy of surgery. By taking care of ourselves and each other, we also will take better care of our patients.

What do I know of these stresses, after a lifetime in the cloisters of academia? My own academic career took me from New York, NY, where I attended medical school and trained, to three predominately rural states: West Virginia, Mississippi, and Iowa. I stay in contact with former residents in both academic and private practice and with surgeons in mostly rural practice around my area. I also am an avid follower of the American College of Surgeons (ACS) Communities. Reading those daily digests, the sense of unhappiness and frustration engulfing many of my surgical colleagues is striking. This misery stands in stark contrast to the sense of joy and vocation that called many of us to surgery. And let me add that we in academia also experience and must respond to these pressures.

**Sources of stress**

Some of the challenges include the following: drastically declining reimbursement, the rapid pace of technological innovation, increasing specialization within general surgery, closure of small hospitals, consolidation of hospital systems, conversion to employed status for many in private practice, threat of litigation, what I call “weaponized” peer review, dysfunctional electronic health records, closed networks, and many others. Some topics that made the list of “Hot Threads” on the ACS Communities in 2019 are as follows: “Why is general surgery dead?” “Hospitals and ageism,” and “While inflation has increased, reimbursement has been pitiful.” Other threads included vigorous discussions of surprise medical billing legislation, Medicare for all, threats to private practice, and activity after clinical retirement. This list just scratches the surface.

How do these issues affect us, and what tactics can we use to circumvent them? Changes are needed at the global (that is, national and international) level and the local level (that is, within our own individual medical communities). We also need to take action individually, to allow ourselves to experience and project joy—the joy that drew us to this amazing vocation in the first place.

Danielle Ofri, MD, an attending physician at Bellevue Hospital, New York, recently published an editorial in the New York Times with the inflammatory title, “The business of health care depends on exploiting doctors and nurses.”1 “One resource seems infinite and free: the professionalism of caregivers,” she wrote. The editorial leads off with a familiar scenario: “You are at your daughter’s recital and you get a call that your elderly patient’s son needs to talk to you urgently.” And another: “Your patient’s MRI [magnetic resonance imaging] isn’t covered, and the only option is for you to call the insurance company and argue it out.” She goes on to describe how “one additional task after another is piled onto the clinical staff members, who can’t—and won’t—say no.”

**An assault on our moral fiber**

The result of these challenges is an epidemic of burnout. In a recent survey of ACS Governors, more than 50 percent of the respondents reported experiencing burnout at some point in their career.2 A previous survey of the ACS membership in 2008 yielded similar results.

Freudenberger defined burnout in 1975 as “a constellation of symptoms—malaise, fatigue, frustration, cynicism, and inefficacy—that arise from excessive
demands on energy, strength, or resources in the workplace." Key symptoms include a feeling of emotional exhaustion and a tendency to treat colleagues or patients as objects. If you do a PubMed search on “burnout,” you will find innumerable references documenting burnout in various clinician populations around the world. Burnout is now the most accepted term used to describe clinician distress in an inherently dysfunctional system.

The problem with the term burnout is that it seems to imply that if we were just stronger, smarter, better, we wouldn’t burn out. As a surgeon, I don’t like the term. What burns out? A defective light bulb. A candle guttering to its end. We’d like to think that surgeons do not burn out. Yet the very nature of our work and our ethos in today’s environment predisposes us to the condition. We take on tough cases and expect excellent outcomes. We suffer, find workarounds, and continue to advocate for our patients until the burden becomes unendurable. The very dedication and perfectionism upon which we surgeons pride ourselves may render us more susceptible. Failure to recognize the symptoms, to name the problem, leads to delayed intervention.

It is crucial to recognize that burnout is a symptom of a problem in the workplace, not a weakness of the clinician. Burnout and disruptive behavior are on a continuum; when too much pressure has accumulated over time, the clinician erupts. At the breaking point, surgeons may consider early retirement or become clinically depressed. Suicide can be an extreme consequence.

The National Academy of Medicine just released Taking Action Against Clinician Burnout—A Systems Approach to Professional Well-Being. But we don’t need just a systems approach. We need systemwide change and individual strategies to develop the resilience to survive these assaults.

I prefer the term “moral injury” to describe the distress many of us are feeling. Moral injury is a term that initially was used to describe some of the symptoms of soldiers returning from the Vietnam War who had a constellation of symptoms that appeared to relate to threats to a soldier’s moral fiber, rather than threats to their own life (as in classic post-traumatic stress disorder). Wendy Dean, in a recent editorial, described it in the medical environment as resulting from “the challenge of simultaneously knowing what care patients need but being unable to provide it due to constraints that are beyond our control.”

Here are some examples of distress often experienced in health care: A patient needs an operation, but the insurance company won’t cover it. A patient needs a medication but can’t afford it (and the insurer won’t cover it). You request a specific instrument—maybe just a stapler or a suture—and are told to use something else, something that someone somewhere has judged to be “equivalent” because the hospital has a contract with the manufacturer.

To paraphrase Dean and others, surgeons are smart, tough, durable, and resourceful. If we could have “MacGyvered” ourselves out of this situation by working harder, smarter, or differently, we would have done it. In fact, our constant efforts to MacGyver our way out of a bind and to get our patients the care they need may have led to our evolving burden of moral injury—the continued erosion of our moral fiber. Think of a rope, fraying against the sharp surface of the edge of a rocky cliff, strand by strand parting, until it breaks.

Another concept that applies to surgeons is that of the “second victim.” Whenever a complication, a medical error, or a death occurs, the first victim is the patient. The “second victim,” often forgotten, is the surgeon who feels responsible for the event. Remember the old saying that every surgeon carries a graveyard around in his or her head? When the complication or death is the result of a medical error, or a liability suit has been filed, the surgeon’s suffering intensifies; hence, the term “second victim.” Because we intervene so directly and decisively in the lives of our patients—that is, we are uniquely privileged and allowed to inflict the controlled trauma of an operation—the inherent imperfections of our own

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Olga M. Jonasson, MD, FACS, and her contributions to the joy of surgery

When Olga M. Jonasson, MD, FACS, was a medical student at the University of Illinois at Chicago in the late 1950s, she told her chief, Warren Cole, MD, FACS, that she wanted to be a surgeon. He thought this idea was absurd.* Through sheer determination, hard work, and excellence, she joined the house staff at the University of Illinois, where Cook County Hospital was the prime attraction. After his initial skepticism subsided, Dr. Cole became her mentor, advising her to obtain additional training in research to prepare for an academic career. She spent a year at Walter Reed Army Hospital, Washington, DC, studying immunohistochemistry and another year at the Massachusetts General Hospital, Boston, studying transplantation immunobiology. She established a tissue-typing laboratory (initially with grant funding from the National Institutes of Health), which ultimately was used at six Chicago transplantation locations, and performed the first kidney transplantation in Illinois in 1969.

When Dr. Jonasson was named chief of surgery at Cook County Hospital in 1977, she was the first woman to hold such a position at a major medical center and considered the preeminent woman among academic surgeons in the U.S. at the time. She retained her preeminence for the rest of her life and continues to influence the course of surgery and the careers of surgeons to this day.

In 1987, Dr. Jonasson left Cook County Hospital to become the Robert M. Zollinger Professor of Surgery and Chair at The Ohio State University, the first woman to hold such a position in the U.S. During that tenure, she co-authored an editorial published in the *Journal of the American Medical Association*, “A pregnant surgical resident? Oh my!”† That editorial provided the first rational discussion of and description of a practical manner for accommodating the process of childbearing during surgical residency.

After Dr. Jonasson left Ohio State, she returned to Chicago and became Director of Education and Surgical Services at the ACS in 1993. Under her leadership, grants totaling more than $13 million dollars were secured to fund research studies, including one that demonstrated that the National Surgical Quality Improvement Program could be transferred from the Veterans Affairs (VA) hospital system to the more generalized environment.‡ This initiative, now run under the aegis of the ACS, has moved the peer-review process, well-intended but susceptible to individual prejudices, into a more objective realm and provided road maps to better operations and patient care.

She undertook studies of the work conditions of surgical residents and quality of care.* She was instrumental in developing the ACS Clinical Trials Methods Course in 1997, modeled after a similar course offered by the VA.§ These are only a few key initiatives that Dr. Jonasson spearheaded or facilitated during her ACS tenure.

It seems to me surgeons have two sources of joy—our personal lives and our professional ones. Within the hospital environment, we find joy in what we do for patients and in the exercise of our skill.

art and the deep sense of personal responsibility inculcated in us by our mentors returns to haunt us.

Responding to the assaults
Both the system and the surgeon need to combat these assaults. At the systemic level, we need tort reform and a more rational system for compensating victims of errors. At the individual level, we must support each other when such an event occurs. Too often the “second victim” retreats into a kind of self-imposed isolation at a time when both collegial and institutional support are needed.

Added to these burdens are individual stressors, such as student debt, care for children and elderly parents, and plans for retirement. Many of these encumbrances disproportionately fall upon women because of our natural role as caregivers.9

Finding joy
But what about joy? How can we recapture that sense in our own lives as surgeons? I have told you that I will talk about three spheres of action:

• Individual action—actions or strategies we can all incorporate

• Local action—actions at the hospital staff, county, or state level

• Global action—actions that our professional societies, including the ACS and the American Medical Association (AMA), are undertaking and must expand on our behalf

First, let’s acknowledge that what we do is miraculous and should give us joy. When I retired from clinical practice, I sought a way to communicate the joys and challenges of surgical practice to the lay public and began studying narrative medicine. What is narrative medicine? You can think of it as the intersection between the humanities and medical practice, as well as a set of tools that facilitate incorporation of the humanities into medical training.10

I recently led a narrative medicine session for a group of pediatrics residents. I used a format that incorporates three elements: close reading of a short piece of literature, a period of quiet reflective writing (that is, writing in response to a prompt), and then time to share what is written. Sharing is completely voluntary. No preparation is required, and no homework is assigned. All this work is done in slightly less than an hour.

For this session, I used Suite X of the William Carlos Williams poem “January Morning,” which begins, “The young doctor is dancing with happiness in the sparkling wind, alone at the prow of the ferry!” The stanza concludes with just one more sentence. The entire piece is two sentences, each ending with an exclamation point.

We discussed this poem for approximately 15 minutes, speculating about the setting, the source of the doctor’s happiness, and so on. Where was he going on the ferry? Perhaps to meet a loved one. Maybe to a new job. Possibly on vacation. Why dancing? Why a doctor? Why alone?

Then I gave them the writing prompt, “Write about a time when you felt like dancing with happiness.” Some wrote of the hospital environment, but most wrote about profound personal experiences, such as the birth of a child. Some shared what they had written. At the conclusion of the hour, one resident said, “We don’t talk about joy enough.” Think about that—we don’t talk about joy enough.

It seems to me surgeons have two sources of joy—our personal lives and our professional ones. Within the hospital environment, we find joy in what we do for patients and in the exercise of our skill. A surgeon whom I respect greatly put it this way in a recent e-mail: “It’s the great results that are joyful, whether a cosmetic surgery or a lifesaving one. Seeing the patients’ results is a joy for me.”

ACS Past-President Carlos A. Pellegrini, MD, FACS, FRCS(Hon), FRCSI(Hon), FRCS(Ed)(Hon), in his keynote speech to the New York Surgical Society, invoked the
Japanese concept of “ikigai”—an intersection of four conditions: what you love doing, what you are good at doing, what the world needs, and what you can be paid to do. For surgeons, the superimposition of these four factors places us in that fortunate zone. Most of us went into surgery because we loved it—loved the art and science and the difference that we could make in the lives of our patients. Most of us are really good at it, the world definitely needs surgeons, and we get paid for it. When all four intersect, all is well. When one of the four is missing; so, too, is the satisfaction.

I recently asked a pediatric surgery colleague what operation he most enjoys doing. He told me that he gets the most satisfaction from doing a simple pyloromyotomy for hypertrophic pyloric stenosis. The improvement is dramatic, immediate, and life-changing for both the small patient and the family. Everyone is happy.

I became curious, so I queried our General Surgery ACS Community members, asking, “What is your absolutely favorite operation? And, if you have time, why?” It was a totally unscientific survey. I primed the pump by confessing that I had always loved to drain pus. I was amazed by the results. Some surgeons wrote of delicate or technically demanding operations, such as a Whipple or a parathyroidectomy or carotid endarterectomy. Several wrote eloquently of their satisfaction with life-changing operations, particularly for patients who had no other recourse. These were not necessarily dramatic “saves,” but rather operations that made a significant difference in a patient’s life. One described incorporating a panniculectomy into an incisional hernia repair, thus giving the patient a bonus. Another described repairing a scrotal hernia that “went down to the knees” on a global outreach mission and the satisfaction of seeing the man walk away, unencumbered, afterward.

Right colon resection through a transverse incision was an unexpected favorite that, when I thought about it, made a great deal of sense. Appendectomy—both open and laparoscopic—was near the top of the list, both because of technical satisfaction and the life-changing element. Several surgeons agreed that draining pus, especially perirectal abscesses, was highly satisfying. Some mentioned that their favorite operation was whatever they were doing at the time. One surgeon cited the pleasure of helping residents do their first case.

And when someone posted the need to keep the focus on the patient, not self, many agreed.

**Recommendations for recapturing the joy of surgery**

This comment leads directly to my first recommendation: Focus on the patient, not on yourself. In the early 1900s, Sir Berkeley Moynihan, KCMG, CB, FRCS, of Leeds, U.K., said, “The most important person present at an operation is the patient. This is a truth not everywhere and always remembered.” One of Dr. Jonasson’s former trainees said, “She taught me how to be a doctor first, a doctor who put patients first…. She taught us to be uncompromising.”

A corollary of this lesson is the admonition to focus on task, not self. This simple advice was given, year after year, to our surgical residents by our program director at the University of Iowa, William “John” Sharp, MD, FACS. This focus helps us avoid endless rumination about how much we wish we could get a cup of coffee, get home on time, grab a bite to eat, or even fit in a quick pit stop. I’ve invoked it myself during long nights on trauma call.

Don’t lose sight of the miraculous—the unexpected save or the everyday things we take for granted. Cultivate a quality of mindfulness.

A hospital chaplain who was allowed to observe a kidney transplant later told me that urine started to come out of the ureter as soon as the blood vessels were attached. She told me that the surgeon said, “Look, it is making pee!” She said that she felt she was standing upon sacred ground.

Talk with your patients. Find out their priorities and their concerns. We surgeons speak truth. Blunt and plainspoken to a fault, we sometimes are criticized...
Focus on the patient, not on yourself. A corollary of this is the admonition to focus on task, not self.

for that. Yet who among us has not been called to the bedside of a patient and taken on the hard duty of explaining, to patient and family, that intervention is futile? The very concept of palliative care has grown from this sort of honest discussion of alternatives. When you make evening rounds, take time to sit at the bedside. Hold out your hand. Often, the patient will reach out and grasp your hand with theirs. I loved to feel those warm fingers in mine, the strength of the grasp, the human touch.

Cherish your loved ones. Take care of each other. Reach out to colleagues and peers. Avoid isolation. Consider the nurses and other health care professionals in your hospital as colleagues; you are all working together to help patients.

Consider participating in the ACS Communities. Users have described these online discussions as a kind of virtual surgeons’ lounge, where problems of all sorts—clinical and administrative—can be shared, and triumphs celebrated. Remember the “second victim.” Reach out to colleagues who may have been affected by medical error or death. Don’t retreat into a cocoon if you are the one so affected.

Make time for your spiritual life, whatever that may be. Something as simple as making a list at the end of the day of things for which you are grateful can lift your mood. Cultivate compassion and maintain a sense of humor. Develop resilience, the quality that is often cited as an antidote to burnout.

Take time to teach. When we teach, we nurture our own souls, as well as those of our students. The very word “doctor” derived from the Latin word for teacher. If you are in an academic position, then teaching is an integral part of your tripartite mission. Herand Abcarian, MD, FACS, said of Dr. Jonasson that her main strength “was her infectious enthusiasm that the students and residents got from her…. She made them all wish they were surgeons. It was just a remarkable thing.”

You don’t have to be an academic surgeon to make teaching part of your daily routine. Teaching is like watering a garden—both the garden and the gardener are nurtured. Teach everyone around you. Of course, educate your patients and their families, but also teach the nurses, the aides, the nurse anesthetists. Share your knowledge in little moments of enlightenment. And be prepared to listen and to learn yourself. Collegial conversation with physicians in other specialties educates both.

Seek opportunities to educate the lay public. Whether it is through Stop the Bleed® training, a few words about breast cancer at halftime during a “think pink” women’s basketball game, or a course on surgical anatomy for senior citizens, get the word out.

If you are near a medical school, volunteer to help in simulation labs, or to teach an Advanced Trauma Operative Management® course or an Advanced Trauma Life Support® course, or to lead other formal activities. If you are not close to a medical school, you are probably rural, so consider allowing a medical student to shadow you as part of a rural elective.

Consider surgical volunteerism. Learn about Operation Giving Back.

Develop new skills

Be prepared to periodically reinvent yourself and to see these reinventions as opportunities to explore new terrain. I tell our trainees and students that you will need to expand their skills about every five years or so. The necessity for reinvention may come from within—as your practice changes or as a result of technical innovation in your area of practice.

Technical innovation can be explosive and cataclysmic, or it can be evolutionary. I, and most older general surgeons, have experienced both. In 1987, the first laparoscopic cholecystectomy was performed, and in 1989, the first series of cases was published. The world of general surgery underwent a seismic change. Until then, laparoscopy had been primarily a gynecologist’s tool that a small number of visionary surgeons used for diagnostic purposes. Cholecystectomy was, and is, one of the most common operations general surgeons
History of the Olga M. Jonasson, MD, Lecture

The ACS Women in Surgery Committee (WiSC), the friends and colleagues of Dr. Jonasson, and women in surgery throughout the country established this lecture in 2007 to honor the memory of Olga M. Jonasson, MD, FACS, who died in August 2006. Dr. Jonasson was a true pioneer and trailblazer. She was a leader in academic surgery, exemplified by her becoming the first woman chair of surgery in U.S. history. She was a devoted teacher and mentor to countless numbers of surgeons, both men and women.

This lectureship is a testimony to leadership and education in surgery and a reflection of the capacity of women to reach academic pinnacles. Nominations for the lecture come from the WiSC. The following individuals have delivered the lecture at the ACS Clinical Congress:

<table>
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<tr>
<th>Year</th>
<th>Lecturer</th>
<th>Title</th>
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<tbody>
<tr>
<td>2018</td>
<td>Joan Reede, MD, MS, MPH, MBA, Boston, MA</td>
<td>A Path Toward Diversity, Inclusion, and Excellence</td>
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<tr>
<td>2017</td>
<td>Kathryn D. Anderson, MD, FACS, Eastvale, CA</td>
<td>A Quiet Pioneer Who Started a Revolution</td>
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<td>2016</td>
<td>Alexa Canady, MD, FACS, Pensacola, FL</td>
<td>The Journey: Becoming a Neurosurgeon and Back Again</td>
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<td>2015</td>
<td>Julie A. Freischlag, MD, FACS, Sacramento, CA</td>
<td>Resilience</td>
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<td>2014</td>
<td>Barbara L. Bass, MD, FACS, Houston, TX</td>
<td>Our Lives As Surgeons: Finding a Sense of Place and Purpose</td>
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<td>2013</td>
<td>Pauline W. Chen, MD, FACS, Haverhill, MA</td>
<td>Conduct Unbecoming</td>
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<td>2012</td>
<td>Carol-anne Moulton, MD, ON, Canada</td>
<td>Peeking Behind the Curtain—Surgical Judgment Beyond Cognition</td>
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<td>2011</td>
<td>Patricia J. Numann, MD, FACS, Syracuse, NY</td>
<td>Effective Advocacy</td>
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<td>2010</td>
<td>Nina Totenberg, Washington, DC</td>
<td>Women in the Professions</td>
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<td>2009</td>
<td>Karin M. Muraszko, MD, FACS, Ann Arbor, MI</td>
<td>Leadership Development and Mentoring in the Age of Restricted Work Hours</td>
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<tr>
<td>2008</td>
<td>Anna Marie Ledgerwood, MD, FACS, Detroit, MI</td>
<td>Myths in Surgical Care</td>
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<tr>
<td>2007</td>
<td>Nancy L. Ascher, MD, PhD, FACS San Francisco, CA</td>
<td>The Ultimate in Surgical Translation: Transplantation</td>
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perform. It was done through a big incision. The new operation came into widespread use without the benefit of institutional review boards or randomized clinical trials. We learned a lot from that experience and do things better now.

Every general surgeon in practice had to decide whether to adopt the new technique. Some took this opportunity to retire. But the early adopters and their students rapidly developed the instruments, techniques, and applications that we are still using today. The Society of American Gastrointestinal and Endoscopic Surgeons (SAGES) stepped into the breach and developed training programs and materials.

How do you learn new skills? You build upon old skills, you fall back upon transferrable skills, you read everything you can, and you take every advantage of the training opportunities national organizations such as SAGES, the ACS, and the American Society of Breast Surgeons (ASBrS) offer. You seek mentors and proctors. When I was learning how to do laparoscopic cholecystectomy, my proctor was a supremely skilled gynecologist who was facile in performing difficult laparoscopic pelvic dissections for infertility.

Laparoscopic cholecystectomy required acquisition of a completely new skill set. Most changes have been less cataclysmic. A more typical example might be the continued evolution of breast surgery. For those of us who trained in the late 1970s, lumpectomy, image-guided biopsy, sentinel lymph node biopsy, and nipple-sparing mastectomy replaced the modified radical mastectomy we learned to do. But these skills were an extension of those techniques already learned.

General surgeons who have taken trauma call and used ultrasound for focused abdominal sonography for trauma exams or to facilitate line placement are well-positioned to add breast ultrasound to their repertoire. A basic ultrasound course taken online through the ACS, coupled with hands-on courses at the ASBrS and a case log, allows one to attain certification.

My point is, just as suturing and knot-tying are transferrable skills, so are facility with ultrasound, the Seldinger technique, and other fundamental techniques, which makes accommodating evolutionary change in our practice a bit easier.

Our surgical societies, with the ACS leading the way, are providing and must continue to provide training opportunities for surgeons who change practice patterns, who move into a different practice and need new skills, or who wish to bring new techniques to their community. We need to be nimble, to anticipate and produce high-quality educational offerings that facilitate skills acquisition by moving, as we do during a difficult dissection, from known to unknown.

Don’t forget that part of change requires you as a surgeon to keep current on multidisciplinary management. Neoadjuvant therapy to downstage malignancy and permit less mutilating surgery has drastically changed our approach to cancer at a variety of sites. Accurate risk assessment allows better patient counseling.

Seek additional education in management, leadership, teaching, and other “nonmedical” issues. Take advantage of short courses at national meetings. Distance learning and online courses are available to augment your knowledge in almost any area. I was fortunate to have evening courses at Millsaps College just a couple of blocks away and partners willing to let me out on time when I decided to get a master of business administration degree. Now, low-residency programs are available at many big-name schools. Consider your tuition to be an investment in your own future.

Value diversity

Cherish diversity and each other. View your individual differences as sources of strength, rather than weakness. We recently celebrated the first all-woman astronaut space walk. You might ask, why did it take so long, and why is it remarkable? Consider biologic diversity in the context of space travel.

In 2013, the National Aeronautics and Space Administration (NASA) asked the Institute of Medicine to impanel a committee to look at ethical issues
surrounding the human exploration of space. The committee explored a couple of fundamental issues: First, what should NASA do if a mission exceeded allowable exposure parameters? What was the ethical way to proceed? The deep space environment is hostile, and for many health sequelae, you can almost think in terms of dose-response curves—the longer an astronaut is exposed, the more likely it is that a health problem will develop.

To make this concept concrete, consider the issue of radiation exposure. What if assignment to a mission would result in an astronaut exceeding approved exposure standards? Radiation happens to be easier to quantitate and has established standards. The second question was how to incorporate fairness. If women, for example, were more susceptible to a given exposure than men, should they be excluded from the mission? I served on a committee that wrote a report defining an ethically solid approach that incorporated fairness.\textsuperscript{15}

I learned a lot from this experience—most importantly, there is no perfect, invulnerable astronaut. Women are typically smaller than men and may endure isolation and confinement better. They also appear to be less susceptible to the retinal changes associated with microgravity.

Spacesuits no longer come in just one size, and an astronaut no longer needs to be chosen to fit the suit. Sure, NASA had to scramble to come up with two of the right size, and that’s embarrassing, but the point is that the system was able to accommodate.

There is strength in diversity.

\textbf{Get involved}

With respect to changes that must occur at the institutional level, I would urge you to seek leadership opportunities by becoming involved in the various committees of your hospital. Reinvigorate meetings of your county medical society—at the very least, it allows collegial interaction with other specialists, and at the best it provides an avenue to advocate for legislative and systemic change. Become active in the surgical section of the AMA.

Similarly, participate in your state chapter of the ACS. It can provide a wonderful forum for networking, sharing views, and advocating for change.

The ACS provides ample opportunities at the national level as well. Simply by attending the Clinical Congress and sitting in a lecture hall, and, more importantly, talking with your peers from other parts of the U.S. and even the rest of the world, you are influencing the future and helping your own career.\textsuperscript{16}

In July, the College introduced ACS THRIVE (Transforming Healthcare Resources to Increase Value and Efficiency)—a joint initiative with Harvard Business School.\textsuperscript{17} Here is a new initiative, looking for energetic, qualified, and interested surgeons. It is a chance to get involved and become part of the solution at the national level.

Volunteer, participate, and reinvigorate yourself. The standard advice to young surgeons starting out is, “Say no”—or, perhaps more accurately, be careful not to overextend yourself. I would urge you to “Say yes” to every opportunity you’re offered in your professional life. Time appears to be fixed—there are only 24 hours in a day—but it is highly elastic. The old saying, “work expands to fill the time available” can be turned on its head, and you can find the time to do work that you love.

Don’t assume that you are too young, too old, or unqualified. If you are interested, put your name forward or have a colleague do so. If you are turned down, just do it again with another group. Remember that you may be rejected for what seems like a trivial reason—wrong specialty or wrong region of the country, for example.

I often invoke the “rule of 3s”—one out of three tries will succeed. If you succeed every time, you aren’t aiming high enough. If you never succeed, you need to reexamine your goals. But if you can succeed one out of three times, you are doing well. Rejection is part of life, not necessarily something to be feared.
Attend the ACS Leadership & Advocacy Summit in Washington, DC. Attend the didactic sessions and stay to educate your legislators on health care issues. No experience in advocacy? Never contacted your legislators? Training is provided. This conference is an easy place to start. If we do not educate our lawmakers, who will? Big Pharma, hospital associations, and liability attorneys—that’s who.

I previously mentioned the surgical section of the AMA. I’d like to briefly highlight an AMA program called STEPS Forward. This program comprises a series of modules to “empower teams...to identify and attain appropriate goals and tactics well matched to your practice’s specific needs and environment.” One module is “Creating the organizational foundation for joy in medicine—organizational changes lead to physician satisfaction.” Note the focus: organizational changes.

Take care of yourself

Make time for wellness. Find a way to incorporate stress-relieving physical exercise in your daily routine, even if all you can do is park your car at the far end of the lot and walk briskly to and from the hospital. The University of Iowa Hospitals and Clinics, Iowa City, where I practiced until retirement and continue to teach, has miles of corridors and sky walks. I bet your hospital does, too. Follow good health habits. Find and work with a good primary care physician.

Make room in your life for the humanities and creativity. One of our hospital chaplains (not the one I mentioned previously) always carried small pieces of paper with short poems printed on them. She’d pull one out and hand it to you, saying, “Here’s a pocket poem.” How long does it take to read a pocket poem? Or to write a brief poem yourself, draw a quick sketch, or pull out your smartphone and take a photograph of rabbit tracks in the fresh snow or the sun shining through autumn leaves?

If you are in the latter half of your career, think about and prepare for retirement. Find ways to stay involved.

REFERENCES


continued on next page
Modify your practice, if necessary, to accommodate the inevitable changes of aging. Cultivate other interests.

If you are just starting out, take charge of your career and shape it to the form you wish it to assume. I’ve spent my entire life in academics, and it’s been a wonderful journey. I’ve trained surgeons who went on to become academic leaders and surgeons who went into small, rural practices. I’m proud of all of them. Whatever you do, devote yourself to your patients, your family, your job, and your community.

Women who have chosen surgery as their vocation are exceptionally well qualified, I believe, to cultivate the sense of joy and to pass it along to students who may be considering a career in medicine in general or in the surgical specialties. Look at the smile on Dr. Jonasson’s face in the photo on page 16. Who can doubt that this supremely competent woman surgeon loved her vocation? We were drawn to a career in surgery not because it was easy or expected, but because of our passion for the art and science. Let’s use that passion as a catalyst to change the system, our institutions, and our lives for the better.

Our interventions as surgeons forever change lives—not just those of our patients, but also their families, and sometimes we affect the very fabric of a community. We need to fight back vigorously, both individually and collectively, against the forces that would stifle our sense of wonder and reduce us to mere technicians. We stand, you stand, at the intersection between disease and wellness, offering if not cure, at least significant improvement.

**Acknowledgments**

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**REFERENCES, CONTINUED**


Surgeons, patients, and policymakers are concerned about the impact that surprise medical bills have on patients and the patient-physician relationship. The American College of Surgeons (ACS) has advocated for a comprehensive solution that would remove patients from the middle of the payment negotiations between providers and insurers and that requires equitable and coordinated efforts by health care insurers, hospitals, and physicians.

Over the last year, members of Congress have been identifying and debating proposals to eliminate surprise medical bills for out-of-network care. In its advocacy efforts, the ACS has sought to provide policymakers with the physician’s perspective on this issue. Legislation to address surprise medical billing should protect patients, increase insurance plan transparency and accountability, and address narrow and inadequate networks. Furthermore, any solution should not rely on a benchmark payment rate, or rate setting, based on negotiated in-network rates or a percentage of Medicare to pay for out-of-network care. If policymakers do not follow these suggestions in crafting a solution to alleviate surprise medical billing, it could have large-scale ramifications on the health care system. The ACS asserts that a viable solution to the issue of surprise billing must strike a careful balance, allowing physicians and insurers to negotiate a final payment through a fair independent dispute resolution (IDR) process, while protecting patients from surprise medical bills.

Protecting patients by increasing transparency
The ACS has asserted that any legislation to address surprise medical bills should keep patients out of the middle. Patients who require emergency care are particularly at risk of receiving unanticipated medical bills because often they are unable to make informed choices about where they receive care. When receiving
emergency care, patients should only be responsible for their in-network cost-sharing amounts. To preclude patients from being burdened with negotiations between insurers and providers, physicians should receive direct payment or assignment of benefits from the insurer. The ACS maintains that although patients should not be responsible beyond their in-network cost-sharing amount, health care plans should be required to work with physicians to ensure fair compensation for the care delivered.

Too often, despite being diligent about seeking care from in-network providers, patients may find themselves receiving surprise medical bills from physicians who are not in their insurance network. Often, patients have no way of accurately determining in advance which physicians will be involved in their care. Unfortunately, surgeons also are limited in their ability to help patients avoid these unanticipated costs because they are equally unable to accurately predict who might be involved in an episode of care or those individuals’ contract status with specific insurance plans.

To effectively remedy this problem and increase insurance plan transparency, insurers should be required to update their provider directories at least once a month to optimize the accuracy of and usefulness to patients seeking care from in-network physicians. In addition to improving transparency of provider networks, insurers should be required to provide greater transparency with regard to deductibles and required cost-sharing amounts for both in-network and out-of-network care. Any legislative solution that does not address these issues would serve to simply ignore one of the major root causes of surprise medical billing. By making sure insurers are transparent about required cost-sharing amounts for beneficiaries and that provider directories are up-to-date, patients can avoid “unexpected” bills.

**Addressing narrow and inadequate networks**

Health insurers are taking increasingly drastic steps to offer lower-cost plan options in an effort to attract consumers. Unfortunately, consumers may be unaware that less generous plans have an insufficient number of providers in their networks relative to both the number of covered patients and the lack of breadth in the specialties included in such networks. Insurance plans often choose to offer products with narrow and inadequate networks as a mechanism to manage costs. When consumers sign up for these plans, insurers do not adequately inform them that the provider networks are excessively restrictive, which often results in gaps in their health insurance coverage.

Most physicians prefer to be in-network because it is better for both their patients and their practices, but insurers often control the market, leaving physicians with little room to negotiate. According to the Centers for Medicare & Medicaid Services (CMS), 39 percent of counties in the federally facilitated exchange (FFE) have a single issuer, meaning that 19.8 percent of enrollees have access to only one insurer. Similarly, five states had only one issuer in 2019. Because of extreme health plan market dominance, unfettered by applicable and effective antitrust regulation, insurers increasingly are not acting in good faith in contract negotiations, often offering contracts of adhesion, which provide for a “take it or leave it” payment level. Subsequently, if physicians accept this low rate, the following year’s in-network payment rate often drops even lower. However, if physicians elect to not participate in the plan because of in-network rates, then it will become more difficult to attract patients and they will face more administrative burdens.

Insurers have a significant disincentive to create adequate networks because their own costs may be much lower when their covered patients see physicians who are out-of-network. The fact is, insurers can pay these physicians less than in-network physicians or may choose to deny claims outright for out-of-network care. Regardless, it is the patient who ends up with higher deductibles for out-of-network care or, in some cases, does not receive credit toward fulfilling their annual deductible obligations.

As Congress continues to advance legislation on surprise billing, the ACS’ position is that legislation
aimed at effectively and permanently remedying surprise billing must address network adequacy. Insurance plans must be mandated to meet minimum standards of network adequacy to include contracting with an adequate number of surgeons, specialist and subspecialist surgeons, emergency physicians, and hospital-based physicians. In addition, Congress should consider geographic and driving distance standards, as well as maximum wait times. Comprehensive oversight and rigorous enforcement of network adequacy will be required from both the federal and state governments to ensure the effectiveness of such requirements.

Proven IDR model
The ACS supports a proven IDR or arbitration model as an effective means of reducing surprise medical bills. The out-of-network law passed in New York State serves as a useful template for federal legislative efforts. New York’s law holds insurers accountable for maintaining adequate networks of physicians and specialists to ensure that patients have greater access to in-network care. The law further establishes reasonable patient benchmarks and an effective IDR mechanism for those circumstances in which the payment offered is in dispute because of factors such as the complexity of the patient’s medical condition or the special expertise required. This law has struck a careful balance among the interests of key health care stakeholders, including physicians, hospitals, and health insurers, and has been successful in protecting patients from large, unexpected medical bills. The ACS is advocating that federal legislative solutions to address unanticipated medical billing be modeled on the New York State law.

The ACS has encouraged key congressional committees to use a fair and equitable IDR process. Demonstrated IDR models encourage the arbitrator to review a range of factors to make their determination. This process brings all parties to the table as equals. Specifics that the arbitrator should consider are as follows:

- Level of training, education, and experience of the physician and the circumstances and complexity of the case
- Individual patient characteristics
- The usual and customary cost of the service (as defined by the 80th percentile of charges for that service in that region) determined by an independent benchmarking database, such as FAIR Health Inc.
- Commercially reasonable amounts for comparable services or items in the same geographic area, which reflect the market value of services provided
- The market share held by the out-of-network health care provider or that of the plan or issuer
- Other economic data, such as previous contracting history

Other stakeholders have voiced concerns that consideration of the 80th percentile of usual and customary costs would lead to increased rates; however, the evidence suggests otherwise. According to a report from the Center on Health Insurance Reforms, Georgetown University McCourt School of Public Policy, Washington, DC, New York’s 2014 Law to Protect Consumers from Surprise Out-of-Network Bills Mostly Working as Intended: Results of a Case Study, the New York IDR model has been effective thus far. This study assesses the implementation of New York’s law five years after enactment and how the law is working for consumers, providers, and insurance company stakeholders. The study found a 13 percent average reduction in physician payments since the law was enacted.1 State regulators also report that the law has not had an inflationary effect on insurers’ annual premium rate filings. Participants in the study further note that, prior to the law, New York health maintenance organizations were required to pay out-of-network physicians’ full billed charges for emergency services when physicians did not agree to
While it is important that Congress find a solution to protect patients from surprise medical bills, the ACS has significant concerns with the use of median contracted or in-network rate as a benchmark for paying out-of-network physicians.

### Unintended consequences of rate setting

While it is important that Congress find a solution to protect patients from surprise medical bills, the ACS has significant concerns with the use of median contracted or in-network rates as a benchmark for paying out-of-network physicians. Setting the payment benchmark at the median contracted rate will expand the disproportionate power that health plans have with physicians and will likely have two major negative consequences:

- For those physicians who want to be part of the health plan’s network, the ability to negotiate a payment rate with the health plan will be unfairly biased toward the insurer.

- For those physicians who are in-network and paid above the median in-network rate, the health plan will have unfettered power to lower the payment rate.

If a physician is in-network and paid in the 80th percentile above the median rate, in the next contract negotiation the health plan could offer the physician the 65th percentile rate with no alternative. The physician would be forced to accept the insurer’s lower offer or go out-of-network and receive the median in-network rate. Insurers have no incentive to negotiate an adequate rate with the physician and could intentionally lower the median rate with each new contract.

Furthermore, setting a benchmark rate could increase consolidation within health care. Providers, having no leverage to negotiate, will have to accept the median rate, be forced out of network, or leave independent practice and become hospital employees. This situation will further drive consolidation. Accepting a federally benchmarked rate, as some stakeholders are advocating, could have a significant impact on the U.S. health care system.

### Congressional proposals

Since the fall of 2018, policymakers have been holding roundtables and hearings, and collecting feedback on surprise billing proposals. Legislators have proposed different solutions to the problem, but members of Congress and the Administration have expressed a clear commitment to addressing the issue.

**Senate action**

Sens. Bill Cassidy (R-LA) and Michael Bennet (D-CO) convened a bipartisan working group to develop a legislative proposal. Through their efforts, which included conversations and formal feedback from stakeholders, they developed the Stopping the Outrageous Practice (STOP) of Surprise Medical Bills Act, S. 1531, which would prohibit balance billing for emergency services and certain out-of-network care. Although the legislation includes an IDR process, it also uses a benchmark of insurer-dictated median in-network rates for out-of-network care. Hence, if an insurer offers an unfair payment, the physician could appeal the claim to an IDR. Although the inclusion of an IDR process was a positive step, the legislation contained a restriction that would prevent the independent arbitrator from considering charges from physicians in the same geographic area.

The ACS voiced formal opposition May 17, 2019, to the legislation, which would require arbitrators to use

a negotiated rate. The IDR process likely has served to reduce those payors’ costs.

The Georgetown report acknowledged that the IDR is not perceived as “a slam dunk for either side.” As of October 2018, IDR decisions have been split approximately evenly between providers and payors, with 618 disputes decided in favor of the health plan and 561 decided in favor of the provider. However, insurers have tended to win most out-of-network emergency services disputes (534−289), whereas providers have won most surprise bill disputes (272−84). The study highlights that observers do believe the legislation has sent a signal to insurers and providers alike to “just be reasonable and work it out amongst yourselves if you can.”2

**Unintended consequences of rate setting**

While it is important that Congress find a solution to protect patients from surprise medical bills, the ACS has significant concerns with the use of median contracted or in-network rates as a benchmark for paying out-of-network physicians. Setting the payment benchmark at the median contracted rate will expand the disproportionate power that health plans have with physicians and will likely have two major negative consequences:
insurance-controlled data rather than an independent benchmarking database. An independent database, such as FAIR Health, which is used successfully in New York, is essential to maintaining the integrity of the arbitration process.3

Shortly after the STOP Surprise Medical Bills Act was introduced, in June 2019 Senate Health, Education, Labor, and Pensions (HELP) Committee Chairman Lamar Alexander (R-TN) and Ranking Member Patty Murray (D-WA) introduced the Lower Health Care Costs Act, S. 1895. Before this legislation was introduced, the ACS provided feedback on ways to reduce health care costs by increasing price transparency and improving value and submitted comments on a draft outline of the HELP Committee bill. The Lower Health Care Costs Act would prohibit balanced billing for emergency services and for out-of-network nonancillary services provided at an in-network facility if no notice is provided to the patient. The legislation took the route of establishing a payment benchmark for out-of-network care at the median in-network rate. The legislation does not contain an independent dispute resolution process. On June 20, the ACS issued a press release opposing the legislation because it would use the insurer-dictated federal payment rate setting as a shortcut to address the root cause of surprise medical billing.4 The HELP Committee approved the bill, but it has yet to reach the Senate floor.

House action
ACS advocacy efforts to oppose rate setting proposals have been successful in ensuring a more robust dialogue regarding the need for an effective and fair IDR process. Having heard the physician community’s concerns about the insurer-friendly Senate proposals, Reps. Raul Ruiz, MD (D-CA); Phil Roe, MD (R-TN); Joseph Morelle (D-NY); Van Taylor (R-TX); Ami Bera, MD (D-CA); Larry Bucshon, MD, FACS (R-IN); Donna Shalala (D-FL); and Brad Wenstrup, DPM (R-OH), introduced legislation, the Protecting People from Surprise Medical Bills Act, H.R. 3502. The ACS supports the framework of this legislation, which is modeled on the effective state law in New York. H.R. 3502 would allow the arbitrator to consider actual charge data for the same service, in the same geographic area, performed by a qualified specialist or subspecialist, that is sourced from a statistically significant and wholly independent benchmarking database such as FAIR Health. Along with support from the health care community, the champions of this legislation have built support for a solution that includes an IDR process, and the legislation has more than 100 cosponsors.

Echoing the actions of the Senate HELP Committee, the House Energy and Commerce Committee developed the No Surprises Act, H.R. 3630, which was included in the Reauthorizing and Extending America’s Community Health (REACH) Act, H.R. 2328. As introduced, the No Surprises Act would prohibit balance billing for emergency services at in-network facilities. The legislation would allow for balance billing for certain out-of-network services if informed consent was received prior to the care being delivered. However, the No Surprises Act would set a benchmark payment rate at the median in-network rate for out-of-network care and does not contain an IDR process.

Because of the dedicated efforts of Representatives Ruiz and Bucshon, House Energy and Commerce Committee Chairman Frank Pallone (D-NJ) and Ranking Member Greg Walden (R-OR) agreed to an amendment to the legislation that would establish an IDR process. Although the inclusion of an IDR was a step in the right direction, in its current form the IDR would be almost completely unusable. The legislation includes a threshold for IDR consideration. In 2021, the median contracted rate paid by the insurer would need to exceed $1,250 for a provider to appeal a claim to the IDR. This threshold would be indexed to the inflation measure Consumer Price Index for all Urban Consumers and would increase for subsequent years. Physicians would be unable to batch claims together from the same insurer for the same or similar procedure to meet that $1,250 threshold. On July 17, 2019, the House Energy and Commerce Committee voted the legislation favorably out of committee.
The ACS has significant concerns about advancing a sweeping solution that will have unintended consequences for the health care system in order to pay for other expiring programs.

Solutions on the backs of physicians
Although all stakeholders seem to agree that congressional solutions to address surprise medical billing should protect patients, it is unclear whether Congress will be able to arrive at one solution. It is clear, however, that rate setting proposals like the House’s No Surprises Act and the surprise billing provision in the Senate’s Lower Health Care Costs Act save the federal government money—money that would fund the reauthorization of expiring health care programs.

The Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) estimate that, over the 2019–2029 period, the No Surprises Act would increase revenue by $20.9 billion and reduce direct spending by $1 billion, for a total reduction in the deficit of about $21.9 billion. The CBO acknowledges that most health care services are delivered inside patients’ networks, and more than 80 percent of the estimated budgetary effects of the No Surprises Act would arise from changes to in-network payment rates. The CBO and JCT maintain that if out-of-network care were reimbursed at median in-network rates, payments to providers—inside and outside of networks—would converge around those median rates. Similarly, the CBO estimated that the surprise billing provisions of the Lower Health Care Costs Act would save the federal government $24.9 billion over a 10-year period.

The ACS has concerns about advancing a sweeping solution that will have unintended consequences for the health care system. Accepting a federally benchmarked rate or using rate setting to resolve the issue of surprise billing could have a deleterious effect on all physician payment and open the door to large-scale health care reform. The ACS opposes both the No Surprises Act and the Lower Health Care Costs Act because they contain a one-sided solution to the issue of patients receiving unanticipated medical bills.

What to expect
As 2019 was coming to an end, there was a possibility that surprise billing policy might end up in the end-of-year government funding bill. The ACS wrote to congressional leadership stating that a comprehensive solution should avoid the long-term consequences of setting payment benchmarks, provide a fair and accessible independent dispute resolution process, increase the transparency of insurance plans, address network adequacy, and level the playing field between physicians and insurers. The ACS highlighted its opposition to any solution that uses a payment benchmark at the median in-network rate for out-of-network care.

As details of the government funding package were coming together, the Senate HELP Committee and the House Energy and Commerce Committee both pushed for Congress to act on surprise billing. On December 9, 2019, Chairman Alexander, Chairman Pallone, and Ranking Member Walden modified the Lower Health Care Costs Act to include an IDR process for claims in which the allowed amount exceeds $750. The agreement would not allow for the batching of claims and restricts how frequently the IDR process can be used. Advocates for the proposal pushed for its inclusion in the government funding bill to pay for other expiring health care programs. The ACS opposed the new proposal, as it continues to use the insurer-dictated median in-network benchmark rate as payment for out-of-network care and contains an unusable and restrictive IDR process. The ACS continued to advocate that Congress should not rush a bad solution to offset funding for other end-of-year health care programs.

Soon after the bicameral announcement on the Lower Health Care Costs Act, Chairman Neal and Ranking Member Brady announced that the House Ways and Means Committee would exert its jurisdiction over the issue and would craft legislation to address the issue of surprise medical billing. The exact details of the proposal were unavailable at press time; however, the committee laid out a framework that includes an independent, mediated negotiation process to resolve billing disagreements. The College appreciates what appears to be congressional willingness to further examine this complex issue. Given the congressional dissension on this issue, surprise billing policy was omitted from the end-of-year funding
package, H.R. 1865, the Further Consolidated Appropriations Act of 2020. This legislation, which provided funding for government programs for the rest of the fiscal year, also extended some expiring health care programs through May 22.

The timeline for advancing surprise billing legislation at the federal level will likely align with the May 22 deadline. Because health care priorities will need to be addressed before their expiration, Congress likely will enact a broader health care package that contains a surprise billing proposal. The ACS continues to educate members of Congress, particularly individuals who serve on the committees of jurisdiction. Both the House Ways and Means Committee and the House Education and Labor Committee leadership have indicated interest in moving legislation through the committee process.

Until Congress reaches consensus on this issue, the state legislatures likely will continue to address this issue on their own, leaving a patchwork of disparate laws across the nation. For details about state-level legislation, see the November 2019 issue of the Bulletin.

The ACS continues to engage with policymakers at all levels to encourage a balanced approach to this issue that has significant ramifications for patients and physicians alike. ♦

REFERENCES


Committee on Trauma advocates for improved care of severely injured patients

by Hannah Chargin and Christopher Johnson, MPP

The American College of Surgeons (ACS) has waged a continuous effort to improve care for injured patients since 1922, when it established the Committee on Fractures. Now known as the ACS Committee on Trauma (COT), the committee has more than 3,500 Fellows working to develop and implement meaningful programs for trauma care in local, regional, national, and international arenas. The COT looks to develop and implement programs that support injury prevention and ensure optimal patient outcomes across the continuum of care.

Advocacy at both the local and federal levels is a pillar of the COT and is vital to the effort to improve trauma care. Support for trauma systems, injury prevention, and research funding are all affected by state and federal representatives and agencies, and the College continues to be a trusted resource on Capitol Hill and in state governments.

Federal legislation

The ACS Division of Advocacy and Health Policy (DAHP) advances the College’s health policy agenda, which includes a robust trauma portfolio. The ACS COT advocacy team encourages members of Congress to support bipartisan trauma legislation that strengthens trauma care with the goal of minimizing injury and preventable deaths. Specific pieces of trauma-related legislation are as follows.

HIGHLIGHTS

- Summarizes ACS COT advocacy initiatives at the local and federal level
- Provides updates on PAHPAI, Stop the Bleed® firearm-related injury prevention, and trauma funding
- Describes future legislative goals, including the creation of a trauma task force aimed at creating a national trauma system
PAHPAI
After extensive efforts by the DAHP staff, surgeon advocates, and in conjunction with our trauma partners, on June 24, 2019, President Donald Trump signed S. 1379, the Pandemic and All-Hazards Preparedness and Advancing Innovation (PAHPAI) Act of 2019. This legislation was created to improve the nation’s response to public health and medical emergencies and called for appointing an Assistant Secretary of Preparedness and Response (ASPR) to oversee the nation’s disaster response. The ASPR’s responsibilities would include implementation of the recommendations from the June 2016 National Academy of Sciences, Engineering and Medicine report, *A National Trauma Care System: Integrating Military and Civilian Trauma Systems to Achieve Zero Preventable Deaths After Injury.*

Included in this reauthorization is the ACS-supported Mission Zero Act. Mission Zero builds upon the legislative framework passed in the fiscal year 2017 National Defense Authorization Act by further incorporating military trauma care providers into the civilian setting. These military-civilian trauma care partnerships will increase military health care readiness and ensure the provision of high-quality trauma care both domestically and abroad. The grant was authorized for $11.5 million for fiscal years 2019–2023 and will be facilitated by the ASPR.

Now that Mission Zero has been authorized, the Appropriations Committees will need to fund these grants at the authorized amount. DAHP staff and its partners have begun to lay the groundwork to ask Congress for full funding.

Stop the Bleed initiatives
Over the last several years, the staff of the ACS DAHP and Fellows of the College have offered bleeding control training to members of Congress and congressional staff. DAHP staff hosts quarterly training with the Senate Sergeant at Arms to train Senate staff and actively pursues large-scale training courses in both congressional chambers. Through this effort, the ACS has demonstrated the importance of Stop the Bleed® on Capitol Hill and in district offices across the nation.

These training courses have resulted in bipartisan legislation focused on further disseminating Stop the Bleed training. On May 7, 2019, Reps. Alcee Hastings (D-FL) and Brad Wenstrup, DPM (R-OH), introduced H.R. 2550, the Prevent Blood Loss with Emergency Equipment Devices (BLEEDing) Act of 2019. This legislation would provide grant funding to states for bleeding control kits and training. With 27 cosponsors, this bill continues to gain traction and raise awareness about Stop the Bleed. DAHP staff is working with the House champions to identify senators to introduce a companion bill in the Senate.

Similar to cardiopulmonary resuscitation training, a civilian familiar with basic bleeding control techniques is better equipped to save a life. The effort to make this training and bleeding control kits available to the public through a Department of Homeland Security grant program will help to drive the goal of reducing or eliminating preventable deaths from bleeding.

Firearms morbidity and mortality prevention
Despite the polarizing political rhetoric around firearms, the ACS COT has promoted a nonpartisan public health approach to firearm injury prevention. This strategy includes implementing evidence-based violence prevention programs through ACS COT-verified trauma centers and fostering a dialogue with professional organizations to create consensus around reducing firearm injury and death.

The College has had numerous opportunities to share the work of the COT before Members of Congress and their staff. The ACS testified before the U.S. House of Representatives Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies at a hearing titled Addressing the Public Health Emergency of Gun Violence and before the U.S. House of Representatives Energy and Commerce Subcommittee on Health at a hearing titled A Public Health Crisis: The Gun Violence Epidemic in America.
In 2019, ACS Fellows and chapters added the surgeon perspective on state legislation to help stem the prevalence of violence and firearm injury and death.

Research funding
Federally funded research from the perspective of public health has contributed to reductions in motor vehicle crashes, smoking, and sudden infant death syndrome. The ACS believes this same approach should be applied to firearm-related injuries and gun safety. The ACS has repeatedly supported funding for the Centers for Disease Control and Prevention (CDC) to conduct public health research into firearm morbidity and prevention.

Last year, the College joined more than 100 medical, public health, and research organizations asking Congress to appropriate $50 million in funding for firearm morbidity and mortality prevention research. Subsequently, the House passed H.R. 2740, the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act. This legislation passed on June 19, 2019, with a vote of 226–203 and included ACS-supported language providing $50 million for firearm morbidity and mortality prevention research.

Background checks
The House passed H.R. 8, the Bipartisan Background Checks Act of 2019 February 27, 2019, by a vote of 240–190. This legislation requires all firearm sales to go through the National Instant Background Check System established under the Brady Handgun and Violence Prevent Act.

This legislation is supported by the recommendations outlined in the ACS Firearm Strategy Team Work Group Consensus Statement and is a key step in addressing this public health crisis.

Liability protections for trauma care providers
Under the Emergency Medical Treatment and Labor Act, physicians are mandated to stabilize a patient who presents at a hospital emergency department (ED). Surgeons in emergency settings provide complex, high-risk surgical care for severely injured patients, often with minimal information about the patient. Unfortunately, the high liability risk associated with providing such care is broadly acknowledged as a key factor in the growing shortage of specialists participating in emergency on-call panels.

The Health Care Safety Net Enhancement Act, H.R. 3984, introduced by Reps. Bill Flores (R-TX); Roger Marshall, MD (R-KS); and Brian Babin, DDS (R-TX), would address the problem by providing Federal Tort Claims Act liability protections to on-call and ED physicians.

State legislation
Stop the Bleed
The Stop the Bleed campaign made significant advancements in 2019 with the enactment of legislation in three states: Arkansas, Indiana, and Texas. In Arkansas, H.B. 1014 requires high school students to complete a Stop the Bleed course, whereas Indiana (H.B. 1063) and Texas (H.B. 496) both passed bills that nearly mirror the ACS’ model legislation requiring public school personnel to be trained in bleeding control and that schools have bleeding control kits on site. The Illinois Terrorism Task Force announced in September that the state would fund the installation of bleeding control kits for all public schools.

Other legislation to install bleeding control kits in schools or public places was introduced in the following states: California, A.B. 1705; Illinois, H.B. 3432; Michigan, H.B. 4334; Missouri, H.B. 1005, H.B. 249; Massachusetts, H. 1870, S. 1337; New York, A. 4484; North Carolina, H.B. 288; Pennsylvania, H.B. 1072; and Tennessee, S.B. 259, H.B. 215.

Trauma funding
The Connecticut Chapter opposed legislation, S.B. 46, which would prohibit trauma centers from charging a trauma activation fee that helps provide the resources required to ensure the state’s trauma system has the necessary health care professionals, facilities, and equipment to save lives. At present, Connecticut does not allocate public funding for the state’s trauma centers. Grassroots efforts by the chapter and testimony
from ACS Fellows garnered enough opposition to the bill to successfully prevent its passage.

The Louisiana Chapter sounded a call to action in support of H.B. 380 to increase driver’s license fees by $2.75 and to direct the funding to the Louisiana Emergency Response Network, the state’s trauma system. Despite support from the Louisiana Chapter and the state’s trauma hospitals, the legislation failed to gain enough support to pass.

Meanwhile, the Texas legislature passed H.B. 2048, which eliminates the Texas Driver Responsibility Program, which generates $71 million to fund the statewide trauma system. The revenue for the trauma system will be replaced with a mix of traffic fines and fees. On April 3, 2019, Ronald M. Stewart, MD, FACS, Medical Director, ACS Trauma Programs, testified before the Texas House Homeland Security and Public Safety Committee in support of the bill.

The Michigan Chapter received the 2019 ACS Enhanced Advocacy Grant to pursue legislation to establish a comprehensive statewide trauma system. The chapter is a member of the Michigan Trauma Coalition, composed of more than 90 member hospitals and trauma centers across Michigan, which is pushing for the legislation.

Violence prevention and firearms
In 2019, ACS Fellows and chapters added the surgeon perspective on state legislation to help stem the prevalence of violence and firearm injury and death. In California, Fellows supported two bills related to violence prevention. A.B. 166 would establish a pilot Medi-Cal program to fund violence prevention services, and A.B. 521 would fund the University of California Firearm Violence Research Center at UC Davis to develop multifaceted education and training programs for medical and mental health providers on the prevention of firearm-related injury and death. The Governor signed A.B. 521 but vetoed A.B. 166.

The New Jersey legislature enacted a package of safety bills—S. 3301, S. 3309, S. 3312, and S. 3323—that will create and fund the New Jersey Violence Intervention Program and Hospital-Based Violence Intervention Program Initiative.

The Delaware Chapter supported passage and enactment of H.B. 63, which revises the charge of “unlawfully permitting a child access to a firearm” to “unsafe storage of a firearm,” placing the emphasis on firearm safety and proper storage. Under the revised statute, a crime is committed when a person intentionally or recklessly stores or leaves a loaded firearm where a minor or another unauthorized person can access the weapon.

The Virginia Chapter submitted comments to the State Crime Commission charged with studying and taking public comments on potential firearm-related legislation in response to the May 31, 2019 Virginia Beach shooting. The chapter’s comments included the ACS Statement on Firearm Injuries and a copy of “Firearm-related injury and death in the United States: A call to action from the nation’s leading physician and public health professional organizations,” which was published in Annals of Surgery.

Distracted driving
State legislatures continue to pass legislation to address distracted driving. A total of 131 bills on various forms of distracted driving were introduced in 2019. Legislation enacted or vetoed include the following:

• Arizona H. 2318 includes an all driver texting ban, handheld ban, and a ban on viewing and transmitting of non-navigational video. However, the Governor vetoed S. 1141 to classify distracted driving as “reckless driving” in certain circumstances.

• Arkansas S. 534 bans use of handheld devices in work and school zones, as well as a cell phone ban for drivers with graduated licenses. Enforcement will charge perpetrators with a primary offense.

• H.B. 107 in Florida upgrades the texting ban enforcement to a primary offense, but permits video chatting when the vehicle is stationary and exempts autonomous vehicles.
State legislatures continue to pass legislation to address the problem of distracted driving. A total of 131 bills on various forms of distracted driving were introduced in 2019.

- **Illinois** S.B. 85 prohibits the viewing of video or using a hand or finger to compose, send, read, access, browse, transmit, save, or retrieve e-mails, text messages, instant messages, photographs, or other electronic data. H.B. 2386 increases the fine and penalties for crashes involving electronic device use that cause great bodily harm.

- **Louisiana** legislation, H.R. 303, creates the Wireless Telecommunications and Vehicle Safety Study Commission to study the use of a wireless telecommunications device while operating a motor vehicle.

- **Minnesota** H.F. 50/S.F. 91 broadens the state’s handheld ban to prohibit video viewing while in traffic. It permits the use of hands-free mode for composing, reading, or sending electronic messages.

- **Rhode Island** H. 6186/S. 785 bans the use of wireless handset for text messages.

- **Tennessee** H.B. 164/S.B. 173 extends the handheld ban in school zones and prohibition on viewing and recording video, gaming, and engaging with other electronic entertainment.

- **Virginia** S.B. 1768 prohibits the use of any personal electronic device in a work zone.

- In **New Hampshire**, the Governor vetoed H.B. 198, which would have repealed the prohibition on texting while driving.

**Motorcycle helmets**

The **Connecticut** Chapter testified at a hearing of the Joint Transportation Committee in support of H.B. 7140, which would require anyone on a motorcycle to wear a helmet. The bill passed out of the legislature after it was amended to remove the universal helmet requirement. A similar bill in **Iowa** to create a universal helmet law for all motorcycle riders and passengers failed.

Legislation was introduced in **Arizona, Maryland, Massachusetts, Missouri, Nebraska, New Jersey, North Carolina, Virginia, Washington, and West Virginia** to weaken existing state law by exempting adults 21 years or older from the requirement to wear a helmet, whereas legislation in **New York** called for the state Department of Transportation to study the efficacy of motorcycle helmets in preventing injury.

All the proposed bills failed except **Missouri’s**, which the state legislature passed, but the governor vetoed. The ACS sent a letter urging Missouri Gov. Mike Parson (R) to veto the bill. The **North Carolina** Chapter initiated a call to action resulting in more than 7,000 e-mails sent to the House Health Committee opposing the legislation to repeal the state’s universal helmet law.

**Seat belts**

A total of 75 bills were introduced in 2019 related to seat belt and child restraints in motor vehicles. The **Louisiana** Chapter engaged the legislature with grassroots in support of S.B. 76 to update the state’s child safety guidelines to mirror the requirements set by the American Academy of Pediatrics. The Louisiana bill passed and become law August 1, 2019, when Gov. Jon Bel Edwards (D) signed it.

The **New York** Chapter initiated a call to action in support of A. 6163/S. 4346, legislation that would require the use of seat belts by all passengers age 16 and older riding in any seating position in a motor vehicle. The New York bill failed despite the chapter’s efforts.

In **Alabama**, S.B. 254 requires that all passengers wear a seat belt while the car is in motion; however, only front seat belt usage is subject to primary enforcement. In **Maine**, S.B. 389 exempts passengers older than 18 years of age from wearing a seat belt if the number of passengers exceeds the vehicle seating capacity and all the seat belts are in use.

**Oregon** enacted H.B. 2347, which clarifies that a person driving a vehicle for the purpose of delivering newspapers or mail is exempt from wearing a seat belt. **Texas** Gov. Greg Abbott (R) vetoed H.B. 448, a child safety restraint bill, which requires children younger
than two years old, shorter than three feet four inches, or less than 40 pounds to be secured in a rear-facing child passenger safety seat system.

Washington’s H.B.1901 provides an exemption from seat belt use for individuals who have a physician’s order that they not use the restraints for medical reasons. H.B. 1012 requires that a child younger than two years old must be secured in a rear-facing child restraint system, a child younger than four in a forward-facing secured seat, and a child less than four feet nine inches must be in a booster seat.

What’s ahead
The COT will continue to build on the momentum of the past year to achieve advocacy priorities by supporting the grants created by Mission Zero, continuing Stop the Bleed trainings for members of Congress and their staff, and serving as a resource on firearm-related legislation. ACS State Affairs is working with the Stop the Bleed Advocacy Workgroup to develop an advocacy guide and model legislation to assist with lobby days and local efforts.

The DAHP staff is continuing efforts to introduce legislation that follows recommendations from the National Academies of Science, Engineering and Medicine report, A National Trauma Care System: Integrating Military and Civilian Trauma Systems to Achieve Zero Preventable Deaths After Injury. The goal of potential legislation would be to create a trauma taskforce that would create a national trauma system and establish a National Institute on Trauma Research.

For questions or additional information on trauma priorities, contact Hannah Chargin, Congressional Lobbyist, at hchargin@facs.org. For information on state trauma legislation, contact Christopher Johnson, MPP, State Affairs Associate, at cjohnson@facs.org.

REFERENCES
One of the most significant and disturbing developments in colorectal cancer (CRC) is its increasing occurrence in adults younger than 55 years old. In May 2018, the American Cancer Society updated its 2008 recommendations, lowering the age to initiate screening average-risk adults to 45. The organization previously recommended beginning screening at age 50. The new recommendation to start at age 45 is a qualified recommendation, indicating “there is clear evidence of benefit of screening but less certainty about the balance of benefits and harms or about patients’ values and preferences, which could lead to different decisions about screening.” The decision to decrease the screening age was informed by data indicating an increasing incidence and mortality of CRC in adults age 50 years and younger. Overall, the incidence and mortality of CRC is declining. However, in the subset of patients younger than 50 years old, the trend has been escalating since the 1990s. Given this increased incidence, the
American Cancer Society has not only lowered the age to initiate screening, but also has recommended continued screening to age 75. Continued screening in adults ages 76 to 85 years should be individualized and, for patients older than age 85, should be discouraged. The new guidelines also emphasize offering both structural (endoscopic and radiologic) and stool-based options to increase screening.

Rationale for new recommendations
CRC continues to pose a large disease burden in the U.S. It is the third most commonly diagnosed cancer and the second leading cause of cancer death in the nation. Risk factors associated with the development of CRC include cigarette smoking, excess body weight, diets high in red and processed meats and low in fiber, alcohol consumption, and sedentary lifestyles. Adenocarcinoma of the colon and rectum typically develop from precancerous adenomatous polyps through a series of mutations. Premalignant lesions represent a time for cancer interception as they can be identified and removed with endoscopic screening. Screening also can identify early-stage colorectal cancers that can be identified and treated prior to metastasis. Many randomized controlled trials have demonstrated that screening for CRC has decreased incidence and mortality associated with the development of the disease.¹

Temporal trends show that CRC incidence and mortality have been declining among adults ages 55 and older because of both reduced risk factors and increased screening. However, recent national data indicates increasing incidence in adults younger than 55 years old. The American Cancer Society’s guideline development group (GDG) was tasked with reviewing the most recent incidence and mortality data to make recommendations on CRC screening. The GDG is a multidisciplinary panel of volunteers composed of generalist clinicians, biostatisticians, epidemiologists, economists, and a patient representative. In its review, the GDG used the same data and reports as the U.S. Preventive Services Task Force (USPSTF) 2016 update, which included data from the National Cancer Institute’s Surveillance, Epidemiology, and End Results (SEER) registry, to obtain incidence and mortality data. SEER collects and publishes cancer incidence and mortality data from population-based cancer registries covering approximately one-third of the U.S. population. In addition, the GDG used a recent systematic evidence review and updated modeling to reflect the most recent SEER incidence data.

The American Cancer Society then commissioned the Cancer Intervention and Surveillance Modeling Network CRC group, including MISCAN-CRC (Microsimulation Screening Analysis Colorectal Cancer Model, Erasmus University Medical Center, Rotterdam, Netherlands, and Memorial Sloan Kettering Cancer Center, New York, NY); SimCRC (Simulation Model of Colorectal Cancer, University of Minnesota, Minneapolis, and Massachusetts General Hospital, Boston); and CRC-SPIN (Colorectal Cancer Simulation Population model for Incidence and Natural history, RAND Corporation, Santa Monica, CA).² The GDG then used the GRADE (grades of recommendations, assessment, development, and evaluation) methodology to make its recommendations. Using this most recent incidence and mortality data, the American Cancer Society recommissioned the modeling group to determine the best screening methods and intervals using the up-to-date data from SEER. These revised modeling data informed the recent decrease in age to 45 to start screening for CRC.

The SEER data demonstrated an increased incidence of CRC in adults younger than 50 years old starting in the late 1980s.¹ U.S. adults younger than 50 years old had a 51 percent increase in the incidence of CRC from 1994 to 2014 and an 11 percent increase...
in mortality from 2005 to 2015. The increased incidence in adults younger than 50 was most pronounced for rectal cancer, which doubled between 1991 (2.6 of 100,000) and 2014 (5.2 of 100,000). A cohort of adults born in the 1990s is twice as likely to develop colon cancer and four times as likely to develop rectal cancer compared with a cohort born in the 1950s. This increasing incidence is not solely a result of increased detection as evidenced by the increased mortality associated with the increased incidence. The recent CRC incidence data among young white adults younger than 50 years old from the late 1980s to 2014 approached the same incidence as the U.S. African-American population. Several organizations now recommend screening African-American patients at age 45.

Few randomized controlled studies evaluating the efficacy of screening for CRC have included patients younger than 50 years old. The American Cancer Society extrapolated data from these trials on safety and efficacy in modeling to make its updated recommendations. The modeling then calculated the life years gained by screening after recommissioning MISCAN and SimCRC to incorporate updated SEER data on incidence, mortality, and screening safety and efficacy in the younger than 50 years old group. This modeling demonstrated significant life years gained and an acceptable risk/benefit ratio by starting screening at age 45.

Many national organizations make recommendations on CRC screening, including the American Cancer Society, USPSTF, and the U.S. Multi-Society Task Force on Colorectal Cancer. Prior to the latest American Cancer Society recommendations, these three organizations had similar CRC screening guidelines. In general, they agreed that screening should begin at age 50 and made recommendations on both structural (colonoscopy, flexible sigmoidoscopy, and computer tomography colonography), as well as stool-based studies (high-sensitivity guaiac fecal occult blood testing [gFOBT], fecal immunochemical testing [FIT], and fecal immunochemical deoxyribonucleic acid [FIT-DNA] testing). The most recent USPSTF recommendations were published in 2016 and used similar SEER data to inform their recommendations. However, the USPSTF claimed that the data were insufficient to support screening patients younger than 50 years old and, therefore, has maintained the standard of starting screening at the age of 50.

**Screening options**

Because 40 percent of adults are behind on screening, the new American Cancer Society guidelines aim to increase screening by providing patients with several options. The society’s recommendations emphasize offering several structural and stool-based methods to increase screening. Starting at age 45, the guidelines recommend structural studies including colonoscopy, repeated every 10 years if no pathology is found; flexible sigmoidoscopy every five years; or computed tomography colonography every five years. Stool-based studies include high-sensitivity gFOBT testing annually, FIT testing annually, or FIT-DNA testing every three years. Stool-based studies are less invasive, do not require mechanical bowel preparation, and can be completed in the privacy of one’s home. These tests may be more appealing to some patients and may result in increased rates of screening. All positive, nonstructural screening tests, however, must be followed up with a colonoscopy.

At present, private insurers and the Centers for Medicare & Medicaid (CMS) have no legal obligation to provide coverage for screening adults younger than 50 years old. The USPSTF, commissioned by Congress in 1984 and composed of 16 individuals, was tasked with making recommendations for screening. Screening methods with a USPSTF grade A recommendation, based on the Affordable Care Act of 2011, do not result in any cost sharing for patients
and are, therefore, covered. However, because the most recent 2016 USPSTF recommendations still call for screening starting at age 50, insurers have no obligation to cover this screening. Unless the USPSTF changes its recommendations, coverage decisions will be left up to individual health care plans. Insurers set premiums annually, and, typically, there is a one- to two-year delay before any health care plan modifies its coverage policies. Physicians should check with individual insurers before making screening recommendations to avoid overburdening their patients with the cost of screening.

The American Cancer Society is the first organization to recommend starting screening at age 45 for average-risk adults based on the increased incidence of CRC in U.S. adults younger than age 55. The reason for the increased incidence is unknown but is likely multifactorial, representing a mix of genetic and environmental influences. Further work is needed to determine the causes and decrease the incidence of CRC. Physicians and patients should engage in shared decision making regarding the type of screening to be used, but a clear emphasis in the new guidelines is to offer choices to increase screening.

References


Editor’s note: The Communications Committee of the Resident and Associate Society of the American College of Surgeons (RAS-ACS) offers an annual essay contest. The theme of the 2019 essay contest was Cut It Out: Changing the Status Quo. The winning essay follows.

Recently, I heard a scrub technician compliment a staff surgeon this way: “I’ve never seen him throw an instrument.” There is no reason to laud reasonable behavior, except in the context of a culture of abuse.

Surgery as a field remains troubled by a paternalistic and frequently angry social character. Euphemistically called “disruptive behavior,” abusive conduct has been addressed as a patient safety issue by The Joint Commission, with an alert in 2008 and a mandate for policy in 2009. Estimates of the prevalence of disruptive behavior are high; 77 percent of the respondents in one study said they had witnessed physicians engaging in disruptive behavior.

These numbers don’t surprise me. I decided to pursue a career in surgery in spite of the culture as I had experienced it—the uncomfortable comments, male superiors who stood too close, and demeaning treatment from residents and fellows. Early in my residency, to get some perspective on the culture I am enmeshed in, I read _Forgive and Remember: Managing Medical Failure_ by Charles L. Bosk, PhD. The cultural
characteristics of surgery that Bosk described in this sociological study—male, cold, rational, typified by abuse and harassment—rang true to my observations almost 40 years later.

In 1979, perhaps this reality was kept quiet. In the early 21st century, it is openly discussed and studied. Nonetheless, disruptive physicians still are often given a pass, frequently on to other institutions. Culture is slow to change.

The culture of surgery is ripe for disruption of this disruptive behavior, and indeed this shake-up is happening. We must insist on respectful conduct as a minimum. While administrative actions are ongoing, needed, and welcome, the ultimate focus must be on change in conduct on the personal, day-to-day level, reaching all levels of the hospital hierarchy.

One way we can support this shift is by increasing diversity in surgery, as many surgeons and leaders are working to do. We need gender parity in surgery as a bulwark against the long-accepted behavioral norms we’ve inherited from our (overwhelmingly) male antecedents.

Women accounted for 34 percent of physicians in the U.S. in 2015, and just 19 percent of general surgeons.¹ Patients need women in surgery. A Canadian study of 1.2 million patients found decreased odds of death among patients treated by female surgeons compared with patient mortality rates among male surgeons, controlling for differences in patient factors and surgeon factors.² We must make our profession inclusive and positive in order to provide the best care for our patients while being well, whole, people.

REFERENCES

ACS quality and safety case studies:
Hospital-based preoperative clinic applies ERAS and Strong for Surgery guidelines to optimize patients for surgery

by Dawn Davis, MSN, RN, NP-C; Vickie Hurst, BSN, RN-BC; Benjamin DuBois, MD, FACS; Christy Mills, DNP, RN, CPHQ, HACP; and Jessica Davis, RN, SCR

With traditional perioperative care, day-of-surgery cancellations and surgical complications can result from multiple factors, including poor blood sugar control, inadequately managed disease processes, frailty, poor nutrition, smoking, delirium, and unaddressed medications.

In 2016, American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP®) data for colorectal surgery at CHRISTUS St. Michael Health System (CSMHS), Texarkana, TX, demonstrated an overall postoperative occurrence rate of 32.7 percent, an average length of stay (LOS) of 7.4 days, and average variable costs of $6,346, including labs, radiology, pharmacy, and supplies. In the ambulatory care unit, blood sugar control (blood glucose <200 mg/dl) on the day of surgery was 87.7 percent, and the day-of-surgery cancellation rate was 4.9 percent.

CSMHS is a faith-based, community, not-for-profit, 354-bed acute care facility that provides health care services in 13 predominately rural counties in northeast Texas, southeast Arkansas, and southwest Oklahoma, and southwest Arkansas. To improve patient outcomes, CSMHS initiated a nurse practitioner (NP)-driven, hospital-based preoperative clinic. The clinic was developed using the principles of Enhanced Recovery After Surgery (ERAS) Strong for Surgery checklists and guidelines. In the preoperative clinic, the NP captures ACS NSQIP variables, identifies patient risk factors using Strong for Surgery checklists, and follows ERAS guidelines to prepare patients for surgery. The goal is to enhance the surgical care of the patient, reduce the LOS without increasing readmissions, minimize postoperative complications, decrease healthcare costs, and increase patient quality of life and satisfaction.

Putting the plan in place
In 2016, the CSMHS quality department team attended the annual ACS Quality & Safety Conference, and through the conference sessions gained a better understanding of ERAS principles and Strong for Surgery guidelines. We brought these concepts back to our institution and began to implement these two programs in the hospital.

The team gathered information on successful ERAS programs across the nation, and in 2016 our medical executive committee approved a colorectal ERAS program as a process improvement project for our hospital. It became apparent that a preoperative clinic within the hospital would serve as a gateway for the ERAS program and would help to ensure the principles were properly implemented. Once the original Strong for Surgery guidelines were published, they were added to the program, and the preoperative clinic was on its way to implementation.

The ERAS principles were introduced at the team’s initial meeting in September 2016. Shortly after this meeting, we began to develop the ERAS algorithms and measurements. We completed the preoperative, intraoperative, and postoperative algorithms in February 2017.

The team hired a preoperative clinic NP in early 2017, and by April 2017 we began piloting ERAS on colorectal surgery patients. We also introduced the nutrition, blood
sugar, medication, and smoking Strong for Surgery checklists to the team and finalized our program logo and education booklet. During this time, our surgeon champion began providing education on ERAS and Strong for Surgery guidelines to the community surgeons and hospital staff.

The clinic officially became operational in June 2017, with ERAS colorectal and the first four checklists for Strong for Surgery. We began to track the ACS NSQIP/ERAS variables for colorectal surgery. When the ACS introduced the Strong for Surgery checklists for delirium, prehabilitation, safe and effective pain control, and patient directives, we added them to our repertoire.

Early in 2018, the team began planning for ERAS orthopaedic operations and the integration of ERAS with the Agency for Healthcare Research and Quality Safety Program for Improving Surgical Care and Recovery (ISCR). In October 2018, we implemented orthopaedic ERAS and ISCR for knee replacement, hip replacement, and hip fractures. The team now is implementing the ERAS and ISCR gynecology guidelines.

In preparation for implementation, the surgeon champion provided education to the community surgeons and select hospital staff. The clinical education department provided house-wide education, and all nursing associates were required to complete online education modules on care provided to the ERAS patient. The team also developed and implemented our data collection methods.

We created ERAS education booklets for patients and their family members. These pamphlets were distributed to physician offices where education is initiated. Brochures also are provided in the preoperative clinic. The NP was responsible for educating patients on preoperative, postoperative, and discharge instructions, as well as applying the Strong for Surgery checklists to each patient.

The surgeon and anesthesiologist write the pre- and postoperative ERAS orders, and nursing staff is responsible for carrying them out.

We assembled a multidisciplinary team from the following areas of the hospital:

- Administration
- Anesthesia
- Case management

**FIGURE 1. YEAR ONE ERAS—COLORECTAL RESULTS**

*ERAS started with colorectal*
No additional costs or funding beyond normal hospital operations were necessary to implement and maintain the quality improvement (QI) program.

Results
We obtained data using the ACS NSQIP database. Additional information was obtained during the preoperative visit, hospital stay, and postoperative phone calls, which were conducted two months after the surgical procedure.

Analysis of colorectal ERAS data for one year indicated that patient LOS decreased from 7.3 days to 5.2 days (see Figure 1, page 45). The average variable costs were reduced from $6,346 to $4,359. Postoperative occurrences as defined by ACS NSQIP decreased from 32.7 percent to 19.6 percent.

Strong for Surgery data for one year indicates that blood sugar control (blood glucose <200 mg/dl) on the day of surgery has improved, going to 95.6 percent of patients from 87.7 percent of patients (see Figure 2, this page). Patient-reported smoking cessation rates are 18.5 percent two months after surgery.

Since implementation of our preoperative clinic, day of surgery cancellations have decreased from 4.9 percent to 0.95 percent of cases (see Figure 3, page 47).

In addition to the processes outlined here, we assess the nutritional needs of our patients and, when appropriate, place patients on an immunomodulating supplement; we consult a registered dietitian as needed. We provide counseling and documents for completion of advance directives/medical power of attorney to 100 percent.
of patients in the preoperative clinic. We also provide diabetic and smoking cessation counseling, screen for delirium, and recommend consults as necessary from physical therapy, cardiology, pulmonology, and case management.

Upon evaluation of our implementation process, the main barriers we encountered were a slow-changing culture and time-consuming data collection. Constant teamwork, communication, and surgeon engagement have been key for culture change. The progress creates a smoother path for our future ERAS programs. A clinical data analyst was added to our team to support data collection and abstraction.

Strong support from our surgeon champion and leadership team contributed to our success. We also have an engaged multidisciplinary ERAS team. Communication was key and was accomplished using frequent ERAS meetings, operating room information boards, memos to the surgeons, and online staff education.

Cost savings data have yet to be finalized.

**Lessons learned for others**

Key components for successful implementation of this QI initiative included the following:

- Support from the surgeon champion, senior leadership, and frontline management is necessary.
- Engaged team members and clear communication are crucial for success.
- Keep it simple. Use Strong for Surgery checklists and ERAS principles to guide your data collection. Begin by tracking data your hospital can collect easily and build from there. Even if the data are less positive than expected, the information highlights the areas that need improvement and can be helpful in forming a plan.
- Don’t try to reinvent any wheels. Use the resources available through the ACS and other organizations that have already developed evidence-based standards.

FIGURE 3. PATIENT OPTIMIZATION REDUCES DAY-OF-SURGERY CANCELLATIONS
The American College of Surgeons (ACS) Clinical Research Program (CRP) sponsored several sessions at Clinical Congress 2019, in San Francisco, CA. The following is a review of those programs that summarizes key learning points and outlines the ACS CRP’s efforts to promote education and quality improvement in oncology, as well as clinical trial participation among the ACS membership.

**Designing and Running a Clinical Trial**

Historically a five-day endeavor, this day-long didactic course for residents, fellows, and practicing surgeons interested in conducting clinical trials reviewed the path from trial design to completion and publication. Led by Judy Boughey, MD, FACS, Chair, ACS CRP Education Committee, and Kamal M.F. Itani, MD, FACS, chief of surgery, Veterans Affairs Boston Health Care System, and professor of surgery, Boston University, MA, the course began with guidance about how to identify a critical gap in surgical or medical knowledge and develop a well-designed scientific study question. Speakers reviewed schemas for clinical trial design, with a focus on two increasingly popular methodologies: neoadjuvant and window-of-opportunity trials. Attendees then learned about statistical analytical approaches, regulatory aspects, safety monitoring and reporting, and funding mechanisms, as well as the structure of the oncology cooperative groups. Edward Livingston, MD, FACS, AGAF, deputy editor of clinical reviews and education at Journal of the American Medical Association, closed the session by providing insight into how to ensure successful publication of completed trials.

**Clinical Trials in Personalized Medicine in Oncology**

Systemic therapy for solid tumors traditionally has focused on histologic origin to define treatment strategies. Because tumor sequencing has evolved rapidly, the use of a patient’s unique mutational profile to determine treatment also has changed quickly. These transformations were the focus of a panel session co-moderated by Flavio Rocha, MD, FACS, member, CRP Cancer Care Standards Development Committee, CRP Education Committee, and Video-Based Education Committee, and Christina Roland, MD, MS, FACS, Vice-Chair, ACS CRP Education Committee.

Jason Sicklick, MD, FACS, assistant professor of surgery, University of California San Diego Health Moores Cancer Center, highlighted the impressive response rates that can be achieved when matching scores are used to determine treatment, with up to 30 percent of heavily pretreated patients with metastatic cancers achieving tumor response. Dennis Wigle, MD, PhD, FACS, consultant, division of general thoracic surgery, department of surgery, Mayo Clinic, Rochester, MN, emphasized the importance of enrolling patients with resected lung cancer in clinical trials, including in the ALCHEMIST trial (NCT02194738)—a unique trial platform designed to evaluate the combination of chemotherapy with
Use of neoadjuvant immunotherapy strategies in locally advanced melanoma has shown great promise, allowing for real-time assessment of tumor response, as well as tissue acquisition to identify novel mechanisms of resistance.

immunotherapy in patients with resected lung cancer. Susan Tsai, MD, MHS, FACS, associate professor of surgery, Medical College of Wisconsin, Milwaukee, described the challenges of precision medicine in pancreatic cancer, particularly related to rapid tumor profiling for molecularly guided neoadjuvant therapy in localized pancreatic ductal adenocarcinoma. Dr. Rocha closed the session with a discussion of the differences in colon cancer based on “sidedness” (left versus right colon cancer), which is a topic that may be incorporated into the next iteration of National Cancer Center Network treatment guidelines.

Management of Peritoneal Malignancies
Garrett Nash, MD, MPH, FACS, FASCRS, vice-chair for quality and safety, department of surgery, Memorial Sloan Kettering Cancer Center (MSKCC), New York, NY, and Rebecca Snyder, MD, MPH, FACS, member, CRP Cancer Care Standards Development Committee and CRP Education Committee, co-moderated a well-attended Panel Session. The session included a lively debate on the role of heated intraperitoneal chemotherapy (HIPEC) for patients with colorectal carcinomatosis, conducted by Olivier Glehen, MD, PhD, head, general and oncologic surgery department, Centre Hospitalier Lyon Sud (Hospices Civils de Lyon), France, and H. Richard Alexander, MD, FACS, chief surgical officer, and chief, surgical oncology, Rutgers Cancer Institute of New Jersey, and regional director, surgery, Monmouth Medical Center, Robert Wood Johnson Medical School, New Brunswick, NJ.

In this session, the authors discussed the recently presented PRODIGE-7 trial, which randomized patients with colorectal carcinomatosis to treatment with systemic chemotherapy and either cytoreductive surgery or cytoreductive surgery + HIPEC. Median overall survival in both groups was approximately 41 months, a significant improvement in survival compared with historical data. The study did not show an association between intraperitoneal chemotherapy and improved survival in this study, prompting significant controversy among surgeons who treat this disease. Professor Glehen attributed the lack of observed benefit of HIPEC to the specific chemotherapy agent (oxaliplatin) and short duration of administration (30 minutes). Dr. Alexander said earlier studies demonstrated similar efficacy of intraperitoneal mitomycin-C and oxaliplatin, suggesting that perhaps neither agent will provide a meaningful survival benefit in the setting of modern systemic chemotherapy.

The panel included an overview of the data regarding HIPEC for gastric cancer by Brian Badgwell, MD, FACS, professor, department of surgical oncology, division of surgery, The University of Texas MD Anderson Cancer Center, Houston, and ovarian cancer by Oliver Zivanovic, MD, PhD, surgeon, section, ovarian cancer surgery, and

Cracking the Code to Clinical Trial Enrollment
Physician participation in clinical trials can be challenging because of administrative barriers, such as the time required to complete training and certification. An open forum, Cracking the Code to Clinical Trial Enrollment, provided guidance on completing requirements, such as obtaining a Cancer Therapy Evaluation Program identification, enrolling in the National Cancer Institute Registrations and Credential Repository, and completing enhanced training requirements such as Good Clinical Practice. Materials from this session are available on the Clinical Research Program website at facs.org/crp.
Immunotherapy for the Treatment of Solid Tumors

Immunotherapy is increasingly used to treat patients with solid tumors such as metastatic melanoma and advanced lung cancer with significant benefit. This session, Immunotherapy in the Treatment of Solid Tumors: Emerging Roles of the Surgeon, moderated by Dr. Roland, focused on how best to incorporate surgery in the multidisciplinary management of these complex cases, as well as the treatment of immunotherapy complications requiring surgical intervention.

Charlotte Ariyan, MD, PhD, FACS, a general surgeon at MSKCC, noted that understanding the incidence, unique toxicity profile, and optimal management of immunotherapy-related surgical issues not previously seen with traditional cytotoxic chemotherapy is critical. Use of neoadjuvant immunotherapy strategies in locally advanced melanoma has shown great promise, allowing for real-time assessment of tumor response, as well as tissue acquisition to identify novel mechanisms of resistance.

Rebecca Auer, MD, MSc, FRCS, FACS, associate professor, department of surgery and department of biochemistry, microbiology, and immunology, University of Ottawa, ON, described the spectrum of the inflammatory environments seen in patients with colorectal cancer, highlighting the first Food and Drug Administration approval of immunotherapy for patients with mismatch-repair deficient tumors.

George Plitas, MD, Jeanne A. Petrek Junior Faculty Chair, MSKCC, reviewed emerging data on differences in response to immunotherapy seen in patients with localized versus metastatic breast cancer, as well as variable responses based on hormone-receptor expression.

John Stewart, MD, MBA, FACS, physician executive, oncology services, and associate director, clinical research, University of Illinois at Chicago Cancer Center, rounded out the session with an insightful review of oncolytic viruses currently on clinical trial for peritoneal malignancies and head and neck cancers.

Surgeon involvement...is critical to unlocking the full potential of this promising class of agents.

Cancer Care Standards

Led by co-moderators Matthew H.G. Katz, MD, FACS, Chair, CRP Cancer Care Standards Development Committee, and Kelly Hunt, MD, FACS, Program Director, ACS CRP, and member, CRP Cancer Care Standards Development Committee, this session focused on best practices from Operative Standards for Cancer Surgery Volumes 1 and 2 and featured a panel of experts who reviewed data demonstrating the benefits of these standards. The session, which emphasized how incorporating these recommendations into practice can lead to improved patient outcomes, was especially timely because the operative standards for melanoma, breast, colon, lung, and rectal cancers recently have been incorporated into the 2020 Commission on Cancer accreditation standards.* This integration is a notable step toward improving oncologic outcomes by reducing variation in the way cancer operations are performed across the U.S.

Biliary tract cancers are rare, with an estimated 12,000 newly diagnosed cases per year, not including intrahepatic cholangiocarcinoma. Biliary tract cancers are divided into intrahepatic, extrahepatic cholangiocarcinoma, and gallbladder cancer. Extrahepatic cholangiocarcinoma can then be divided into perihilar cholangiocarcinoma (Klatskin tumor) and distal common bile duct cancer. Gallbladder cancer is the most common type of biliary tract cancers, followed by perihilar and then distal common bile duct cholangiocarcinoma. Although intrahepatic cholangiocarcinoma represents only approximately 10 percent of biliary tumors, in recent years, incidence of intrahepatic cholangiocarcinoma has increased.

The cholangiocarcinoma also can be classified by the growth pattern of the tumor: mass-forming, periductal infiltrating, and intraductal. The mass-forming type is most commonly observed for intrahepatic cholangiocarcinoma and is associated with a high rate of lymph node metastasis. The periductal infiltrating type is commonly seen in perihilar cholangiocarcinoma. Intraductal growth type can be seen in any part of the biliary tree and is the rarest of the three. For intrahepatic cholangiocarcinoma, mixed type of mass-forming and periductal infiltrating is associated with significantly worse prognosis with no reported five-year survival and median overall survival of 8.3 months.

**Intrahepatic cholangiocarcinoma**

Extrahepatic cholangiocarcinoma typically presents with obstructive jaundice. On the other hand, intrahepatic cholangiocarcinoma rarely exhibits symptoms and is incidentally detected by cross-sectional imaging. Consequently, intrahepatic cholangiocarcinoma often is diagnosed in late stage. Furthermore, diagnosis of intrahepatic cholangiocarcinoma is a diagnosis of exclusion, with broad differential diagnoses of metastatic cancer, hepatocellular carcinoma, cholangiocarcinoma, or benign liver mass. Meticulous and systemic diagnostic work-ups should be employed to establish the diagnosis of intrahepatic cholangiocarcinoma. High-quality, enhanced cross-sectional imaging is a must and sometimes needs both computed tomography (CT) and magnetic resonance imaging (MRI) to characterize the mass and narrow the list of differential diagnoses. Detailed medical history, including colon cancer risk and screening, alcohol consumption, viral hepatitis risk, travel history, and exposure to hepatotoxin, should be taken. Lab tests should include viral hepatitis panel, autoimmune hepatitis serology, iron studies, copper studies, carbohydrate antigen 19-9 (CA19-9), carcinoembryonic antigen, and alpha fetoprotein. CA19-9 could be diagnostic in cases of primary sclerosing cholangitis; however, in other cases, sensitivity is relatively low, particularly in the presence of biliary obstruction or cholangitis.

High-quality cross-sectional imaging is the cornerstone of the diagnosis and treatment of this difficult disease. Particularly for hilar cholangiocarcinoma, liver protocoled CT or preferably enhanced MRI should be obtained before any instrumentation to the biliary tree. Once the biliary tree is decompressed, it is difficult to accurately assess the...
extent of the tumor in biliary tree, which creates significant difficulty in assessing whether the tumor can be resected and developing a surgical plan.

Biliary tract cancers are biologically aggressive with poor prognosis. Even for resected distal cholangiocarcinoma, which has better prognosis among cholangiocarcinoma, five-year survival has been reported as 36–42 percent.5,6 Five-year survival rates among patients with perihilar and intrahepatic cholangiocarcinoma are reported as 20–43 percent and 20–35 percent, respectively.6,7 Surgical resection is the mainstay of the curative-intent treatment; however, resection typically involves either large liver resection or pancreaticoduodenectomy with nodal dissection. Node dissection is an integral part of the surgical treatment because nodal metastasis is one of the strongest prognostic factors. Dissection of the node should include the lymph nodes along the hepatic artery to the celiac axis and lymph nodes along the common bile duct to retropancreatic area. Another important prognostic factor is margin negative resection. For the hilar cholangiocarcinoma, many experts recommend routine addition of caudate lobe resection to necessary liver resection to decrease the risk of margin positive resection because bile ducts of the caudate lobe originate from the hilar portion of the bile duct. Most cases of perihilar cholangiocarcinoma require resection of a significant amount of the liver—either lobectomy or trisectionectomy. Because of the magnitude of the operation, associated morbidities and mortalities are significant.

**NCDB data analysis**

The National Cancer Database (NCDB) from 2012 to 2014 captured 72.5 percent of the cancer cases in U.S. For the following analysis, NCDB data from 2010 to 2013 for patients 18 to 79 years old diagnosed with their first or only malignant or in situ primary were analyzed for intrahepatic, perihilar, and distal cholangiocarcinoma. The three types of cholangiocarcinoma were defined by primary site, histology/behavior, and a site-specific factor that distinguishes the subsite of the primary site C24.0.

The primary site for intrahepatic cholangiocarcinoma was C22.1, whereas distal and perihilar were C24.0. For all three cholangiocarcinoma types, the histology/behavior codes were 8160/3 and 8180/3. Only distal and perihilar cholangiocarcinoma used the site-specific factor to define cholangiocarcinoma type.

Distal cholangiocarcinoma’s site-specific factor values consisted of distal bile duct, common bile duct, common duct not otherwise specified, and subsite of extrahepatic bile ducts not stated or subsite stated as middle extrahepatic bile duct and treated with pancreaticoduodenectomy.

Perihilar cholangiocarcinoma site-specific factor values consisted of perihilar bile duct(s), proximal extrahepatic bile duct(s), hepatic duct(s), Klatskin tumor, and subsite of extrahepatic bile ducts not stated or subsite stated as middle extrahepatic bile duct and treated with combined hepatic and hilar resection.

Three-year survival analysis was performed using the Kaplan-Meier method and

### TABLE 1. CANCER TYPE FOR DIAGNOSIS YEARS 2010–2013

<table>
<thead>
<tr>
<th>Factor</th>
<th>Distal cholangiocarcinoma N (%)</th>
<th>Intrahepatic cholangiocarcinoma N (%)</th>
<th>Perihilar cholangiocarcinoma N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall N</td>
<td>455 (18.7%)</td>
<td>1,544 (63.6%)</td>
<td>429 (17.7%)</td>
</tr>
<tr>
<td>Pathologic stage</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I</td>
<td>*</td>
<td>324 (21.0%)</td>
<td>34 (7.9%)</td>
</tr>
<tr>
<td>II</td>
<td>267 (58.7%)</td>
<td>278 (18.0%)</td>
<td>128 (29.8%)</td>
</tr>
<tr>
<td>III</td>
<td>*</td>
<td>114 (7.4%)</td>
<td>129 (30.1%)</td>
</tr>
<tr>
<td>IV</td>
<td>101 (22.2%)</td>
<td>828 (53.6%)</td>
<td>138 (32.2%)</td>
</tr>
<tr>
<td>CoC program category</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Academic</td>
<td>289 (63.5%)</td>
<td>1,094 (70.9%)</td>
<td>319 (74.4%)</td>
</tr>
<tr>
<td>Community</td>
<td>166 (36.5%)</td>
<td>450 (29.2%)</td>
<td>110 (25.6%)</td>
</tr>
</tbody>
</table>

*Because of cell sizes less than 30, this cell cannot be reported.
95 percent confidence limits. The Commission on Cancer (CoC) program category—academic versus community (consisting of community and comprehensive community) cancer programs—was examined by the type of cholangiocarcinoma and the American Joint Committee on Cancer, 7th Edition pathologic stage group. This analysis was completed using Statistical Analysis System (9.4, Cary, NC) along with the significance threshold of $p < 0.05$.

Of the three types of cholangiocarcinoma, 18.7 percent were distal, 17.7 percent were perihilar, with the majority of cholangiocarcinomas diagnosed and/or treated at academic cancer programs (see Table 1, page 52).

Survival differences existed for patients of certain
Although we could not narrow it down because of the limited amount of granular data available in the NCDB, considering relatively advanced primary tumor, if adequate nodal dissection is not routinely employed, then under-staging could create lower survival.

REFERENCES

Acknowledgment
Statistical support for this column was provided by Amanda E. Browner, MS, Statistician, NCDB.
A look at The Joint Commission: Revisiting *To Err Is Human* 20 years later

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

The Institute of Medicine (IOM, now known as the National Academy of Medicine) 20 years ago published the landmark report, *To Err Is Human: Building a Safer Health System*. This report increased awareness of medical errors in the U.S. and also called for health care system changes that would lead to improvements in patient safety and quality of care.

The report cited a study that estimated at least 44,000 patients die annually in the U.S. as a result of medical errors, with an additional study suggesting it could be as high as 98,000. The report also stated that deaths attributed to medical errors exceeded “the number attributable to the eighth-leading cause of death,” which at the time was suicide. More importantly, the report highlighted the fact that most medical errors were the result of failures of the system rather than specifically attributable to individuals.

Still work to be done
Two decades later, Mark R. Chassin, MD, FACP, MPP, MPH, president and chief executive officer of The Joint Commission—a member of the IOM Committee on Quality of Health Care in America that wrote the *To Err Is Human* report—believes that although that report and others have led to improvements in the health care system, the rates of familiar quality issues remain too high.

For surgeons, quality issues that still demand attention include wrong-site surgery and the continued incidence of unintended retained foreign objects (URFOs). URFOs were the top sentinel event reported to The Joint Commission in 2017 (124 reported) and again in 2018 (121 reported). A total of 104 incidents of wrong-patient, wrong-site, wrong-procedure events were reported in 2017, with another 98 reported in 2018.

Dr. Chassin touched on the *To Err Is Human* report and more in a *Modern Healthcare* commentary, “One-size-fits-all approach to patient safety improvement won’t get us to the ultimate goal—zero harm.”

In the *Modern Healthcare* commentary, Dr. Chassin also wrote that “the method we have employed is the ‘one-size-fits-all’ best practice.” But that approach often leads to modest or inconsistent improvements that are difficult to sustain over time.

“We cannot continue to use the same methods and expect different results,” Dr. Chassin wrote. “Evidence is accumulating that process improvement methods long used successfully in industry—Lean, Six Sigma and change management, taken together—are far more effective than the ‘one-size-fits-all’ best-practice approach.”

Dr. Chassin also spoke with Nancy Foster, American Hospital Association vice-president for quality and patient safety, for the *Advancing Health* podcast.

• Commit to a goal of zero harm

• Drastically overhaul the institutional culture

• Understand that safety processes often fail at rates of 50 percent or more
The report marked a pivotal moment in the health care industry, policymaking, and society’s expectations about how health care is provided.

In the episode, Dr. Chassin described the impact of the *To Err Is Human* report on health care safety.

**Now what?**

So where do we go from here? In a recent *High Reliability Healthcare* blog post, Dr. Chassin reflected on the future impact of *To Err Is Human* and how health care can continue to improve. “We’ve made some significant progress, but the next major gains will arise only from the efforts of health care leadership and organizations, not government, business, market forces, nor patient advocacy groups,” Dr. Chassin wrote. He also asked that after 20 years, “Who is satisfied with the current state?” He noted, “If we’re not satisfied, we need to change the way we have been going about improvement.”

My personal take on the IOM report is positive. I believe that before the report was published, health care leaders were primarily focused on innovation. The report marked a pivotal moment in the health care industry, policymaking, and society’s expectations about how health care is provided. Starting in early 2000 (the report was released in November 1999), attention rapidly shifted from a focus on innovation as a way to advance health care to a focus on safety. That movement toward safety has grown ever since, and that, I believe, has provided enormous benefits to our patients.

Am I satisfied with the rate of harm surgical patients continue to experience? Of course not. However, safety is not a static goal line but rather a moving target. New processes, new devices, new ways of providing treatment—yes, innovation—continues full throttle, and while these advances have benefited society in a significant way, they also have created vulnerability and risks that were not present before. Managing those risks, creating a culture of safety, and continuing to focus on ways to identify and eliminate threats before they become errors is, in my view, the greatest legacy of this report and a moral imperative for every surgeon.

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**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.

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**REFERENCES**


Before giving a recent lecture, I mentioned to my hosts that my father, Sydney P. Schiff, MD, FACS, had studied at their medical school, Queen’s University in Kingston, ON, during World War II. They quickly located the graduation picture on the library wall. In the photo, my father is seated, beaming from the front row and holding the class sign. I lamented the fact that they did not have the opportunity to meet him—my father has been long gone—and he seems today a larger-than-life character from a lost age. Asked to elaborate, I offered them a story from the Woodstock Festival of 1969, in Bethel, NY—one that poignantly highlights the striking metamorphosis that our society and medicine have undergone in the last half-century.

**A call to serve**

Dr. Sydney P. Schiff was a product of the World War II generation that cultivated an ethos of community engagement and public service. An epitome of such service was practicing medicine, and he surmounted considerable poverty-inflicted barriers to pursue our profession. After his internship, he commanded a U.S. Army hospital on Shemya Island in the Aleutian chain. With the war having just ended, he hurled himself into caring for the local Aleutian islanders. His black-and-white photographs of the lives into which he intercalated are haunting reflections of their mutual bond. Typifying what was to become a lifelong one-man rage against disease and injustice was his letter to the U.S. Bureau of Indian Affairs complaining of our nation’s discriminatory policy of denying veterans’ benefits to Native Americans who had served the war effort in often covert roles. He (and in later years his colonel) was proud of his colonel’s infuriated threat that the Army could find a worse posting than Shemya for him if he ever wrote such an unauthorized letter again. I still have some of the crafted artifacts that the Aleut presented to him in gratitude for his years of devoted care.

When he returned to the mainland and completed his surgical residency, he settled with his wife Rose in a rural county, nailed up the shingle for his solo general surgery practice on Main Street in Liberty, NY, and started making house calls with a large black bag. For many years, he was the only Fellow of the American College of Surgeons in Sullivan County. Solo practice general surgery in the rural U.S. at the time would include substantial general adult and pediatric practice, and he did some forensic pathology on the side. Before Medicare and Medicaid, he typically charged low-income patients $2.00 a visit, explaining that “no one likes charity.” A constant stream of fresh local farm produce turned up on our front porch from his patients, for whom he was always on call.

**On the ground**

Novelist Eileen Pollack, then a local teenager, crafted a character, Doctor Rock, modeled after my father in one of her first published short stories in 1990, “Past, Future, Elsewhere,”* which paid homage to the battle he

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waged during the medical crisis of the 1969 Woodstock Festival.

Woodstock, with more than 400,000 attendees, rapidly overwhelmed all anticipated medical services. There were countless injuries, drug overdoses, and deaths—an event unlike anything that rural county had ever experienced.

When the New York State Police called my father about the evolving crisis at the music festival, he immediately closed his solo practice office. He had held a longstanding position as the county’s medical director of civil defense, so he ordered the release of the county’s emergency medical supplies, then stockpiled for the possibility of a nuclear war. Commandeering a local school gymnasium at Monticello, he set up cots, and with volunteers from nearby hospitals’ nursing staff, organized a field hospital. Well before civilian medevac (medical evacuation) helicopter services, and with roads impassable because of the throngs of people who abandoned cars and vans to walk to the festival site, the state police used their helicopters to transport injured concertgoers to his makeshift hospital for treatment and triage. Fittingly for his hands-on version of medicine, he flew on multiple flights, serving as the medical flight crew.

Much of the intake was routine trauma. He was a skilled orthopaedist and was typically in a fine mood and humming while applying plaster after setting fractures. I don’t think I have ever met a physician who enjoyed practicing their art as much as my father did.

Lysergic acid diethylamide (LSD) overdoses were a new challenge for him. He placed unmanageable patients in restraints and administered intravenous fluids until they returned to humanity. He treated this endless stream of muddy, injured, and exhausted patients for three straight sleepless days and nights, returning home only when these young people no longer needed his care.

Flash forward
None of what he did is unthinkable for a physician, although, admittedly, few of us today have the range of skills to handle such a broad spectrum of medical problems by ourselves. The relentless commoditization of health care and the pressures toward professional risk aversion would further complicate such efforts today. But most of us would hope we could have risen to the occasion and done our best if faced with a similar situation then or now.

No, the unthinkable contrast with today was the aftermath. He had performed perhaps the most heroic
act of his professional life during the festival. Medicine was his creed—it was duty and religion—with the firm conviction that he was responsible for his actions. One day during the weeks after Woodstock, two New York Times reporters drove up from New York, NY, to interview him for a story that likely would have brought him fame for his service. But some deep-seated part of his soul felt that doing the interview would be completely wrong. It would have cheapened and demeaned devoted responsibility.

So, with little time left, he called his friend, an iron worker who lived down our country road, and convinced him to take off the rest of the day to go hunting. Timing his actions, he offered the reporters the silent image of him leaving the house in a red plaid jacket with a rifle slung over his shoulder, getting into his car, and driving away. He offered the most noble
response he could think of after his most noble deed was done, albeit, without a horse or a sunset to ride into alone. Our family tried to explain what we could to the apoplectic journalists at the door.

His comment to me later was, “If you do something really good, don’t brag.”

I have spent my professional life thinking of that comment. It stands in such progressively stark relief 50 years later as our society changes. Recently, the New York Times reporter and columnist David Brooks eloquently wrote of “the basic modesty code that has always ennobled the American middle class: Don’t brag.” His colleague Bret Stephens recently wrote of Neil Armstrong, “He stayed humble, and human, in the era of relentless puffery and self-promotion. This, too, feels as bygone as the Saturn V, The Right Stuff, and the ‘one small step’—and as missed.” Would these two commentators, Brooks and Stephens, have appreciated being denied such a story?

Too many treasured facets from the culture of that generation, along with most who served with my father during Woodstock, are no longer with us. Despite the Woodstock era’s social radicalism and upheaval, no one at that time could have envisioned our trajectory toward a society increasingly screen-connected, self-glorifying yet interpersonally cold, and often irresponsibly detached. Despite a turbulent fracturing and partitioning of our democratic polis’ identity at that time in the late 1960s, our societal divisions seemed more readily bridged with empathy and compassion and a consensus call to action when people were suffering.

My father was only one of many who devoted their time and efforts to the young people at Woodstock. If you were one of the many patients he treated or are one of their descendants, he sought neither your thanks nor remuneration. But he would have been so very pleased to know that you have done well.

The 2019 Trauma Quality Improvement Program (TQIP®) Annual Scientific Meeting and Training, November 16−18 in Dallas, TX, drew 1,960 attendees, including TQIP participants, staff, speakers, and exhibitors. The program included sessions tailored for trauma medical directors, program managers, coordinators, and registrars.

The 10th annual TQIP conference focused on high-functioning teams and error management, including a live trauma simulation session featuring an ad hoc trauma team with a post-session debriefing. The program also featured a keynote address by Todd Maxson, MD, FACS, chief, trauma program, Arkansas Children’s Hospital, Little Rock. Dr. Maxson shared his singular experience witnessing the functioning of the Arkansas Trauma System from both sides—as a surgeon and, later, a patient. In addition, the meeting featured sessions describing the traits of high-reliability organizations as they apply to trauma, the evolving role of hospital-based interventions, and updates on TQIP and Committee on Trauma (COT) initiatives.

**Live trauma simulation**
The live multidisciplinary resuscitation simulation—a first for the TQIP meeting—featured staff from Parkland Memorial Hospital in Dallas, a Level I trauma center. Jeffrey E. Carter, MD, FACS, medical director, Louisiana State University School of Medicine, New Orleans, moderated the trauma scenario and co-led the debriefing.

To begin the simulation, all 13 members of the resuscitation team identified his or her role in the simulation. According to the MIST (mechanism, injuries, signs, treatment and trends) report provided in real-time to both the team and the audience, the 57-year-old male “patient” was involved in a rollover motor vehicle crash with confined space patient extrication. His injuries included chest and abdominal pain and bruising, multiple lacerations, and head trauma. Moulage was used on the live patient to effectively depict realistic wounds and injuries. Vital signs and imaging results were projected to both the simulation team and the audience in real time. The team worked together to care for the patient, taking into account all the new information communicated to them. The simulation lasted from arrival in the emergency department to the decision to move the patient to the operating room.

“What do you think you did well, and what could you have done better?” Dr. Carter asked at the conclusion of the 20-minute simulation. The Parkland team offered the following critiques.

• What they did well:
  
  − All of the roles were assigned, and everyone knew what his or her job was during the simulation.
  
  − The team was familiar with equipment in the room (for example, how the respiratory cart was set up), which expedited patient care.
  
  − The lead physician remained engaged with prehospital emergency medical services (EMS)/handoff personnel to let them know they were receiving the information being provided.

• Areas for improvement:
  
  − Enhanced closed-loop communication to keep team
members informed of the status of request or action, including maintaining visual contact to confirm messages received and understood.

- Dr. Maxson, providing the perspective of a patient, noted that the patient in the simulation had a primary concern—whether his wife had been contacted—and noted that this concern did not get passed on in the EMS handoff brief. “From the patient’s standpoint, I thought [the team] demonstrated a lot of empathy, but there were still opportunities to maintain that vigilance regarding the patient’s perspective of the situation,” Dr. Maxson said.

Following the live simulation, Joseph A. Ibrahim, MD, FACS, medical director, Orlando Regional Medical Center (ORMC), FL, described how his facility implemented a similar trauma simulation program. “You play like you practice. We shouldn’t be practicing with our real patients,” Dr. Ibrahim said. At ORMC, simulation program administrators started by identifying the top 10 admission scenarios and incorporating that data into the mock-trauma design plan. The intended goals of these
drills were threefold, according to Dr. Ibrahim: “Improve efficiency, define roles, establish loop closure for the cases that didn't do well.”

“The unanticipated benefits of simulation, at least initially, were improved collaboration, improved practices, and implementation of new protocols and practices,” he said.

At the end of the session, Avery Nathens, MD, PhD, FACS, FRCSC, Medical Director, American College of Surgeons (ACS) Trauma Quality Programs, conducted an informal poll of attendees, which revealed that approximately one-third conduct trauma simulation drills at their facilities, although many more expressed interest in developing similar programs.

**Surgeon receives care in system he created**

Dr. Maxson shared his experience as both a surgeon and a patient with the Arkansas Trauma System—a system he helped to establish—in his keynote address.

Dr. Maxson was on call at Arkansas Children’s Hospital, Little Rock (where he is chief of the trauma program) on September 1, 2017. He was riding home on his Triumph Bonneville during a quick break when he was struck by another driver in a Jeep Cherokee. After the initial shock of the situation started to subside, Dr. Maxson asked a couple of helpful individuals to make two calls: one to 911 and the other to Children’s Hospital informing them he couldn’t take call that night.

Dr. Maxson requested that the paramedics take him to the University of Arkansas for Medical Sciences (UAMS) Hospital—the only ACS-verified adult Level I trauma center in the state.

“First and foremost, you should have the opportunity to be cared for at an ACS Level I trauma center, and unfortunately that is not the case everywhere, and so we are going to keep pushing until that becomes a reality. I’ve ridden the beautiful bike everywhere in the state of Arkansas, and it’s just a fact that had I not been that close to UAMS Hospital, the story would have turned out differently.”

The crash left Dr. Maxson with multiple injuries, including broken bones in his right arm, torn ligaments and a proximal tibial fracture, a torn bladder, and, what he called the “coup de grace,” a shattered pelvis.

Upon arriving at UAMS, Dr. Maxson said he was instantly identified by colleagues, some former students, whom he credits with saving his life. Dr. Maxson eventually underwent five operations in as many days.

“Do the things you do, do them right, and do them every time,” he said. “Do not veer from your protocol. Damage control resuscitation works. Hypotensive resuscitation works. Our adherence to protocols has to be baked-in. And what you do with the data enables us to create a clinical practice guideline because it takes the best information out there and lays it out, tracks it, and holds us responsible for that.”

After returning home a few weeks later, Dr. Maxson was able to resume his work remotely as Chair of the COT Verification Review Committee, as well as prepare for Arkansas Children’s
Hospital’s upcoming verification visit. These activities were essential to his recovery, he said, as they kept him focused on goal-oriented tasks.

Dr. Maxson concluded his presentation by underscoring the importance of postdischarge care for trauma patients, including assistance obtaining rehabilitation equipment, scheduling appointments, and working with insurance companies.

“Patients need a navigator. I live in the system, and it was very difficult. The insurance claims process is purposely obfuscating. How do you handle it when you’re getting bills, and the insurance is saying they’re not going to pay for it? I am a tenured professor at the University of Arkansas, and the person who hit me had full coverage. I was at work, so workers’ comp was a potential—which all three of these entities pointed a finger at the other and said ‘this is not our responsibility.’”

Dr. Maxson returned to active practice and teaching in the middle of 2018, and he acknowledged the efficiency of the Arkansas Trauma System—which he helped create in 2009—as a key factor in his recovery. Citing a study published in the Journal of the American College of Surgeons, Dr. Maxson noted that the Arkansas Trauma System saved taxpayers $186 million—a ninefold return on investment from the $20 million the states received annually in public funding.

“We had a 31 percent preventable mortality rate in the state of Arkansas in 2008, and by 2013, we cut that number to 16 percent, and now it’s below 10 percent,” Dr. Maxson said. “But what about the 10 to 1 patients who don’t die—patients, like me, who are discharged from the hospital? What is their outcome? That is the piece we don’t know, and I am happy that this is the direction TQIP and the College are moving toward because this is how we will continue to prove our value.”

TQIP update

Dr. Nathens described the difference between error reduction and quality improvement. “An error is the failure of a planned action or the use of a wrong plan to achieve an aim. Errors occur as a result of an act. Quality improvement modifies the delivery of health care services to increase the likelihood of desired outcomes,” Dr. Nathens said.

An estimated 2 million Americans have died from trauma-related incidents since 2001, and of the 147,790 such U.S. deaths in 2014, approximately 20 percent may have been preventable if appropriate and timely care had been delivered postinjury, Dr. Nathens said. He noted the great variation in the quality of trauma care and outcomes for injured patients in the U.S.

“In November 2018, we rolled out the TQIP Mortality Reporting System, a web-based portal modeled after the Aviation Safety Response System. We now have 300 preventable deaths in the system,” he said, adding that the system is designed to “use the combined experience of TQIP centers to identify patterns and design interventions to reduce preventable deaths.”

Of the cases logged into the system (all IP addresses anonymous), 60 percent are attributed to human failure. “Simply put, mistakes occur because people don’t know what to do because they haven’t
been taught or they haven’t learned the information. In these situations, training and education may be effective, but training doesn’t make us any less likely to slip up,” he said. “Slips are the domains of experts—they know what they need to be doing, but due to fatigue or memory lapse, for example, errors can occur.”

Dr. Nathens also summarized other TQIP initiatives, including the November 2019 release of the Best Practices Guidelines for Trauma Recognition of Child Abuse, Elder Abuse, and Intimate Partner Violence—a resource for trauma center health professionals to identify, evaluate, manage, document, and report patients who have been abused. (The guidelines are available for download at facs.org/tqipbestpractices.)

Quality and process measures also are addressed with specific recommendations for each type of abuse.

Dr. Nathens outlined the new TQIP Data Quality Report, which includes filters such as injury severity, outcomes, and patient characteristics. When a facility receives this report, they are asked to “identify the root causes of the data quality concern, correct and resubmit the data, complete the questionnaire and highlight actions taken, and provide feedback on the overall process.”

The ACS COT has introduced an Advancing Leadership in Trauma Center Management Course—a new two-day, in-person course designed for multidisciplinary participation, Dr. Nathens announced. The course provides strategies for the oversight of trauma system development, performance improvement, effective response models, and high-performance teams. The next course will take place May 14–15 in Chicago, IL.

In addition, Dr. Nathens revealed plans for revising the Resources for Optimal Care of the Injured Patient manual (the Orange Book), including a change in format that will more closely align the book with the other quality programs’ standards. “We are going to align with the new ACS format, and the content will be divided into nine categories, including institutional administrative commitment, program scope and governance, facilities and equipment resources, personnel and services resources, patient care expectations and protocols, data surveillance and systems, quality improvement, professional and community education, and research,” he said.

Dr. Nathens described the standards revision as an “inclusive process with 2,157 responses across [the 23 Orange Book] chapters,” with the goal of developing standards that “ensure utility, relevance, and effectiveness” in providing care for the injured patient. Once the standards revision is completed in the first quarter of 2020, it is anticipated the updated manual will be completed in 2020, with release of the new book in 2021. “We are working to make the transition as smooth as possible for our trauma centers,” Dr. Nathens said.

**COT update**

ACS COT Chair Eileen M. Bulger, MD, FACS, highlighted several key COT initiatives, most notably in the areas of firearm injury prevention, trauma system development, and Stop the Bleed®.

She summarized the work of the inaugural Medical Summit on Firearm Injury Prevention in February 2019, which brought together representatives from 45 professional medical and injury prevention organizations and
“We have five stories written for the public on our website describing why having a trauma system is important,” Dr. Bulger said. The series of stories is titled “Putting the Pieces Together: A National Effort to Complete the U.S. Trauma System.”

the American Bar Association under the leadership of the ACS COT to develop a consensus-based approach to this public health issue. “The meeting was energizing and gave us the opportunity to see where we can better collaborate,” she said.

Dr. Bulger also provided updates on three ACS-led firearm injury prevention initiatives, including the ACS COT Injury Prevention Committee workgroups that are developing best practices in firearm injury prevention along with input from summit partners; the FAST Work Group (Firearm Strategy Team), which consists of surgeons who own firearms and are implementing their recommendations on injury prevention, firearm safety, and advocacy-related activities; and ISAVE (Improving Social Determinants to Attenuate Violence), a multidisciplinary panel of both medical and nonmedical professionals charged with studying the root causes of violence and recommending innovative programs to reduce it.

Dr. Bulger underscored the importance of supporting a national U.S. trauma system. “We have five stories written for the public on our website describing why having a trauma system is important,” she said. The series of stories, titled “Putting the Pieces Together: A National Effort to Complete the U.S. Trauma System,” examines the history of trauma care and trauma system development in America, explores civilian-military partnerships to translate battlefield lessons to the home front and back again, identifies why the 60-year military-civilian partnership is a model for a national trauma system, summarizes the challenges facing America’s trauma systems, and outlines the steps experts are taking to fill the gaps in state and regional systems and achieve the goal of zero preventable deaths and disability from injury.

“Now in its third year, the Stop the Bleed program has trained more than 1.2 million people in all 50 states and in more than 110 countries,” Dr. Bulger noted. “It is on the backs of all of you that we are doing this.” She noted the October 2019 launch of the new public-facing website, stopthebleed.org, which was developed to meet the evolving needs of the general public in terms of education and empowerment. Dr. Bulger also highlighted expanded Stop the Bleed educational offerings in development, including an electronic hybrid course and new versions tailored to specific age groups.

The COT’s 100th anniversary is in 2022, and the committee is looking for feedback on how to mark this milestone, Dr. Bulger added.

Applying high-reliability concepts in trauma

In a session titled High Reliability Concepts Applied to Trauma, speakers defined the characteristics of high-reliability organizations (HROs)—groups connected through a singular function that have the potential for catastrophic failure (firefighters, law enforcement, and so on), yet routinely engage in near error-free performance. “Multiple and unexpected failures are built into society’s complex and tightly coupled systems,” said session moderator, Anne Rizzo, MD, FACS, vice-chair of surgery, Inova Fairfax Hospital, Falls Church, VA, noting that operator error is a common issue, much more than issues related to technology.
“HROs are characterized by a preoccupation with failure,” said Chapy Venkatesan, MD, MS, FACP, chief quality and safety officer, Inova Health System. They have “someone who relentlessly looks for any signal of failure, views failure as a symptom of system dysfunction until proven otherwise, doesn’t dwell on success, views failure as an opportunity for learning, and believes that in order to increase your success rate, you have to double your failure rate,” he added.

Integrating a preoccupation with failure into clinical practice requires a “chronic, proactive wariness of the unexpected” and the ability to “recognize something is going wrong before it has gone wrong,” Dr. Venkatesan said. Organizational tactics that promote a preoccupation with failure include simulation training, daily safety briefings, patient safety walk rounds, team-based training, and good/great-catch programs.

Another characteristic of HROs is deference to expertise, noted Charles E. Murphy, MD, CPPS, chief safety officer, Inova Heart and Vascular Institute, who described this concept as situations where “decisions are pushed down into the organization to individuals with expertise and specific knowledge.” Dr. Murphy said cultivating a deference to expertise requires sustaining a “pattern of respectful yielding to those with domain-specific knowledge.”

“Operationalizing deference to expertise relies on the following components: flexible decision structures, support for imagination as a tool for managing the unexpected, an awareness of the fallacy of centrality, and listening with humility,” Dr. Murphy said. A “reluctance to simplify” is another HRO concept that can be applied to trauma care, according to Paula Graling, DNP, RN, CNOR, FAAN, assistant vice-president, perioperative services, Inova Fairfax Hospital. HROs take “deliberate steps to question assumptions and received wisdom to create a more complete and nuanced picture of ongoing operations.”

“From a trauma perspective, a reluctance to simplify means we view the trauma victim as complex, unstable, unpredictable—a unique individual with a unique response to stress. It also means we facilitate the broader awareness of the team through good communication and foster an understanding that superficial similarities may mask deeper differences. Think it through if the resuscitation is not working,” Ms. Graling said.

A reluctance to simplify also involves mindfulness—“actively searching for disconfirming data” and harnessing “the collaborative wisdom of the surgical care team,” she said. Dr. Rizzo emphasized that trauma care professionals need to develop a sense of situational awareness, particularly to function effectively within a compressed window of time, and when more than one critical outcome must happen simultaneously. According to Dr. Rizzo, situational awareness in the trauma bay mandates attention to detail, boots on the ground involvement, continuous monitoring, and emotional intelligence.

“If you work in trauma care, chances are you are already very resilient,” said Peter Wu, MD, FASA, CHSE, CPPS, director, anesthesia quality and safety, TeamHealth Anesthesiology, Tampa General Hospital, FL. “The hallmark of an HRO is
not that it is error-free, but that errors don’t disable it,” he said.

Dr. Wu noted that a “blame culture,” in which errors are attributed to specific individuals or processes, is counter to fostering resiliency largely because “disciplinary action gives a false sense of confidence” that the error will not be repeated and hampers “transparent reporting and the ability to identify true root causes.”

He encouraged attendees to move beyond traditional root cause analysis because it implies a single cause in a complex system and fails to address corrective actions. Dr. Wu suggested transitioning toward the root cause analysis and action (RCA2) model developed by the National Patient Safety Foundation. RCA2 focuses on systems-based enhancement and on activity that improves, measures, and sustains quality improvement processes aimed at preventing harm to patients.

**Hospital-based injury prevention**

“Ideally, trauma care systems provide a continuum of care, including prevention, prehospital care, acute care, and rehabilitation,” said David B. Hoyt, MD, FACS, ACS Executive Director. “We have lots of evidence that prevention works, whether it’s related to vehicle safety, alcohol control and intervention, or violence reduction,” he said, noting that successful intervention plans start with rigorous collection of reliable data.

Focusing specifically on firearm-related injuries, Dr. Hoyt said an estimated 100 deaths occur each day. “Many factors contribute to this: mental illness, community distress, childhood trauma, and substance abuse.” The ACS has sought to address these causes and effects “with the work being done by the ACS FAST workgroup, the Firearm Safety and Injury Prevention brochure, the 2019 Medical Summit on Firearm Injury Prevention, and other College programs.”

“By definition, firearm-related violence is a public health issue due to the fact that the issue is population-based,” said Rochelle Dicker, MD, FACS, professor of surgery and anesthesia, vice-chair for critical care, chief of surgical critical care, associate trauma director, University of California-Los Angeles David Geffen School of Medicine. “Firearm homicide is the leading cause of death among African Americans 15–34 years old, and the number two cause of death in Latinos in the same age range. The burden of homicides falls disproportionately on young, minority men.”

“We should practice trauma-informed care. This is an approach that integrates knowledge about the effects of and recovery from trauma, minimizes re-victimization, facilitates recovery and empowerment, and ensures physical and emotional safety,” Dr. Dicker said. To underscore the relevance of hospital-based injury prevention programs, she cited a 2016 study published in the *Journal of Trauma and Acute Care Surgery* that examined 466 clients enrolled in a hospital-based injury prevention program over a 10-year period. The study revealed that the recidivism rate had fallen from a historical control of 8 percent to 4 percent following participation in this program, and that addressing educational needs of the victim is significantly associated with success.
“A public health approach to firearm injury prevention requires both short- and long-term solutions,” said Brendan T. Campbell, MD, MPH, FACS, the Donald W. Hight Endowed Chair in Pediatric Surgery, Connecticut Children’s Medical Center, Hartford. Dr. Campbell noted that physicians should not “focus on whether or not a patient owns a gun but focus on providing them useful information in the event that they do own guns—make firearm ownership as safe as possible.”

According to Dr. Campbell, one-third of U.S. children reside in a home with at least one firearm, and 7 percent of U.S. children live in homes where at least one gun is stored and unlocked. “Parents have unrealistic perceptions of children’s capabilities and behavioral tendencies about guns,” he said. He called for making “evidence-based prevention part of our practice,” specifically by “teaching the importance of safe storage, screening for suicide and intimate partner violence, and engaging firearm owners in the development of the overall prevention process.”

Deborah A. Kuhls, MD, FACS, FCCM, chief, section of critical care, division of acute care surgery, and program director, surgical critical care fellowship, University of Nevada Las Vegas School of Medicine; and Chair, ACS COT Injury Prevention and Control Committee, described mental illnesses (including psychiatric, mood, and anxiety disorders, as well as alcohol- and drug-related disorders) and their link to unintentional injuries. She underscored the importance of determining suicide risk in trauma patients using a universal screening tool, such as the Columbia Suicide Severity Rating Scale. She also suggested screening trauma patients for depression using the nine-question Injured Trauma Survivor Screen, which helps predict those most at risk for post-traumatic stress disorder and/or depression six months after admission to a Level I trauma center. She cited a study of 1,048 seriously injured trauma patients in which 60 percent were found to be depressed at discharge, and 31 percent were suffering from depression at the six-month follow-up.

Dr. Kuhls also described the role of the trauma care team in identifying intimate partner violence (IPV), “a silent epidemic that occurs in 4–6 million relationships in the U.S. each year.” She cited the ACS IPV Toolkit as a notable resource for recognizing the signs of IPV in patients, colleagues, and in yourself. The toolkit is available for download at facs.org/ipv.

The 11th annual TQIP Scientific and Meeting and Training will take place December 6–8, at the Phoenix Convention Center, AZ. ♦
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facs.org/summit
The American College of Surgeons (ACS) will host the ninth annual Leadership & Advocacy Summit March 28–31 at the Renaissance Washington, DC Downtown Hotel. The Summit is a dual meeting offering comprehensive and specialized sessions that provide ACS members, leaders, and advocates with the skills and tools necessary to be effective surgeon leaders. Registration for the 2020 Summit is now open at facs.org/summit.

**Leadership Summit**
The Leadership Summit will feature compelling speakers addressing key topics in surgical leadership. The Summit provides a venue for members to network with ACS leaders and engage with colleagues to learn new and innovative ways to face challenges and enhance their leadership skills. It begins Saturday, March 28, with a Welcome Reception open to all registrants, followed by a full day of programming on Sunday, March 29.

More than 500 ACS leaders and members are expected to participate in the Leadership Summit. Topics will focus on honing the communication and strategic thinking skills necessary for effective leadership in and out of the operating room. Speakers will address key topics, including implementing impactful ideas in care delivery; empowering young surgeons to reach their potential; incorporating innovation, diversity, and inclusiveness in your practice; being an inspirational, multifaceted, and authentic surgical leader; and more. In addition, a portion of the event will be dedicated to sharing ACS chapter success stories and working to identify strategies to enhance and strengthen chapters. The ACS is pleased to welcome Vice Admiral Jerome M. Adams, Surgeon General of the U.S., as the keynote speaker for the Leadership Summit.

For more information about the Leadership Summit, contact Brian Frankel, ACS Manager, International Chapter Services and Special Initiatives, at bfrankel@facs.org or 312-202-5361.

**Advocacy Summit**
The Advocacy Summit offers attendees the unique opportunity to gain insight and the additional tools needed to become knowledgeable and effective advocates for surgery. In 2020, several ACS-supported legislative priorities could be considered by Congress, and surgeon advocates play a critical role to help educate lawmakers about these important issues and effect change. Your participation at the Advocacy Summit is essential to the ACS’s success.

Attendees of this three-day conference can expect in-depth advocacy training, including effective tips and tactics to help communicate policy priorities to policymakers on Capitol Hill and at home. The Advocacy Summit is a great place to meet and collaborate with colleagues and fellow surgeon advocates, meet with key health care policymakers, and become the constituents that legislators turn to when faced with complex questions regarding surgical and health care issues.

Following last year’s summit, the ACS Division of Advocacy and Health Policy (DAHP) has been working on a plethora of federal and state legislative activities, including efforts to address unanticipated/surprise medical billing, modify and implement Medicare physician payment reform, reduce administrative burdens and regulations, ensure that patients have access to quality surgical care, improve electronic health record and
The summit is a dual meeting offering comprehensive and specialized sessions that provide ACS members, leaders, and advocates with the skills and tools necessary to be effective surgeon leaders.

health information technology (HIT) interoperability, secure funding for and enhance cancer care and accreditation, establish bleeding control training for trauma-related injuries, and more. DAHP staff will update attendees about these and other ongoing initiatives, as well as future opportunities that may be coming down the pipeline in the 117th Congress.

As in years past, the Advocacy Summit will follow the Leadership Summit and begin Sunday, March 29, with a dinner and keynote address. Previous speakers include Marine Corps fighter pilot (Retired) Dave Berke, political commentators Nicolle Wallace and Chris Matthews, journalists Bob Woodward and George Will, television journalist Chuck Todd, U.S. Army Gen. (Retired) Stanley A. McChrystal, and author Thomas Goetz.

The sessions planned for the following day will highlight the political environment in Washington, DC, and speakers will outline critical health care issues impacting the surgical community and surgical patients. Attendees then will be able to apply this knowledge at in-person meetings with members of Congress and congressional staff to continue to educate offices about ACS advocacy priorities. This portion of the program provides ACS members the opportunity not only to demonstrate surgery’s strength on Capitol Hill, but also to establish relationships with legislators and their staff to ensure they look to Fellows’ expertise when crafting meaningful health care policy.

The ACS Professional Association Political Action Committee (ACSPA-SurgeonsPAC) hosts a variety of events for members and SurgeonsPAC contributors. These events provide exclusive networking opportunities to members interested in becoming more active participants in the political process. Other SurgeonsPAC sponsored activities include an annual drawing, a political luncheon featuring a special guest speaker, and presentation of the 2019 PAC awards.

For more information about the Advocacy Summit, contact Austin O’Boyle, Grassroots and PAC Coordinator, at aoboyle@facs.org or 202-672-1511. To learn more about SurgeonsPAC activities, contact staff at surgeonspac@facs.org or 202-672-1520.

ACS and MacLean Center offer fellowships in surgical ethics

The American College of Surgeons (ACS) Division of Education is offering fellowships in surgical ethics with the MacLean Center for Clinical Medical Ethics, University of Chicago, IL. The fellowships will prepare surgeons for careers that combine clinical surgery with scholarly studies in surgical ethics beginning with a five-week, full-time course in Chicago in July and August 2020.

From September 2020 to June 2021, fellowship recipients will meet weekly for a structured ethics curriculum. In addition, fellows will participate in an ethics consultation service and complete a research project.

Application materials are due March 15, 2020. For additional information about this fellowship, visit https://macleanethics.uchicago.edu/fellowship/surgical_ethics or contact Patrice Gabler Blair, MPH, Associate Director, ACS Division of Education, at pblair@facs.org.
The American Medical Association (AMA) House of Delegates (HOD) met November 16–19, 2019, with more than 600 delegates and alternate delegates in attendance. More than 26 reports and 89 resolutions were discussed, keeping delegates engaged in important policymaking debates.*

**A look at the issues**

At every HOD meeting, the delegates discuss a spectrum of ideas, issues, and perspectives. Some of these proposals percolate to the surface as being of greater interest to most of the delegates, and some initiatives catch the attention of the surgical community. Following are a few highlight areas from the Interim meeting.

**Vaping**

As one of the more prominent issues of the meeting because of multiple deaths recently attributed to vaping, delegates introduced many resolutions related to this issue. After considerable debate, the HOD adopted the following resolution: “The AMA will urgently advocate for regulatory, legislative, and/or legal action at the federal and/or state levels to ban the sale and distribution of all e-cigarette and vaping products, with the exception of those which may be approved by the [Food and Drug Administration] for tobacco cessation purposes and made available by prescription only; and advocate for research funding to sufficiently study the safety and effectiveness of e-cigarette and vaping products for tobacco cessation purposes.”

**Needlestick injuries**

Delegates raised numerous questions about a resolution pertaining to reimbursement for postexposure protocol for needlestick injuries for medical students, such as application of workers’ compensation laws and state regulations. Language adopted by the HOD directed the AMA to encourage medical schools to have policies in place to address diagnosis, treatment, and follow-up at no cost to medical students exposed to an infectious or environmental hazard in the course of their medical student duties.

**Nonphysician scope of practice**

Policy relating to nonphysician scope of practice was adopted that centered on “board certification” of these health care professionals and expansion of scope of practice through state boards. Specifically, the AMA now opposes efforts to board certify physician assistants in a manner that misleads the public to believe such certification is equivalent to medical specialty board certification. The AMA also opposes any organization’s intent to board certify nonphysicians that appears likely to confuse the public about the unique credentials.

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At every HOD meeting, the delegates discuss a broad spectrum of ideas, issues, and perspectives. Some of these proposals percolate to the surface as being of greater interest to most of the delegates, and some of those initiatives catch the attention of the surgical community.

Aerospace Medicine Association and the American College of Emergency Physicians provided insights on recognizing the most common in-flight emergencies, as well as available resources for responding to these events. They also discussed the legal ramifications of providing care during an in-flight emergency and recounted numerous personal experiences of responding to an in-flight emergency.

**Annual meeting**

The next gathering of the HOD will be its annual meeting, June 6–10 in Chicago, IL. The ACS delegation looks to the Fellowship for guidance in identifying matters of interest to surgery. Resolution ideas may be sent to ahp@facs.org.

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ACS DELEGATION AT THE AMA HOD

The surgeon’s voice is well-respected in the HOD, partly because of the diligence and surgical focus of the College’s delegation. ACS Delegates are as follows:

- **Patricia L. Turner, MD, FACS** (Delegation Chair), general surgery, Chicago, IL; Director, ACS Division of Member Services; member and immediate past-chair, AMA Council on Medical Education
- **Daniel L. Dent, MD, FACS**, general surgery, San Antonio, TX
- **Jacob Moalem, MD, FACS**, general surgery, Rochester, NY
- **Leigh A. Neumayer, MD, FACS**, general surgery, Tucson, AZ; ACS Board of Regents
- **Naveen F. Sangji, MD** (also Young Physicians Section delegate), general surgery, Ann Arbor, MI
- **Kenneth Sharp, MD, FACS**, general surgery, Nashville, TN, ACS Board of Regents

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of medical specialty board certification or take advantage of the prestige of medical specialty board certification for purposes contrary to the public good and safety. In addition, the AMA will consider all available legal, regulatory, and legislative options to oppose state board decisions that increase nonphysician health care practitioner scope of practice beyond legislative statute or regulation.

**Conversion therapy**

The HOD adopted a policy calling on the AMA to develop model state legislation and advocate for federal legislation to ban “reparative” or “conversion” therapy for sexual orientation or gender identity. Over the past few years, the HOD has confronted numerous social issues that broadly intersect with patient care and public health.

**Surgical Caucus**

For many years, the Surgical Caucus has sponsored well-attended education sessions at the AMA HOD. During the Interim meeting, the caucus offered a session titled Is There a Doctor on Board? Dealing with In-Flight Emergencies. Speakers from the Aerospace Medicine Association and the American College of Emergency Physicians provided insights on recognizing the most common in-flight emergencies, as well as available resources for responding to these events. They also discussed the legal ramifications of providing care during an in-flight emergency and recounted numerous personal experiences of responding to an in-flight emergency.
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“Being a Fellow of the American College of Surgeons is representative of the pinnacle of being a surgeon. It represents a level of ethics, skill, and leadership within the surgical community. It presents opportunity—to interact with people around the country, to learn more, and to participate in efforts that shape our discipline and the practice of surgery.”

—Don Jay Selzer, MD, FACS

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Disciplinary actions taken in 2019

The Board of Regents of the American College of Surgeons (ACS) took the following disciplinary action at its February 8, 2019, meeting in Chicago, IL:

- Chukwuma P. Anyadike, MD, a colon and rectal surgeon from Virginia, was suspended from the College with terms and conditions for reinstatement. This action was taken following disciplinary actions by the states of New York, North Carolina, and Ohio based on standard of care issues.

The Board of Regents of the ACS took the following disciplinary actions at its June 7, 2019, meeting in Chicago:

- James R. Lowe, MD, a general surgeon from North Carolina, was suspended from the College with terms and conditions for reinstatement. This action was taken following disciplinary action by the North Carolina medical board for repeated incidents involving alcohol abuse.

- Arthur H. Pomerantz, MD, a general surgeon from Florida, was suspended from the College with terms and conditions for reinstatement. This action was taken following disciplinary action by the state of Massachusetts following an incident involving risk management protocols.

- Douglas M. Rampona, MD, an ophthalmic surgeon from Virginia, was suspended from the College with terms and conditions for reinstatement. This action was taken following disciplinary action by the medical boards in Virginia, New York, North Carolina, and Texas, following an investigation into his prescription practices.

- A general surgeon from Georgia was admonished following disciplinary action by the medical board in Georgia related to personal relationships with patients and former patients.

DEFINITION OF TERMS

Following are the disciplinary actions that may be imposed for violations of the principles of the College:

- **Admonition**: A written notification, warning, or serious rebuke.

- **Censure**: A written judgment condemning the Fellow’s or Member’s actions as wrong. This is a firm reprimand.

- **Probation**: A punitive action for a stated period of time, during which the Member: (a) loses the rights to hold office and to participate as a leader in College programs; (b) retains other privileges and obligations of membership; (c) will be reconsidered by the Central Judiciary Committee periodically and at the end of the stated term.

- **Suspension**: A severe punitive action for a period of time, during which the Fellow or Member, according to the membership status: (a) loses the rights to attend and vote at College meetings, to hold office, and to participate as a leader, speaker, or panelist in College programs; (b) is subject to the removal of the Member’s name from the public listing and mailing list of the College; (c) surrenders his or her Fellowship certificate to the College, and no longer explicitly or implicitly claims to be a Fellow of the American College of Surgeons; (d) pays the visitor’s registration fee when attending College programs; and (e) is not subject to the payment of annual dues. When the suspension is lifted, the Fellow or Member is returned to full privileges and obligations of Fellowship.

- **Expulsion**: The certificate of Fellowship and all other indicia of Fellowship or Membership previously issued by the College must be forthwith returned to the College. The surgeon thereafter shall not explicitly or implicitly claim to be a Fellow or Member of the American College of Surgeons and may not participate as a leader, speaker, or panelist in College programs.
The Board of Regents took the following disciplinary actions at its October 25, 2019, meeting in San Francisco, CA:

• David A. Stalker, MD, a general surgeon from New Mexico, had his full Fellowship privileges restored following a period of probation.

• Richard C. Rooney, Jr., MD, an orthopaedic surgeon from California, was suspended from the College for a period of one year. This action was taken following disciplinary action by the medical board in the state of Washington following a plea agreement with the Department of Defense.

• Anthony Admire, MD, a plastic surgeon from Arizona, was placed on probation with terms and conditions for reinstatement. This action was taken following disciplinary action by the California Medical Board for failure to disclose information on his application for a medical license.

• A urologic surgeon from Utah was censured. This action followed disciplinary action by the California Medical Board related to personal relationships with medical assistants.

• A general surgeon from Florida was admonished. This action was taken following a complaint about statements this surgeon made during a malpractice trial that were alleged to be unprofessional conduct.

• Herman Pang, MD, a cardiothoracic surgeon in Arizona, was placed on probation with terms and conditions for reinstatement. This action was taken following disciplinary action by the Arizona medical board after his treatment of three patients was found to have deviated from the standard of care.

Statewide prehabilitation program and episode payment in Medicare beneficiaries

Charles A. Mouch, MD; Brooke C. Kenney, MPH; Shawna Lorch, CHES; and colleagues in the March issue of the Journal of the American College of Surgeons (JACS) found that participation in a prehabilitation program in Michigan was associated with shorter length of stay and lower total episode payments after surgery. Payors and hospitals should invest in the implementation of simple, home-based prehabilitation programs.

This article and all other JACS content is available at journalacs.org.
Surgeons and Engineers: A Dialogue on Surgical Simulation

The American College of Surgeons (ACS) Surgeons and Engineers full-day meeting on March 11 will serve as a venue for surgeons, academic and industry engineers, scientists, and surgical educators to continue the dialogue between the medical simulation and engineering communities.

It will provide opportunities for the exchange of ideas and potential solutions to address needs in surgical education through the engagement of existing engineering technologies as well as those technologies that are in development.

*The ACS Annual Surgical Simulation Summit will directly follow this meeting on March 12.

TO REGISTER, VISIT facs.org/surg-eng.

Questions? Please contact Gyusung Lee, PhD, at glee@facs.org or 312-202-5782.
The American College of Surgeons (ACS) will host the 13th annual Surgical Simulation Summit March 12–14 at the Swissôtel Chicago, IL. More than 300 people are expected to participate in the summit, which brings together surgeons and simulation center directors, educators, administrators, engineers, and researchers to share best practices, present innovative research, and discuss the latest advances in simulation-based surgical education and training. Registration for the 2020 Summit is now open at facs.org/aeisummit.

The Surgical Simulation Summit begins Thursday, March 12, with a Keynote Address by Jeffrey P. Gold, MD, FACS, chancellor, University of Nebraska Medical Center, Omaha, on the value proposition of simulation-based surgical education. A special panel will complement the keynote address with the following panelists offering their perspectives as distinguished university deans:

- Barbara L. Bass, MD, FACS, FRCS(Hon), FCOSECSA(Hon), incoming dean, George Washington University, Washington, DC; former director of Houston Methodist Institute for Technology, Innovation & Education, TX; and ACS Past-President
- Henri R. Ford, MD, MHA, FACS, FAAP, FRCSEng(Hon), dean and chief academic officer, University of Miami Miller School of Medicine, FL, and ACS Regent
- K. Craig Kent, MD, FACS, incoming executive vice-president of health affairs, University of Virginia, Charlottesville, and former dean, The Ohio State University College of Medicine, Columbus

On Friday, March 13, the ACS is partnering with the American Society of Anesthesiologists (ASA) to explore the unique surgeon-anesthesiologist relationship and explain how simulation-based training can be used to improve team dynamics and patient care.

Panel sessions, scientific paper presentations, posters, and interactive workshops also are planned for the meeting. Concurrent sessions, including a special track for simulation center personnel, will be offered so attendees can maximize their meeting experience. Attendees can mingle with colleagues during a networking reception on Friday evening. The meeting concludes March 14.

For more information about the Summit, contact Cathy Sormalis, Manager, Accredited Education Institutes Program, at csormalis@facs.org or at 312-202-5535.

**Surgeons and engineers event**

Those attendees who are interested in a novel forum for the exchange of challenges and potentially applicable technologies between surgeons, surgical educators, engineers, and scientists are encouraged to register for Surgeons and Engineers: A Dialogue on Surgical Simulation, March 11 at the Swissôtel. For details, visit facs.org/surg-eng.

Register now to participate in 2020 annual ACS Surgical Simulation Summit
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 covering research and activities from the ACS Clinical Congress 2019, held October 27–31 in San Francisco, CA. To access the news items in their entirety, visit the online ACS Newsroom at facs.org/media/acs-in-the-news.

Half of surgery residents report harassment, bullying
HealthLeaders, October 28, 2019
“‘Preventing these types of mistreatment could reduce the huge problem of burnout in the specialty of surgery,’ said [Karl] Bilimoria, [MD, MS, FACS] director of the Surgical Outcomes and Quality Improvement Center at Northwestern University Feinberg School of Medicine, Chicago.

“The survey findings were presented Monday at the American College of Surgeons Clinical Congress 2019 in San Francisco and published on the New England Journal of Medicine website.”

Half of surgical residents—especially women—experience workplace mistreatment
FierceHealthcare, October 29, 2019
“That exposure to discrimination, abuse and harassment in the surgical training environment is associated with burnout and suicidal thoughts, according to the study published in the New England Journal of Medicine.

“The study findings were presented on Monday during the American College of Surgeons’ annual [C]linical [C]ongress in San Francisco.”

Tougher rules on opioids after surgery doesn’t mean more pain for patients
HealthDay/U.S. News & World Report, October 30, 2019
“The percentage of patients who did not receive any opioids after surgery more than doubled, from 12.7% before the new rules to 26% after the new rules.

“The study was to be presented Tuesday at the American College of Surgeons annual meeting, in San Francisco. Such research should be considered preliminary until published in a peer-reviewed journal.”

Medical scribes help clinicians see more patients, study finds
Becker’s Health IT & CIO Report, October 30, 2019
“Incorporating medical scribes into workflows has helped clinicians see more patients, according to research findings presented at the American College of Surgeons Clinical Congress 2019.

“Two attending surgeons at an outpatient surgical oncology practice at Loma Linda (Calif.) University Medical Center piloted the study to evaluate how medical scribes impact clinician workflows. During a four-month timeframe, 335 clinical encounters
were evaluated. Of the patient encounters, 183 were without scribes and 202 were with scribes."

**Delaying gallbladder surgery raises risk of complications**

*HealthDay/United Press International, October 31, 2019*

“The study also found that blood clots in the legs and lungs, and bloodstream infections (sepsis) were more likely in the delayed surgical group. The odds of being readmitted to the hospital within 30 days of surgery were also higher for the delayed surgery group.

“The findings were to be presented Thursday at the American College of Surgeons annual meeting, in San Francisco. Findings presented at meetings should be viewed as preliminary until they’ve been published in a peer-reviewed journal.”

**How bad can surgical training be? See these two new studies**

*Forbes, November 3, 2019*

“A study just published in the *New England Journal of Medicine* reaffirmed what many people in the medical profession should know already: a lot of physicians in training continue to suffer discrimination, abuse, and harassment and this type of garbage treatment is probably contributing to burnout issues.

Another study presented at the American College of Surgeons Clinical Congress in San Francisco showed that these problems go on well beyond training, suggesting deeper systems problems with the profession.”

**Trauma outcomes worse with risk factors for heart disease and stroke**

*Reuters, November 8, 2019*

“Hospital stays averaged 16.5 days for patients with metabolic syndrome, versus 11 days for the other patients. And ICU stays averaged 9 days with metabolic syndrome, versus 5 days without it, according to the study, which was presented at the American College of Surgeons’ Clinical Congress in San Francisco and published in the *Journal of the American College of Surgeons.*”

**San Francisco: #1 city in the U.S. for senior travelers**

*SFGate, November 17, 2019*

“Would your parents agree? My octogenarian parents would. They have been coming to San Francisco once or twice a year to visit me, and also to attend meetings and conventions. They love it here. As a matter of fact my father just flew out for three days to attend the giant American College of Surgeons convention at Moscone Center last month.”

**Surgeons test new wearable tech that helps measure operating skills**

*KPIX, November 14, 2019*

“Now a Stanford scientist and her team are using the technology to help physicians boost the art of surgery. KPIX 5 got an exclusive look at their unusual experiment which recently unfolded at the Moscone Convention Center in San Francisco.

“The convention center was the location for the annual meeting for the American College of Surgeons, where roughly 10,000 surgeons from around the world converged to learn the latest in surgical techniques and to share information.”

**Short-term survival in patients aged 85 years and older after colorectal cancer surgery**

*The ASCO Post, November 12, 2019*

“Results from a preliminary research study showed the majority of patients aged 85 years and older were still alive in the short-term after undergoing segmental colectomy for stage II and III colon cancer. Kaur et al presented these findings at the American College of Surgeons Clinical Congress 2019.”
The Board of Directors of the American College of Surgeons Professional Association (ACSPA) and the Board of Regents (B/R) of the American College of Surgeons (ACS) met October 26 at the Hilton San Francisco Union Square, CA. The following is a summary of key activities discussed. The information provided was current as of the date of the meeting.

**ACSPA**

From January 1 through September 16, 2019, the ACSPA and its political action committee, ACSPA-SurgeonsPAC, collected $360,000 in contributions from more than 900 ACS members and staff. SurgeonsPAC also disbursed more than $300,000 to 95 congressional candidates and political campaign committees. Commensurate with congressional party ratios, 50 percent of the amount given went to Republican and 50 percent to Democratic campaigns.

**ACS**

The Board reviewed reports from the ACS division directors.

**Convention and Meetings**

The B/R approved the dates of October 30–November 4 for Clinical Congress 2033 in Boston, MA, and October 26–30 for Clinical Congress 2036 in Washington, DC.

The ACS continues to extend association management services to domestic chapters and is contracted with 10 chapters. An additional 18 clients are contracted for services.

**Division of Education**

The Division of Education presented the proposed program for Clinical Congress 2020 for comment and review by the B/R.

The Committee on Ethics, housed in the Division of Education, selected three recipients for the Fellowship in Surgical Ethics, which prepares surgeons for careers that combine clinical surgery with scholarly studies in surgical ethics.

**Division of Member Services**

A record number of Initiates—a total of 1,992, with 1,337 from the U.S. and its territories and Canada, and 655 from 73 other countries—were welcomed into the ACS at the 2019 Convocation. This year also marked the highest number of women Initiates in ACS history at 578 (29 percent of the class). Nearly 1,000 Initiates attended the Convocation. During the Convocation ceremonies, the Initiate classes of 1969 and 1994 celebrated their 50 and 25 years of Fellowship, respectively.

The B/R accepted resignations from 12 Fellows and changed the status from Active or Senior to Retired for 75 Fellows. As of September 1, 2019, the College had 81,910 members: 64,414 Fellows, 2,673 Associate Fellows, 11,120 Resident Members, 3,121 Medical Student Members, and 582 Affiliate Members.

In 2019, the Division of Member Services identified opportunities for recruitment among lapsed members in the Resident, Associate, and former Fellow categories and marketed membership to more than 4,500 former Resident Members. A marketing plan was developed for nonmember surgeons who have attended meetings, purchased products from the College, used the ACS Surgery Career Connection, or submitted an article for publication in the *Journal of the American College of Surgeons* (JACS). Additional efforts focused on the development of ongoing communication campaigns for graduating resident members, as well as the distribution of a survey to senior and retired Fellows to determine the types of services and resources they need from the ACS, their interest in assisting with the development of programs and resources related to preparing for retirement, and to assess their overall satisfaction.

In 2019, a series of in-person meetings with the leadership of surgical specialties was initiated to further explore opportunities.
for strategic alignment and collaboration on key issues affecting surgeons. The first of these meetings took place with the American Urological Association. Additional meetings are scheduled for 2020.

Advisory Councils
The ACS has 14 Advisory Councils representing every ACS specialty category. The Advisory Councils engaged in several activities in 2019, such as assisting with the review of expert witness testimony for the ACS Central Judiciary Committee, nominating members for boards and specialty review committees, recommending members to represent the ACS on specialty guidelines writing and review panels, and providing input to specialty society guidelines.

Advisory Councils submitted 123 proposals for Panel Sessions for Clinical Congress 2020. Electronic newsletters continue to be produced to communicate with specialty colleagues on ACS activities and specialty-specific issues and programming. The Advisory Council Pillars and Board of Governors (B/G) Pillars began holding joint meetings at the Leadership and Advocacy Summit and Clinical Congress to explore other opportunities for collaboration.

Archives
The Archives serves as the historical memory of the ACS by collecting and preserving inactive records of enduring value and making them available for research. In 2019, the Archives responded to 104 research requests, including eight in-person research visits. The Archives also received 35 new accessions, including records from the Division of Integrated Communications, Information Technology, College administration, Clinical Congress, scholarships, and various College committee records.

In addition to physically moving the Archives to its new space in the headquarters building, the Archives led several projects to increase the accessibility and use of the collections, including professionally photographing all of the presidential portraits. Other art and artifacts also were photographed for future use in displays.

The second Archives Fellowship was awarded in 2019 to Cynthia Tang, a PhD candidate, to conduct research on her project, An Explosion of Interest: Spreading and Controlling the Laparoscopic Revolution through Surgical Training, 1990–2000.

B/G
Members of the ACS B/G serve as the official, direct communications link between the B/R and the Fellows. The ACS has 290 Governors: 154 Governors at-Large, representing each U.S. state and Canadian province and territory; 87 specialty society Governors; and 49 international Governors.

In 2019, the B/G Executive Committee focused on three priorities: helping chapters grow membership by providing access to recruitment tools and resources, as well as establishing a competition to increase membership; increasing collaboration with ACS Divisions, Advisory Councils, B/R, and so on by holding Joint Pillar meetings with the Advisory Councils at the Leadership & Advocacy Summit and Clinical Congress, as well as expanding joint programming with the B/R for the 2019 B/G Annual Business Meeting; and strengthening communication efforts by exploring additional efforts via ACS communication vehicles.

Key projects and activities for 2019 included conducting the B/G Annual Survey on regulatory burden, surgical workforce, work-life balance, and ACS communication and representation efforts; developing a paper for JACS on perioperative pain management in the ambulatory setting; revising the ACS Statement on Patient Safety Principles for Office-Based Surgery Utilizing Moderate Sedation/Analgesia, and publishing several articles in the Bulletin on the results of...
the 2018 B/G Annual Survey. Educational efforts focused on the development of several joint sessions on topics, such as gender inequality, health literacy, mass casualty events, opioids, and surgical informatics for Clinical Congress 2019.

**Chapters**

ACS chapters work with the College to provide members with benefits, such as the opportunity to network with surgical peers locally, to participate in advocacy efforts, and to offer Continuing Medical Education opportunities. Chapter Services provides guidance and assistance in these areas to the College’s 67 domestic and 47 international chapters. Several new chapters were established recently, including the South Africa Chapter in 2018 and the Iraq Chapter in 2019.

The third annual Chapter Officer Leadership Program for domestic chapter officers provided skills to help chapters build sustainable success through strong volunteer leadership. The next Chapter Officer Leadership Program is scheduled for March 28, 2020.

International Governors and chapter officers met at Clinical Congress 2019 to discuss resources available to international chapters, the new International Fellowship Applicant Interview Process, updates from ACS international regions, and best practices and success stories.

**International activities**

The ACS international presence continues to grow, and 2019 international Initiates comprised more than 30 percent of all new Fellows. In 2018, international efforts across the College were cataloged and the information was expanded in 2019 to coordinate international efforts across divisions, evaluate and improve current programs and services, and enhance outreach.

The ACS also updated its benchmark analysis of its international offerings against other surgical organizations. The analysis included an evaluation of requirements for Fellowship, membership benefits, dues structure, and annual meeting dates.

**International scholarships and travel awards**

The ACS International Relations Committee (IRC) provides scholarships to international surgeons to attend major meetings of the College. Scholars attend courses, lectures, and panel sessions, give presentations, and develop collegial networks with other Fellows. Current programs include International Guest Scholarships, Community Surgeon Travel Awards, International Surgical Education Scholarships, and International ACS National Surgical Quality Improvement Program (ACS NSQIP®) Scholarships. The College also cosponsors programs with the American Society of Breast Surgeons and the American Association for the Surgery of Trauma. The number of applicants for the International Guest Scholarship and Community Surgeon Travel Awards increased in 2019, alongside applicants’ geographic and gender diversity.

Additional emphasis on the recruitment of nonmember applicants to become Fellows is under way. The application and corresponding review portals for scholarships are being redesigned to improve user experience and overall functionality.

**IPV Task Force**

An Intimate Partner Violence (IPV) Task Force was formed in 2018 to raise awareness of the incidence of IPV in the surgical community, educate surgeons to recognize the signs and consequences of IPV in themselves and their colleagues, provide resources for survivors, and create resources and curricula in partnership with other national professional and educational organizations to instruct surgeons about how to recognize IPV in colleagues and trainees. Recent accomplishments include an ACS Statement on Intimate Partner Violence; articles in the Bulletin to raise awareness; an Intimate Partner Violence Toolkit; online resources on the ACS website; a case scenario in the ACS Fundamentals of Surgery Curriculum; a Town
Hall Session at Clinical Congress 2018; distribution of a member survey; development of a grand rounds presentation slide set; a presentation during a Resident and Associate Society of the ACS (RAS-ACS) grand rounds webinar; and a Panel Session at Clinical Congress 2019.

Leadership & Advocacy Summit
More than 560 ACS leaders—a 6 percent increase from 2018—attended the Leadership portion of the eighth annual Leadership & Advocacy Summit. Attendees heard presentations from notable speakers in the medicine and academia on advancing your surgical career, leading and coaching for better performance, using information technology to advance patient care, avoiding error traps in mentoring, and effectively negotiating contracts.

More than 350 attendees participated in the Advocacy Summit, which focused on ACS health policy priorities, as well as the overall political environment. Panelists addressed Medicare physician reimbursement, measuring surgical quality, surprise billing, administrative burnout, and firearm injury prevention research. The program incorporated comprehensive advocacy training and legislative issue briefings in preparation for congressional visits. The 2020 Leadership & Advocacy Summit is scheduled for March 28–31 in Washington, DC.

MHSSPACS
The Military Health System Strategic Partnership ACS (MHSSPACS) was formalized in 2014 between the ACS and the U.S. Department of Defense (DOD) to share knowledge about surgical quality care, trauma systems, education and training of military surgeons, and military-relevant trauma research. With assistance from the MHSSPACS and the Division of Research and Optimal Patient Care, a system-wide Military NSQIP Consortium was formed to include all Military Treatment Facilities (MTF) in the U.S., along with a few located outside of the U.S. The surgeon champions and research staff from these MTFs meet twice a year. In conjunction with the publication of the ACS Optimal Resources for Surgical Quality and Safety manual, a prereview questionnaire was developed for quality verification and an initial site visit was conducted at Walter Reed National Military Medical Center, Bethesda, MD. Additional MTFs are undergoing consultation visits.

The Military Clinical Readiness Program (also known as the Knowledge Skills and Abilities [KSA] Project) includes all members of the combat casualty care team and has resulted in each group formulating the essential knowledge points and skill sets needed for their specialty. Among the surgical specialties, the most immediate need was to define the KSA for expeditionary surgeons. More than 500 knowledge point questions were developed based on the military’s clinical practice guidelines and actual cases performed. A beta test was distributed to 138 military surgeons with excellent results. A hands-on skills assessment course for the expeditionary surgeon was developed, including additional elements for damage control orthopaedics, neurosurgery, ophthalmology, and obstetrics. The course was offered three times in 2019. The development of an aligned multi-model curriculum is under way.

Identifying areas of trauma research relevant to combat casualty care in civilian centers is another mission of MHSSPACS. Funding was secured from the DOD/Combat Casualty Care Research Project to study post-traumatic pulmonary embolism at 17 U.S. trauma centers.

OGB
In the aftermath of Hurricane Maria in 2017, a partnership with the Puerto Rico Department of Health, Puerto Rico’s local ACS chapter, and various local nongovernmental organizations (NGOs) was established through Operation Giving Back (OGB) to provide a continuous mobilization of volunteer surgeons on a rotating, weekly basis. As of August 2019, 13 Fellows have participated in this program.
The six-month pilot of the ACS-College of Surgeons of East, Central and Southern Africa (COSECSA) Surgical Training Collaborative at Hawassa University in Ethiopia, which included two-week rotations by each of the 13 participating U.S. academic institutions, concluded in July 2019. In 2020, each institution will send a faculty member to Hawassa for a month-long rotation to enhance system and faculty capacity in the following areas: education, clinical care, research, and quality. In 2019, the ACS-COSECSA Women Scholars Program expanded to include a historic five scholarships in addition to up to 20 scholarships for women to enter specialty training tracks (three years) upon completion of their basic surgical training (two years). These awards are co-funded by the Association of Women Surgeons Foundation.

OGB presented two panel sessions at the 2019 ACS Quality and Safety Conference. The speakers discussed identifying quality indicators and research priorities in global surgery to spark future conversations on the role of quality in global health and global surgery. OGB’s volunteer database continues to grow, with 73 registered partner organizations providing ongoing volunteerism opportunities and 721 registered volunteer surgeons.

**RAS-ACS**

The August issue of the Bulletin featured articles written by members of the RAS-ACS on the theme of Resident Wellness and Resiliency. In the 2018–2019 academic year, the RAS JACS Journal Club hosted seven online journal clubs with more than 1 million impressions on social media. The RAS-ACS also initiated an Outstanding Mentor of the Year Award to honor mentors who have been instrumental in helping a resident become a leader in ACS. The inaugural recipient, Danielle Saunders Walsh, MD, FACS, was honored at Convocation.

**YFA**

The fifth annual Young Fellows Association (YFA) Advocacy Essay Contest was held to encourage and facilitate participation in the 2019 Leadership & Advocacy Summit. Communications efforts have focused on informing the membership of the benefits and value of ACS across social media channels, the quarterly YFA newsletters, collaboration with RAS on webinars, and on the ACS Communities. YFA further enhanced the breadth of Clinical Congress proposals by partnering with numerous other ACS committees, resulting in 36 session proposals for Clinical Congress 2020. More than 60 ACS members participated in a one-hour Speed Mentoring program at Clinical Congress 2019. The YFA Annual Mentor Program, in its sixth year, is intended to better equip young surgeons for leadership positions in the College. Eight triads of Associate Fellows, young Fellows, and seasoned Fellows met at Clinical Congress 2019.

**DROPC**

The Division of Research and Optimal Patient Care (DROPC) encompasses the areas of Continuous Quality Improvement, including ACS research and the accreditation programs.

**Quality and Safety Conference**

The 2019 Quality and Safety Conference focused on putting the patient first. More than 2,100 attendees participated in the conference. The keynote speaker, Rana L. Awdish, MD, shared lessons learned from being both a physician and a patient. The 2020 Conference will take place July 24–27 in Minneapolis, MN.

**THRIVE**

ACS THRIVE (Transforming Healthcare Resources to Increase Value and Efficiency) was announced at the 2019 Quality and Safety Conference. The program, a collaborative effort between the ACS and the Harvard Business School Institute for Strategy, aims to help hospitals and surgical practices improve value-based care. The
program will be piloted at U.S. hospitals and will focus on measuring the full cycle of care for three surgical conditions. Once the program has defined participation criteria, the process of recruiting for the pilot phase of the project will begin.

**Optimal Resources for Surgical Quality and Safety**
The development of adjunctive and integrated resources/standards based on *Optimal Resources for Surgical Quality and Safety* is near completion. These standards will ultimately be used to launch a Surgical Quality Verification Program. Pilot site visits began with a group of targeted hospitals in the summer of 2018 and continued throughout 2019. The goal is to refine and revise the standards based on the findings from the site visits and to launch the program later this year.

**ACS NSQIP**
A total of 852 hospitals participate in ACS NSQIP—714 in the adult option. The pediatric option represents 16 percent of overall participation. Another 22 hospitals are in various stages of the onboarding process. At present, 129 hospitals outside of the U.S. participate in ACS NSQIP—approximately 15 percent of all participating hospitals. Growth in Canada remains strong and additional sites in Australia have recently joined the program.

**MBSAQIP**
A total of 912 facilities participate in the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP), and 61 surgeon surveyors are expected to complete 275 site visits in 2020. MBSAQIP’s second national enhanced recovery initiative, Employing New Enhanced Recovery Goals to Bariatric SurgeY (E.N.E.R.G.Y.), concluded in 2018 and a publication from this work has been accepted by *Surgery for Obesity and Related Diseases*. MBSAQIP plans to share tools and key learnings from the project by developing an enhanced recovery toolkit, including an interactive video, as well as written materials for centers. MBSAQIP also launched its third national collaborative project, Bariatric Surgery Targeting Opioid Prescriptions, focused on opioid reduction in bariatric surgery. Data will be collected until the conclusion of the project in 2021 and will examine centers’ practices relative to opioid use.

**CSV Program**
The Children’s Surgery Verification (CSV) Quality Improvement Program launched in 2017 with the goal of ensuring that pediatric surgical patients have access to quality care. In all, 138 centers participate in CSV. Approximately 45 of these centers are in the various stages of verification. 20 active sites are fully verified as Level I children’s surgery centers—an 81 percent increase from 2018.

**GSV Quality Improvement Program**
The Geriatric Surgery Verification (GSV) Quality Improvement Program was unveiled at the 2019 ACS Quality and Safety Conference. The program is composed of 30 required, and two optional, patient-centered standards designed to systematically improve surgical care and outcomes for the aging adult population. The GSV program was developed through the Coalition for Quality in Geriatric Surgery project, which took place over a four-year period and was funded by the John A. Hartford Foundation. Hospitals were able to enroll in the GSV program at Clinical Congress 2019.

**ISCR Program**
The Agency for Healthcare Research and Quality Improving Surgical Care and Recovery (ISCR) Program, a collaborative effort between the ACS and the Johns Hopkins Armstrong Institute for Patient Safety and Quality, Baltimore, MD, continues to attract hospitals interested in implementing enhanced recovery practices. Approximately 60 percent of enrolled hospitals also participate in ACS NSQIP. The final cohort will launch
in March 2020 with a concentration on emergency general surgery—specifically appendectomy, cholecystectomy, and laparotomy. The final cohort also will allow participating hospitals to track opioids prescribed for the ISCR patient population in the ACS data platform.

**Strong for Surgery**

Strong for Surgery, a joint program of the ACS and the University of Washington, Seattle, is a quality initiative aimed at identifying and evaluating evidence-based practices to optimize the health of patients before surgery. The program empowers hospitals and clinics to integrate checklists into the preoperative phase of clinical practice for elective operations. Since its release in 2017, Strong for Surgery has more than 500 participating sites. Newly added topics include chronic disease management, mental health, and substance abuse. Strong for Surgery is currently recruiting new sites to pilot the first phase of the new comprehensive checklists. The first phase will allow hospitals to implement the comprehensive checklists in paper form, with the goal of having a second pilot program that will be in electronic format.

**SSR**

The Surgeon Specific Registry (SSR) allows surgeons to track their cases, measure outcomes, and comply with changing regulatory requirements. The SSR can be used to meet the requirements of the Centers for Medicare & Medicaid Services (CMS) Quality Payment Program Merit-based Incentive Payment System (MIPS), as well as the American Board of Surgery Continuous Certification Program requirements. The SSR was approved by CMS to provide MIPS participation through registry-based reporting for the 2019 Performance Year. Several new MIPS 2019 educational opportunities were created, including videos and online hands-on instructional guides.

**Trauma Programs**

The FTL100 Fundraising Campaign was established to generate financial support for 100 Future Trauma Leaders (FTL) to coincide with the 100th anniversary of the Committee on Trauma (COT) in 2022. FTL’s mission is to help foster the advancement of future leaders in trauma. The FTL aims to recruit, mentor, provide program support, and reimburse travel to various trauma meetings for eight participants annually. The COT is seeking funding from previous donors and targeted individuals, independent corporations, not-for-profit organizations, and individual trauma leader groups, with a target goal of $1 million to help support the program and make it self-sustaining.

The COT offered a Research Methods Course in 2019. Topics covered included implementation science, pragmatic and adaptive clinical trials, and patient-centered outcomes research. In partnership with the Coalition for National Trauma Research, the COT is exploring opportunities to submit grant applications to leverage the Trauma Quality Improvement Program (TQIP) infrastructure for high-quality research.

The 2019 TQIP Annual Scientific Meeting and Training took place November 16–18 and focused on error management and high-functioning teams. The keynote address was delivered by Robert Todd Maxson, MD, FACS, who spoke on his experience as a patient in the Arkansas trauma system he helped build. The Best Practice Guidelines on Non-Accidental Trauma, covering pediatric, geriatric, and IPV patients, were released at the meeting (see story, page 61).

The Stop the Bleed® (STB) program’s primary focus is to provide training in the techniques of basic bleeding control and to inform individuals of the importance of learning the skills to become immediate responders in the event of a bleeding emergency.
STB’s goal is to train 200 million immediate responders. The STB initiative continues to grow exponentially, and through strategic partnerships with National Stop the Bleed Month, National Stop the Bleed Day, and the American College of Emergency Physicians awareness of STB has increased and has led to a dramatic increase in registered instructors and courses. As of September 13, 2019, STB had registered more than 62,000 classes, approved more than 60,000 instructors, and combined created training for more than 1 million individuals worldwide.

A redesigned public-facing website debuted this fall to better focus on the general public.

**ACS Foundation**
The ACS Foundation remains focused on securing and growing financial support for the College’s charitable, educational, and patient-focused initiatives. In fiscal year (FY) 2019, the number of individual contributors to the Foundation increased by 14 percent from FY 2018. The annual Fall Appeal generated $147,481, a 21.5 percent increase from FY 2018, including a 17.3 percent increase in individual donor numbers. National Doctors’ Day donations also have experienced strong growth, with contributions increasing 433 percent since its inception in 2016.

The Foundation continues to build its portfolio of projects and initiatives to create a broader menu of giving opportunities. OGB, STB training in rural communities, international scholarship travel awards, fellowship research awards, and the ACS Greatest Needs Fund continue to be supported by generous philanthropic gifts from Fellows.

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You have the passion  
You have the drive  
We have the road map

**Optimal Resources for Surgical Quality and Safety**

It begins [here](https://facs.org/redbook)
Chapter news

by Luke Moreau and Brian Frankel

Domestic and international chapters of the American College of Surgeons (ACS) met in the last several months to host a variety of activities, including annual meetings, skills competitions, advocacy days, and more. Following are highlights and photos from these programs.

DOMESTIC CHAPTERS

Connecticut Chapter: Surgery Interest Nights, December 2019, H. Netter School of Medicine at Quinnipiac University, Hamden, and the University of Connecticut, Mansfield. Medical students learned about various aspects of general surgery residency and chapter resident committee members answered questions, provided insight into applying, and discussed their home programs.

Photo: Surgery Interest Night attendees at the Frank H. Netter School of Medicine at Quinnipiac University.

Delaware Chapter: Delaware Day of Surgery, October 23, Newark. Highlights included a keynote address by Brian P. Jacob, MD, FACS, associate clinical professor, Mount Sinai Hospital, New York, NY, that centered around the impact of social media in surgical education; a paper competition for residents and fellows; Surgical Survivor; and a Robotic Simulator Competition.

Photo: Paper Competition Winners from ChristinaCare, from left: Elissa Dalton, MD, postgraduate year (PGY)-2, third place; Benjamin Gough, DO, PGY-4, second place; and Michael Johns, DO, PGY-3, first place.

Florida Chapter: All-Florida Surgical Advocacy Days, November 12–13, Tallahassee. Approximately 40 surgeons and surgical trainees participated in the annual event. Attendees discussed strategic advocacy, and visited with 23 Florida legislators in the state capitol to advocate for ensuring safe scope of practice, reducing prior authorization barriers to timely care, and obtaining state funding for bleeding control kits in schools and public spaces.
**Massachusetts Chapter (MCACS):** 66th Annual Meeting, December 7, Boston. Winners of the Top Gun Competition from UMass Memorial Medical Center (from left): John J. Kelly, MD, FASMBS, FACS, team mentor; Donald R. Czerniach, MD, FACS; Max Hazeltine, MD; Joshua Scurluck, MD, PGY-5; Edward Kim, MD, PGY-1; and Neal E. Seymour, MD, FACS, Top Gun Chair.

**Michigan Chapter:** Third Annual Initiate Breakfast, October 28, San Francisco, CA. The breakfast, held at Clinical Congress 2019, was an opportunity for the chapter to congratulate new ACS Fellows from Michigan, introduce them to chapter leadership, and invite them to become members.

**New York Chapter:** Annual Membership Dinner, November 12, Manhattan. Marina Kurian, MD, FACS, Chapter President, provided updates to members on chapter activities, delivering education on a regional basis, and hosting a reception during Surgical Education Week. The meeting also featured a discussion on telemedicine and how it is affecting health care. Arthur Cooper, MD, FACS, and William Doscher, MD, FACS, New York Chapter Governors and Co-Chairs of the New York Chapter Legislative Committee, updated members on legislative and regulatory issues affecting surgical care.

**Puerto Rico Chapter:** Ordinary Meeting and Lecture, November 14, San Juan. Francesca Fiorito-Torres, MD, spoke on use of onabotulinum toxin in the management of migraines. The meeting also introduced new Fellows to chapter members and invited them to join.

Photo, from left: Lidia Guerrero, DMD, FACS; Yvonne Baerga, MD, FACS, ACS Governor; Milagros Fernandez, MD, FACS; and Elizabeth Perazza, MD, FACS, Chapter President.
Domestic Chapter Membership Challenge Award:
October 30, San Francisco, CA. This inaugural award was given to the Ohio Chapter and New York Chapter at the Board of Governors (B/G) Adjourned Meeting at Clinical Congress 2019. The six-month challenge saw a 15 percent increase in membership among the 17 participating chapters.

Photo, from left: Terry L. Buchmiller, MD, FACS, then-B/G Member Services Pillar Lead; Steven Stain, MD, FACS, then-B/G Chair; John Como, MD, FACS, President, Ohio Chapter; David Wormuth, MD, FACS, Governor, New York Chapter; and Daniel Dent, MD, FACS, then-B/G Vice-Chair.

INTERNATIONAL CHAPTERS

Argentina Chapter: 98th Argentine Surgical National Meeting, October 14–17, Buenos Aires. As a recipient of the 2019 International Chapter Opportunity Program (the Dr. Pon Fund), the chapter organized the Gastrointestinal Surgical Emergencies Postgraduate Course at the National Meeting. Course directors Alberto Ferreres, MD, FACS(Hon) (left), and Richard Schulick, MD, MBA, FACS, address attendees.
Uruguay Chapter: Chapter Meeting and Federación Latinoamericana de Cirugía Annual Congress, December 2–5, Punta Del Este. Roberto Taruselli, MD, FACS, Chapter Governor (fifth from right), and other local dignitaries welcomed special guests Gerald M. Fried, MD, FACS, FRCSC, Past-Chair, Board of ACS Regents, and ACS Immediate Past-President Ronald V. Maier, MD, FACS, FRCSEd(Hon), FCSHK(Hon), FCCS(Hon) (both to the immediate left of Dr. Taruselli).

Philippines Chapter: Annual Meeting, December 3, Mandaluyong City, Metro Manila, held in conjunction with the Philippine College of Surgeons Clinical Congress. ACS President Valerie W. Rusch, MD, FACS (fifth from left), with Ray B. Malilay, MD, FACS, Chapter Governor, and Nilo De Los Santos, MD, FACS, Chapter President (both to the immediate right of Dr. Rusch), as well as other leaders from the Philippines Chapter.

Japan Chapter: Reception, October 28, San Francisco, CA. A reception was held in conjunction with Clinical Congress 2019. More than 50 participants attended, including members of the Japan Chapter, ACS leadership, and other ACS chapters.
The American College of Surgeons (ACS) Division of Education and the International Relations Committee (IRC) are offering three international scholarships focused on surgical education in 2020. These awards will provide faculty members from countries other than the U.S. and Canada the opportunity to participate in a variety of development activities to gain new knowledge and skills that will be useful in improving surgical education and training in the scholar’s home institution and country.

The scholars will participate in the annual ACS Clinical Congress, including the Surgical Education: Principles and Practice course, as well as other plenary sessions and courses that address surgical education and training across the continuum of professional development. This continuum may include the needs of practicing surgeons across their entire careers, as well as the needs of surgery residents, medical students, and other members of the surgical team.

Following the Clinical Congress, each scholar will visit two Level I ACS-Accredited Education Institutes (ACS-AEIs) selected in advance based on the scholars’ interest areas in surgical education and training. At the conclusion of the Clinical Congress and their visits to the ACS-AEIs, each scholar will send to the IRC and the Division of Education a report outlining the outcomes that have been achieved as a result of the scholarship, specifically focusing on achievement of the objectives outlined in their application for the scholarship. The scholarships will facilitate the scholars’ involvement in subsequent collaborative ventures in education and training under the aegis of the ACS Division of Education.

Each scholarship includes a stipend of $10,000, supporting travel and per diem in North America and the cost of courses at the Clinical Congress and at the ACS-AEIs to be visited. Clinical Congress registration and fees for attendance at the Surgical Education: Principles and Practice course will be provided gratis.

**Requirements**

Applicants must provide documentation of prior experience in surgical education and training, such as involvement in the development and evaluation of education modules, use of novel teaching and assessment strategies, or curriculum design. In addition, applicants must submit a one-paragraph description of their education philosophies, a list of specific educational goals and objectives for their visits, and evidence of support of these goals and objectives from the leadership at their home institutions. These documents will be reviewed by the Division of Education as part of the selection process. At least five years of experience is required beyond completion of all training and fellowships.

Scholarships must be used in the year awarded; they may not be postponed.

Full scholarship requirements for this program are available on the ACS website at facs.org/issurged. The application for the scholarship may be accessed at the bottom of the requirements page. Questions should be directed to scholarships@facs.org.

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A LEGACY OF QUALITY IMPROVEMENT

QUALITY PROGRAMS
of the AMERICAN COLLEGE
OF SURGEONS

facs.org/quality-programs
**MEETINGS CALENDAR**

**Calendar of events**

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

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**FEBRUARY**

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

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**MARCH**

**Egypt Chapter**
March 5–6
Cairo, Egypt
Contact: Prof. Mohey Elbanna,
moheyelbanna@yahoo.com,
egyptianchapter-acs.com

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

**Maryland Chapter**
March 7
Annapolis, MD
Contact: Kathy Browning,
kathy@marylandacs.org,
marylandacs.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

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**APRIL**

**120th Annual Congress of the Japan Surgical Society**
April 16–18
Yokohama, Japan
Contact: Congress Secretariat,
120jss@convention.co.jp,
jss.or.jp/jss120/

**Annual Congress of the German Society of Surgery**
April 21–24
Berlin, Germany
Contact: Dr. Ernst Klar,
Ernst.Klar@med.uni-rostock.de

**Indiana Chapter**
April 24–25
Noblesville, IN
Contact: Tom Dixon,
chapterexec@infacs.org,
infacs.org

**South Dakota and North Dakota Chapters**
April 24–25
Sioux Falls, SD
Contact: Terry Marks,
tmarks@sdsma.org

**Trinidad and Tobago Chapter**
April 26
Piarco Trinidad, West Indies
Contact: Dr. Lakhan Roop,
acs.chapter.tt@gmail.com

**Puerto Rico Chapter**
April 30–May 2
San Juan, Puerto Rico
Contact: Aixa Velez-Silva,
acspuertoricochapter@gmail.com,
acspuertoricochapter.org

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**MAY**

**Florida Chapter**
May 1–2
Orlando, FL
Contact: Brian Hart,
bhart@floridafacs.org,
floridafacs.org

**Missouri Chapter**
May 2–3
Lake Ozark, MO
Contact: Denise Boland,
MissouriChapterACS@gmail.com,
moacs.org

**West Virginia**
May 7–9
White Sulphur Springs, WV
Contact: Ashley Wiley,
westvirginiaacs@gmail.com

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**FUTURE CLINICAL CONGRESSES**

2020
October 4–8
Chicago, IL

2021
October 24–28
Washington, DC

2022
October 16–20
San Diego, CA